DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Manchester VA Medical Center

New Hampshire

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Figure 1. Manchester VA Medical Center, Manchester, New Hampshire (Source: https://vaww.va.gov/directory/guide/, accessed on June 26, 2019)

Abbreviations

ADPNS	associate director for Nursing and 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 Manchester 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 inspections 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 inspection, 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 June 3, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, chief of staff, associate director for Nursing and Patient Care Services (known as ADPNS at the facility), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure with the Executive Council having oversight for several working groups. The director and chief of Quality Management were co-chairs of the Quality, Safety, and Value Council, which was responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes. The facility's leaders had been working together for 14 months, although several had served in their position for years.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders appeared engaged and promoted a culture of safety where employees feel safe bringing forward issues and concerns, but opportunities exist for improvement. The selected outpatient experience survey scores for facility leaders were better than the VHA average, and facility leaders had implemented processes and plans to maintain positive patient experiences.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[1] disclosures of adverse patient events, and patient safety indicator data and identified a substantial organizational risk factor—support services availability. The OIG is concerned with the different standards of care, depending on the hour of the day.

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 leaders 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 "4-star" quality ratings.[3]

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[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.)

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

The OIG noted deficiencies in seven of the eight clinical areas reviewed and issued 17 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 reviews and resuscitation episode review. However, the OIG identified a deficiency with inclusion of required content, specifically consideration of relevant literature, in root cause analyses.

Medical Staff Privileging

The facility generally complied with requirements for privileging. However, the team identified deficiencies with the FPPE and OPPE processes.[4]

Environment of Care

Generally, the facility met privacy measures. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified noncompliance with environment of care cleanliness, infection prevention, and safety at the parent facility.

Mental Health

Generally, the OIG team found compliance with many of the performance indicators, including the designation of a military sexual trauma (MST) coordinator and tracking of MST-related data. However, there were concerns with communication of MST-related issues, services, and initiatives with local leadership; referral for MST-related care of patients with positive MST screens; and completion of MST mandatory training.

Geriatric Care

The OIG team found a lack of providers documenting justification (clinical indication) for medication initiation, patient and/or caregiver education, providers evaluating patient and/or caregiver understanding of education, and medication reconciliation.

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[4] 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."

Women's Health

The facility complied with many of the performance indicators, including requirements for a designated women veterans program manager and clinical champion, clinical oversight of the women's health program, and follow-up care when indicated. However, the team noted noncompliance with the communication of results to patients within the required time frame.

High-Risk Processes

The OIG noted compliance with some of the performance indicators for the operations and management of the urgent care center (UCC). However, the OIG identified deficiencies with required nurse staffing, backup call schedules for UCC providers, and availability of support services.

Summary

In reviewing key healthcare processes, the OIG issued 17 recommendations for improvement directed to the director, associate director and chief of staff. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The 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 75–76, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

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 Manchester 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.[5] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[6] 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)

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[5] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (The website was accessed on January 24, 2019.)

[6] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (The website was accessed on January 24, 2019.)

9. High-risk processes (specifically the emergency department and urgent care center operations and management).[7]
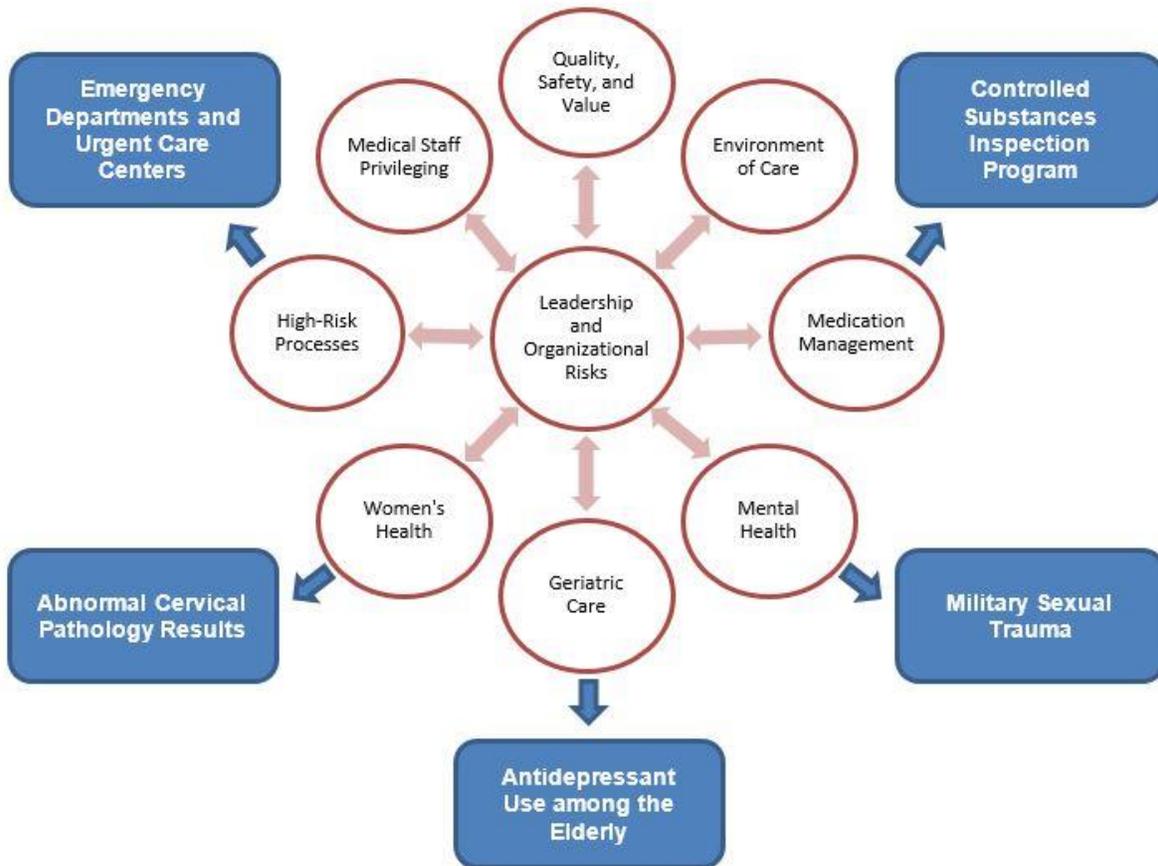
Figure 2. Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

[7] 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;[8] 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 August 15, 2015, through June 7, 2019, the last day of the unannounced week-long site visit. While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.[9]

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.

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

[9] 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.[10] To assess the facility's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement

2. Employee satisfaction

3. Patient experience

4. Accreditation and/or for-cause surveys and oversight inspections

5. Factors related to possible lapses in care

6. VHA performance data

Executive Leadership Position Stability and Engagement

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

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[10] 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.)

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     │ Chief of Staff  │     │      ADPNS       │    │ Associate Director│ │
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Chief of Staff	ADPNS	Associate Director	
Chaplain Community of Care Compensation and Pension Dental Geratrics and Extended Care Medicine Mental Health Optometry Pathology and Laboratory Physical Medicine and Rehabilitation Primary Care Prosthetics Radiology Research Surgery Urgent Care Virtual Medicine	Employee Education Nursing Pharmacy Social Work Sterile Processing Service	Business Office Clinical Engineering Facilities Fiscal Human Resources Logistics Nutrition and Food Office of Information and Technology Police Voluntary	Quality Management

Figure 3. *Facility Organizational Chart[11]*
Source: Manchester VA Medical Center (received June 3, 2019)

At the time of the OIG site visit, the executive team had been working together for approximately 14 months, although several team members have been in their position for many years (see Table 1). Both the director and chief of staff received permanent appointments after serving in acting capacities. The associate director, having been in the position for almost three years, was the most tenured member of the team.

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[11] At this facility, the director is responsible for Quality Management.

Table 1. Executive Leader Assignments

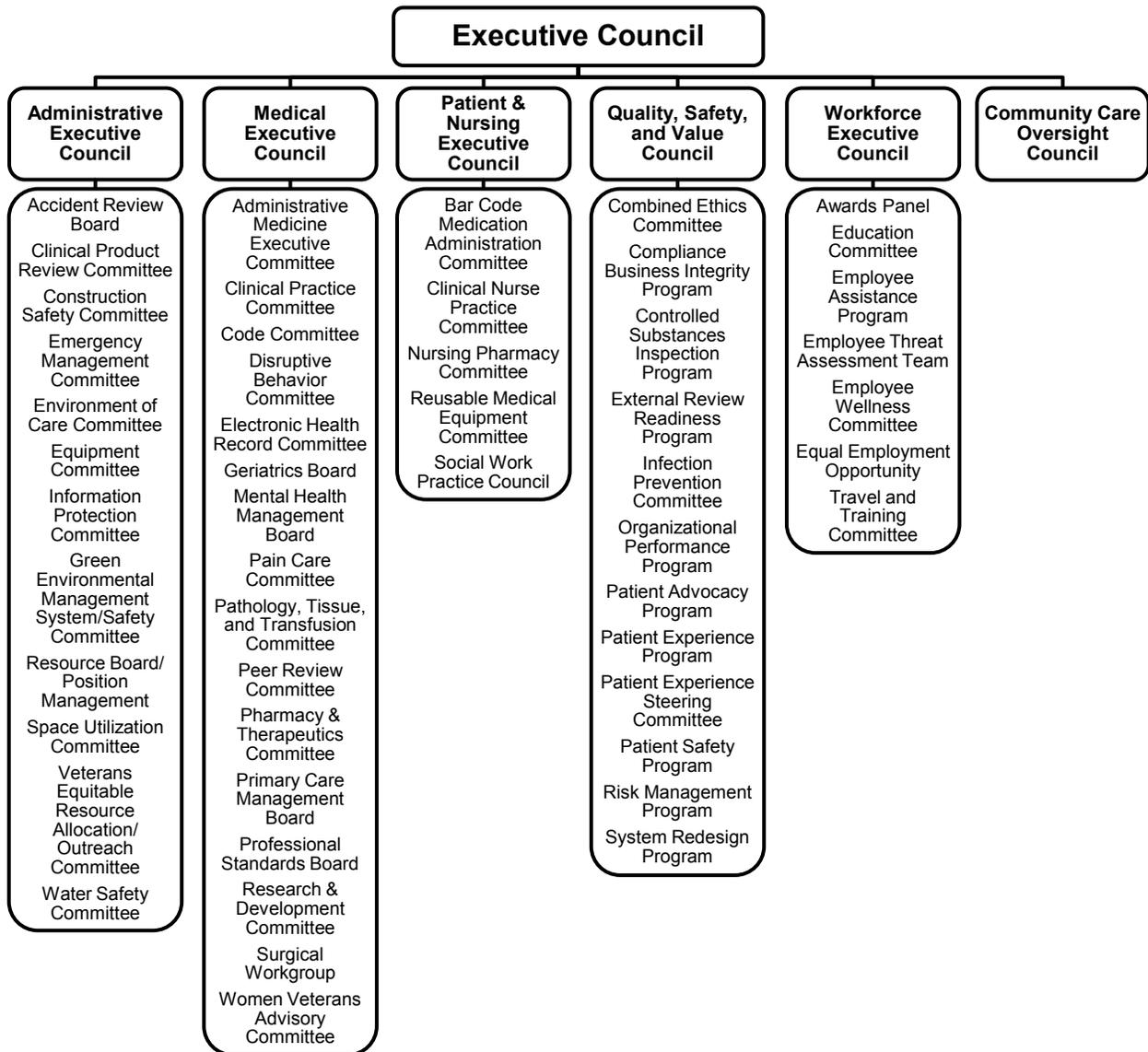| Leadership Position	Assignment Date
Facility director	July 16, 2017 (acting), April 1, 2018 (permanent)
Chief of staff	March 13, 2018 (acting), May 27, 2018 (permanent)
Associate director for Nursing and Patient Care Services	January 21, 2018
Associate director	October 16, 2016

Source: Manchester VA Medical Center's human resources officer (received June 3, 2019)

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

In individual interviews, these executive leadership team members 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 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 Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Council oversees various working groups, such as the Administrative Executive, Medical Executive, and Workforce Executive Councils.

These leaders are also engaged in monitoring patient safety and care through the Quality, Safety, and Value Council, for which the director and chief of Quality Management are co-chairs. The Quality, Safety, and Value Council is responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes and reports to the Executive Council. See Figure 4.

Executive Council

| Administrative Executive Council | Medical Executive Council | Patient & Nursing Executive Council | Quality, Safety, and Value Council | Workforce Executive Council | Community Care Oversight Council |

Administrative Executive Council
- Accident Review Board
- Clinical Product Review Committee
- Construction Safety Committee
- Emergency Management Committee
- Environment of Care Committee
- Equipment Committee
- Information Protection Committee
- Green Environmental Management System/Safety Committee
- Resource Board/Position Management
- Space Utilization Committee
- Veterans Equitable Resource Allocation/Outreach Committee
- Water Safety Committee

Medical Executive Council
- Administrative Medicine Executive Committee
- Clinical Practice Committee
- Code Committee
- Disruptive Behavior Committee
- Electronic Health Record Committee
- Geriatrics Board
- Mental Health Management Board
- Pain Care Committee
- Pathology, Tissue, and Transfusion Committee
- Peer Review Committee
- Pharmacy & Therapeutics Committee
- Primary Care Management Board
- Professional Standards Board
- Research & Development Committee
- Surgical Workgroup
- Women Veterans Advisory Committee

Patient & Nursing Executive Council
- Bar Code Medication Administration Committee
- Clinical Nurse Practice Committee
- Nursing Pharmacy Committee
- Reusable Medical Equipment Committee
- Social Work Practice Council

Quality, Safety, and Value Council
- Combined Ethics Committee
- Compliance Business Integrity Program
- Controlled Substances Inspection Program
- External Review Readiness Program
- Infection Prevention Committee
- Organizational Performance Program
- Patient Advocacy Program
- Patient Experience Program
- Patient Experience Steering Committee
- Patient Safety Program
- Risk Management Program
- System Redesign Program

Workforce Executive Council
- Awards Panel
- Education Committee
- Employee Assistance Program
- Employee Threat Assessment Team
- Employee Wellness Committee
- Equal Employment Opportunity
- Travel and Training Committee

Figure 4. Facility Committee Reporting Structure[12]
Source: Manchester VA Medical Center (received June 3, 2019 and October 31, 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

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[12] The Executive Council directly oversees the Community Care Oversight Council.

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 each selected survey leadership questions was similar to or higher than the VHA average.[14] The response averages for the director and chief of staff were higher than the facility and VHA averages for all four selected survey questions, while the results for the ADPNS were similar to or higher than the facility and VHA scores. Three of the associate director scores were lower than the facility average and two were lower than VHA average. The director discussed initiatives to improve employee satisfaction including rounding regularly and appearing in videos with staff to support the message of the month on the facility's website. In all, employees appear generally satisfied with facility leaders.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPNS Average	Assoc. Director Average
All Employee Survey: Servant Leader Index Composite[15]	0–100 where HIGHER scores are more favorable	71.7	74.6	94.6	81.6	73.5	76.2

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[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	ADPNS Average	Assoc. Director Average
All Employee Survey: In my organization, senior leaders generate high levels of motivation and commitment in the workforce.	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.6	4.4	4.0	3.9	3.4
All Employee Survey: My organization's senior leaders maintain high standards of honesty and integrity.	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.7	4.4	4.0	4.0	3.2
All Employee Survey: I have a high level of respect for my organization's senior leaders.	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.7	4.5	4.1	3.9	3.4

Source: VA All Employee Survey (accessed May 2, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that except for the associate director, the facility and executive leadership team averages for the selected survey questions were similar to or better than the VHA average. Opportunities exist for the associate director to provide an environment where employees feel safe bringing forth issues and concerns. According to the director, the focus last year was increasing clinical staff positions, which may have led to the administrative staff that report to the associate director having felt overlooked, and may have resulted in lower than average associate director scores.

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	ADPNS Average	Assoc. Director Average
All Employee Survey: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.8	4.8	4.2	4.1	3.8
All Employee Survey: *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).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.7	4.5	4.1	3.9	3.4
All Employee Survey: *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)?*	0 (Never) – 6 (Every Day)	1.5	1.5	0.3	1.4	1.5	2.1

Source: VA All Employee Survey (accessed May 2, 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 for two of the four survey questions applicable to this facility that reflect patients' attitudes toward facility leaders (see Table 4). Of the two outpatient survey questions, results reflected higher care ratings than the VHA average. Patients were generally satisfied with the leadership and care provided. Facility leaders appeared to be actively engaged with patients; for example, the director's initiative to conduct meetings and broadcasts with local media to inform veterans and the community of benefits and changes at the facility, rounding to talk with veterans, contacting veterans with concerns, and removing the locked doors to the executive area of the facility.

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

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): Would you recommend this hospital to your friends and family?[17]	The response average is the percent of "Definitely Yes" responses.	66.9	n/a
Survey of Healthcare Experiences of Patients (inpatient): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.2	n/a
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.3	82.5
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.5	77.8

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28,2018)
n/a = not applicable

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.[18] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint

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[17] The facility does not have inpatient beds.

[18] 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.

Commission (TJC).[19] Indicative of effective leadership, the facility has closed all recommendations for improvement.[20]

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 the College of American Pathologists.[21] Additional results included the Long Term Care Institute's inspection of the facility's CLC.[22]

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[19] 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."

[20] 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.

[21] 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.

[22] 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.ltciorg.org/about-us/. (The website was accessed on March 6, 2019.)

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 (*Combined Assessment Program Review of the Manchester VA Medical Center, Manchester, New Hampshire, Report No. 15-00620-548, September 30, 2015*)	August 2015	8	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Manchester VA Medical Center, Manchester, New Hampshire, Report No. 15-00171-533, September 30, 2015*)	August 2015	1	0
OIG (*Healthcare Inspection Inconsistent Transfer Procedures for Urgent Care Clinic Patients with Stroke Symptoms Manchester VA Medical Center, Manchester, New Hampshire, Report No. 15-03288-362, September 7, 2017*)	June 2015	3	0
TJC Ambulatory Accreditation	July 2018	16	0
TJC Behavioral Health Care Accreditation		8	0
TJC Home Care Accreditation		6	0
TJC For Cause (Ambulatory Accreditation)	September 2017	6	0
TJC For Cause (Follow Up)	March 2018	0	n/a

Sources: OIG and TJC (Inspection/survey results received from the chief of Quality on June 4, 2019)
n/a = not applicable.

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable

data and reporting mechanisms. Table 6 lists the reported patient safety events from August 15, 2015 (the prior comprehensive OIG inspection), through June 7, 2019.[23]

Table 6. Summary of Selected Organizational Risk Factors (August 15, 2015, through June 7, 2019)

Factor	Number of Occurrences
Sentinel Events[24]	1
Institutional Disclosures[25]	3
Large-Scale Disclosures[26]	0

Source: Manchester VA Medical Center's chief of Quality Management (received June 3, 2019)

Patient safety indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services provide information on potential in-hospital complications and adverse events following surgeries and procedures.[27] However, this data is not applicable since inpatient care is not provided at the facility.

The OIG's review of accreditation organization findings, sentinel events, and disclosures identified a substantial organizational risk factor—support services availability. The OIG is also concerned with inconsistent availability of care. For example, the urgent care clinic lacks access to on-site support services during evenings, nights, weekends, and holidays. Additionally, anesthesia staff respond to cardiorespiratory emergencies only on Mondays through Fridays from

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[23] 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 Manchester VA Medical Center is a low complexity (3) facility as described in Appendix B.)

[24] 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."

[25] 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."

[26] 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."

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

7:00 a.m. to 3 p.m. to provide advanced airway support (intubation),[28] and there is no advanced airway support available during all other hours. Additional concerns are addressed under the results for the High-Risk Processes topic (see page 48).

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 5 describes the distribution of facilities by star rating.[30] As of June 30, 2018, the facility was rated as "3-star" for overall quality.

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[28] Merriam-Webster defines intubation as "the introduction of a tube into a hollow organ (such as a trachea)" https://www.merriam-webster.com/dictionary/intubation (This site was accessed June 13, 2019.)

[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.)
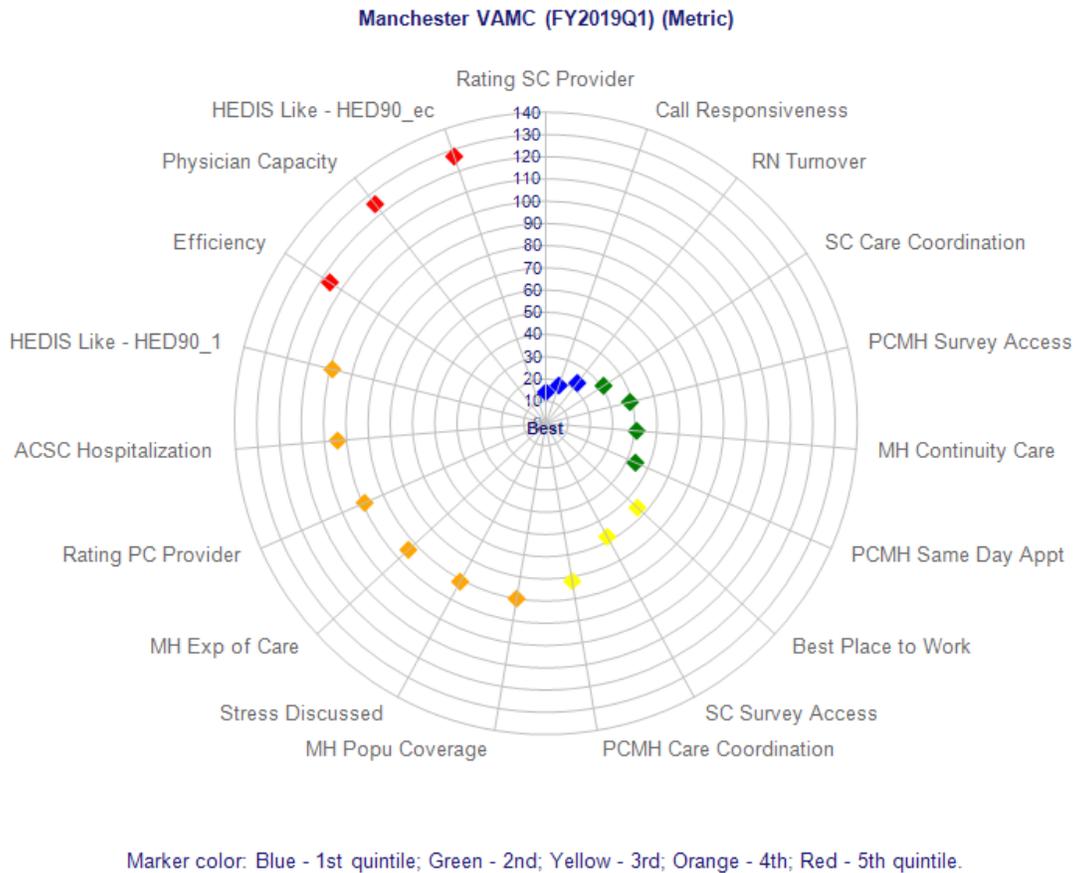
[30] According to the methods established by the SAIL Model, this is based on normal distribution ranking of the quality domain for 130 VA Medical Centers.
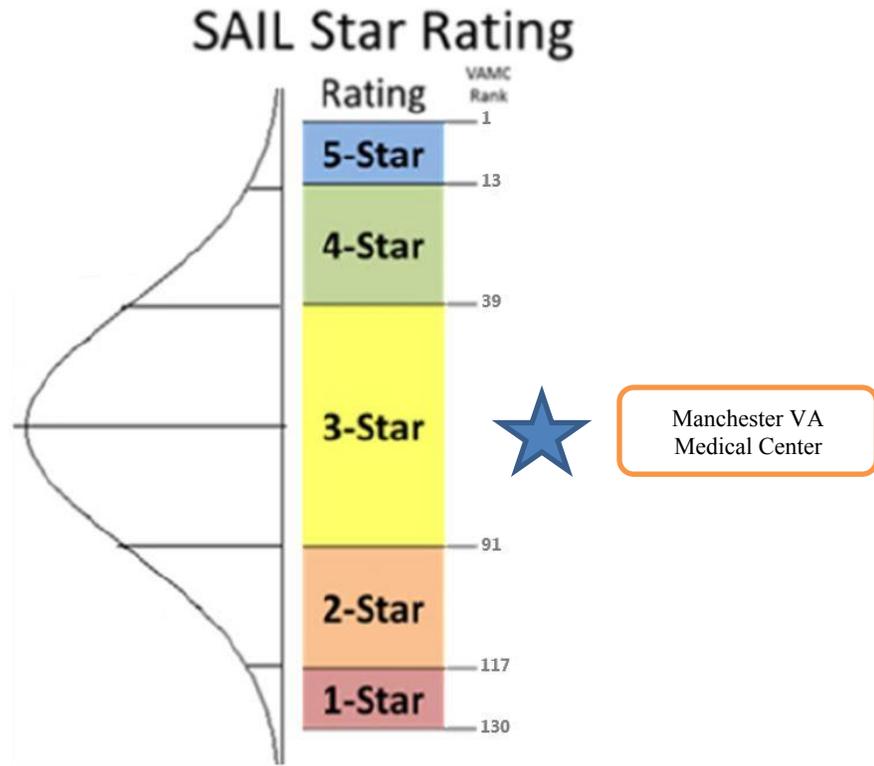
Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed May 2, 2019)

Figure 6 illustrates the facility's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of rating (of) specialty care (SC) provider, registered nurse (RN) turnover, and mental health (MH) continuity (of) care). Metrics that need improvement are denoted in orange and red (for example, MH population (popu) coverage, ambulatory care sensitive conditions (ACSC) hospitalizations, and physician capacity).[31]

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

Figure 6 title: **Manchester VAMC (FY2019Q1) (Metric)**

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

Figure 6. *Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 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

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[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 7 summarizes the rating results for the facility's CLC as of December 31, 2018. The facility has an overall "4-star" rating. Its rating for quality is also "4-star."

**Table 7. Facility CLC Star Ratings
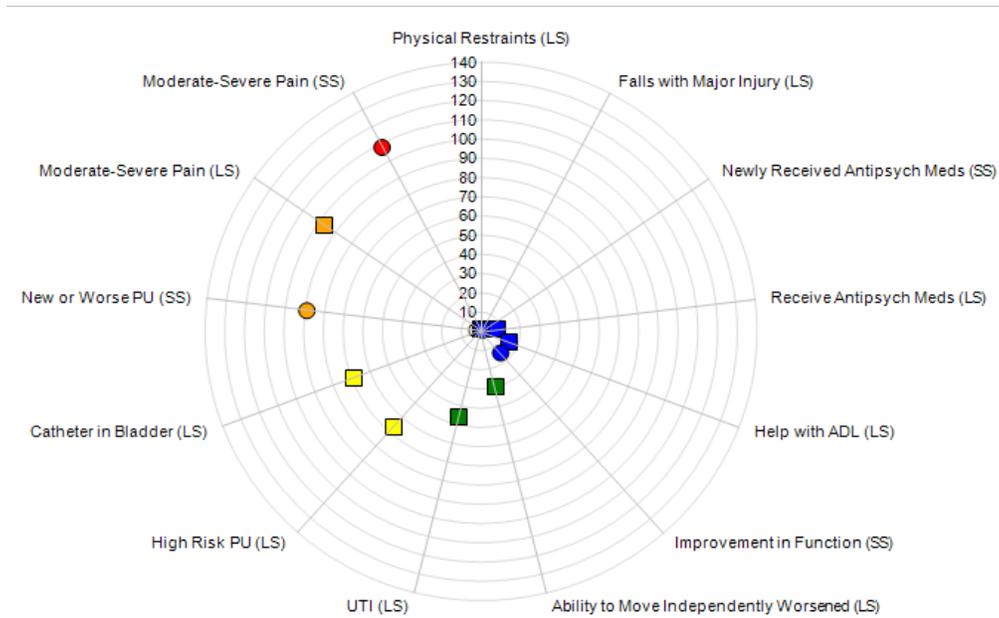(as of December 31, 2018)**

Domain	Star Rating
Unannounced Survey	3
Staffing	5
Quality	4
Overall	4

Source: VHA Support Service Center

In exploring the reasons for the "4-star" quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 7 illustrates the facility's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of falls with major injury–long stay (LS), newly received antipsychotic (antipsych) medications–short stay (SS), and urinary tract infection (UTI) (LS)). Metrics that need improvement and were likely the reasons why the facility had a "4-star" for quality, are denoted in orange and red (for example, new or worse pressure ulcer (PU) (SS), moderate-severe pain (LS), and moderate-severe pain (SS)).[34]

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

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

Figure 7. Facility CLC Quality Measure Rankings (as of December 31, 2018)
LS = Long-Stay Measure   SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team is generally stable and has active engagement with employees and patients as evidenced by high satisfaction scores. Organizational leaders appeared to support patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the facility through active stakeholder engagement). The OIG's review of accreditation organization findings, sentinel events, and disclosures identified a substantial organizational risk—the lack of available support services. Specifically, the OIG is concerned with the urgent care clinic's lack of access to onsite support services during evenings, nights, weekends, and holidays and limited availability of staff to provide consistent and immediate advanced airway support for cardiopulmonary resuscitation events. The senior leadership team was actively engaged and knowledgeable about selected SAIL metrics and are taking actions to sustain and improve care and performance of selected metrics likely contributing to the facility's "3-Star" and CLC's "4-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 nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[42]

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[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] According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." This directive expired July 31, 2019.

[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.

[42] VHA Directive 1190.

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
    - Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee

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[43] VHA Directive 1117(2).

[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 inspections, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

- o Peer review of all applicable deaths within 24 hours of admission to the hospital[47]

- o Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[48]

- UM[49]

  - o Completion of at least 75 percent of all required inpatient reviews

  - o Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database

  - o Interdisciplinary review of UM data

- Patient safety

  - o Annual completion of a minimum of eight root cause analyses[50]

  - o Inclusion of required content in root cause analyses (generally)

  - o Submission of completed root cause analyses to the National Center for Patient Safety within 45 days

  - o Provision of feedback about root cause analysis actions to reporting employees

  - o Submission of annual patient safety report to facility leaders

- Resuscitation episode review

  - o Evidence of a committee responsible for reviewing resuscitation episodes

  - o Confirmation of actions taken during resuscitative events being consistent with patients' wishes

  - o Evidence of basic or advanced cardiac life support certification for code team responders

  - o Evaluation of each resuscitation episode by the CPR Committee or equivalent

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[47] The facility does not provide inpatient care.

[48] VHA Directive 1190. The facility does not provide inpatient mental health care.

[49] The facility does not provide inpatient care.

[50] According to VHA Handbook 1050.01, "the requirement for a total of eight [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of [root cause analyses] is driven by the events that occur and the [Safety Assessment Code] SAC score assigned to them. At least four analyses 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 and resuscitation episode review. OIG is concerned with the availability of advanced airway support for resuscitations only being available when anesthesia staff is onsite Monday–Friday during regular business hours. However, the OIG identified a deficiency with inclusion of required content in root cause analyses that warranted a recommendation for improvement.

Specifically, VHA requires that root cause analyses include specific content to ensure the reviews are thorough and credible. This includes "determination of the human and other factors most directly 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 found that for three of five reviews conducted, relevant literature was not considered. This resulted in reviews that may not have considered current knowledge of the topic. The patient safety manager reported that consideration of relevant literature was not emphasized in the root cause analyses training as a requirement and was not a required field in WebSPOT, VHA's root cause analysis documentation tool.[52]

Recommendation 1

1. The facility director confirms that the patient safety manager includes consideration of relevant literature in root cause analyses and monitors patient safety manager's compliance.

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[51] VHA Handbook 1050.01.

[52] WebSPOT is the software application used for reporting and documenting adverse events in the VHA Patient Safety Information System.

Facility concurred.

Target date for completion: 12/12/2019

Facility response: The Patient Safety Manager (PSM) has included a literature review in all root cause analyses since June 2019; it had previously been considered, but not included, if there was no significant pertinent information. The literature reviews have been entered into the national database, WebSPOT, and along with a synopsis are now reported as "RCA exits" to the Quality, Safety, and Value Council (QSVC) as part of the PSM's standing quarterly report. Root cause analysis exits include only the information that is not protected quality assurance information, as QSVC minutes are open to all employees. During the October 10th, 2019 QSVC meeting, (the first since the OIG visit); 2/2, or 100%, included required literature citation. During the December 12th, 2019 meeting, QSVC will review any root cause data for a sixth month. The Medical Center Director is chair of QSVC, they RCAs are reviewed in council, and the minutes are signed by the Director. Plan for sustainment: all RCA exits will continue to be reported quarterly to QSVC or until provided superseding direction.

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).[53]

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 reprivileging prior to their expiration.[54]

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."[55]

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.[56] 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.[57]

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:

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[53] 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.)

[54] VHA Handbook 1100.19.

[55] VHA Handbook 1100.19.

[56] 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).

[57] 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.)

- Eight 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 months[58]

- Ten LIPs hired within 18 months before the site visit

- Twenty LIPs re-privileged within 12 months before the visit

- No providers underwent a FPPE for cause within 12 months prior to the visit

The OIG evaluated the following performance indicators:

- Privileging

    o Privileges requested by the provider

        - Facility-specific

        - Service-specific

        - Provider-specific[59]

    o Approval of privileges for a period of less than, or equal to, two years

- Focused professional practice evaluations

    o Criteria defined in advance

    o Use of required criteria in FPPEs for selected specialty LIPs

    o Results and time frames clearly documented

    o Evaluation by another provider with similar training and privileges

    o Executive Committee of the Medical Staff consideration of FPPE results in its decision to recommend continuing the initially granted privileges

- Ongoing professional practice evaluations

    o Criteria specific to the service or section

    o Use of required criteria in OPPEs for selected specialty LIPs

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[58] The 18-month period was from December 3, 2017, through June 3, 2019. The 12-month review period covered June 3, 2018, through June 3, 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.

[59] 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.

- o Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities

  - o Evaluation by another provider with similar training and privileges

  - o Executive Committee of the Medical Staff's decision to recommend continuing privileges based on OPPE results

- Focused professional practice evaluations for cause

  - o Clearly defined expectations/outcomes

  - o Time-limited

  - o Provider's ability to practice independently not limited for more than 30 days

  - o Shared with the provider in advance

- Reporting of privileging actions to National Practitioner Data Bank

Medical Staff Privileging Conclusion

The OIG team found general compliance with requirements for privileging. However, during review of the Professional Standards Board minutes, the team found that the Professional Standards Board was not able to evaluate approved clinical privileges for four providers, three predominately administrative and one who responds to medical consult requests, who did not have FPPEs completed due to their low volume of patients seen. The OIG noted that their requested privileges are beyond the scope of their current duties. The OIG also identified deficiencies with the FPPE and OPPE processes that warranted recommendations for improvement.

Specifically, VHA requires the criteria for the FPPE process "to be defined in advance, using objective criteria accepted by the practitioner."[60] All 13 practitioner's profiles lacked evidence that providers were aware of the criteria for evaluation before initiation of the FPPE process. This could result in providers' misunderstanding of the FPPE expectations. The chief of staff reported the service chiefs discussed the evaluation criteria with the providers but did not document the discussion.

Recommendation 2

2. The chief of staff ensures that clinical managers document in practitioners' profiles the focused professional practice evaluation criteria defined in advance and monitors clinical managers' compliance.

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[60] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: 1/31/2020

Facility response: Every FPPE electronic form has been adapted to the requirements and performance indicators of the specialty; the templates are maintained by the credentialing coordinator and were approved in the Medical Executive Council on June 11th, 2019. Since that date, 100% of FPPEs has been initiated and/or completed in a revised format. Service line managers report FPPE status—both completion rate and use of the correct form—to the chief of staff; FPPE status is also reviewed in Medical Executive Council and outliers would be reported to the Executive Council. January 31, 2020 will mark the sixth month of monitoring and allow for the six-month meeting of Medical Executive Council for review—compliance will be considered reached when the number of FPPEs completed on the revised form is greater than or equal to 90% for the sixth month. The chief of staff is the chair of Medical Executive Council; they are also responsible for signing the minutes. Management, development, revisions, and approval are the responsibility of the Professional Standards Board and Medical Executive Council for maintenance in perpetuity; forms are maintained by the Credentialing Coordinator; the process owner is the chief of staff.

For OPPEs, VHA requires that at the time of reprivileging, service chiefs consider relevant service- and practitioner-specific data utilizing defined criteria when recommending the continuation of licensed independent practitioners' privileges to the Medical Executive Council. Such data are maintained as part of the practitioner's provider profile and may include direct observations, clinical discussions, and clinical record reviews.[61] VHA has also identified minimum-required specialty criteria for the professional practice evaluation of four specialty provider types, including gastroenterology.[62] The OPPE process is essential to confirm the quality of care delivered and "allows the facility to identify professional practice trends that impact the quality of care and patient safety."[63]

For 12 of 25 practitioners' profiles, there was no evidence of service-specific OPPE criteria. Furthermore, the OIG noted that the OPPE data collected for one of the gastroenterology practitioners did not include the minimum elements required by VHA. As a result, providers delivered care without a thorough evaluation of their practice. The chief of staff reported that all providers were evaluated on core competencies and the one gastroenterologist's OPPE was completed on the incorrect form due to a lack of oversight.

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[61] VHA Handbook 1100.19.

[62] VHA Memorandum, Requirements for Peer Review of Solo Practitioners, August 29, 2016.

[63] VHA Handbook 1100.19.

For 21 of 25 LIPs who were re-privileged, the facility's Medical Executive Council did not recommend renewal of privileges to the director prior to expiration of current privileges. This resulted in the facility missing the opportunity to identify professional practice trends that could impact the quality of care and patient safety. The chief of staff believed that the Medical Staff Executive Board, a committee with similar membership to the Medical Executive Council but not included in the facility's medical staff bylaws or governance structure, was the appropriate board to review, vote on, and recommend privileging actions to the director.

Recommendation 3

3. The chief of staff ensures that professional practice evaluations include service-specific criteria and monitors compliance.

Facility concurred.

Target date for completion: 1/31/2020

Facility response: October 31st, 2019 was the end of the first full cycle for Ongoing Professional Practice Evaluations (OPPEs) but 100% of OPPEs were completed on the revised OPPE electronic forms that include service-specific criteria. The templates were approved in Medical Executive Council June 11th, 2019 and are maintained by the credentialing coordinator. In the same Medical Executive Council, revised FPPE electronic forms were approved; they are managed in the same way. All FPPE formats have been adapted to the requirements and performance indicators of the specialty. Service Line Managers report status to the chief of staff; PPE status is also reviewed in the Medical Executive Council and outliers would be reported to the Executive Council. January 31st, 2020 will mark the sixth month of monitoring and allow for the meeting of Medical Executive Council for review. The chief of staff is the chair of the Medical Executive Council; they are also responsible for signing the minutes. Compliance is achieved when 90% of the OPPEs and 90% of the FPPEs are completed correctly on the revised forms. Management, development, revisions, and approval of both OPPE and FPPE electronic forms are the responsibility of the Professional Standards Board, and Medical Executive Council for management in perpetuity; they are maintained by the Credentialing Coordinator; the process owner is the chief of staff.

Recommendation 4

4. The chief of staff confirms that specialty providers' ongoing professional practice evaluations include the minimum required specialty criteria and monitors compliance.

Facility concurred.

Target date for completion: 1/31/2020

Facility response: October 31st, 2019 was the end of the first full cycle for Ongoing Professional Practice Evaluations (OPPEs) but 100% of OPPEs were completed on the revised OPPE electronic forms that include the minimum-required specialty-specific requirements and performance indicators. The templates were approved in Medical Executive Council on June 11th, 2019 and are maintained by the credentialing coordinator. Compliance will be considered reached when the number of OPPEs completed on the revised form is greater than or equal to 90%. Service Line Managers report status to the chief of staff; OPPE status is also reviewed in the Medical Executive Council and outliers would be reported to the Executive Council (none to date). The chief of staff is the chair of Medical Executive Council; they are also responsible for signing the minutes Management, development, revisions, and approval are the responsibility of the Professional Standards Board, and Medical Executive Council for maintenance in perpetuity; they are maintained by the Credentialing Coordinator; the process owner is the chief of staff.

Recommendation 5

5. The chief of staff makes certain that the facility's Medical Executive Council reviews the professional practice data in the consideration to continue provider privileges and monitors compliance.

Facility concurred.

Target date for completion: 1/31/2020

Facility response: Professional Practice Evaluations must include both a demonstration of skill as well as specialty-specific professional practice data in order to be approved. One issue highlighted by the OIG demonstrated an extra bureaucratic step added by a previous chief of staff for an additional committee; this step was removed in the Medical Executive Council on June 11th, 2019, along with the confusion associated. Starting October 1st, 2019 (new fiscal year) the chief of staff will identify any credentialing requests that are being made in the context of loss of privileges or license, and forward through Professional Standards Board and Medical Executive Council to the Executive Council (EC). As chair of the Executive Council, the Medical Center Director will ensure that a discussion and the reason for approval, in the context of negative action, is captured in the minutes of the Executive Council. The chief of staff will indicate to the Executive Council what is the status of the concurrence of the VISN chief medical officer. The chief of staff or associate director for nursing and patient services shall report clinicians removed from practice to the Executive Council, depending on the supervisor. Service line managers report status to the chief of staff; OPPE status is also reviewed in Medical Executive Council and outliers would be reported to the Executive Council (none to date). The chief of staff is the chair of Medical Executive Council; they are also responsible for signing the minutes. Compliance will be considered reached when the number of PPEs reported to MEC is greater than or equal to 90% for six months and six-month retrospective review of EC minutes demonstrates 90% or greater of removed staff members were reported to the council. The process owner is the chief of staff.

Additionally, VHA requires that providers with "similar training and privileges evaluate the privilege-specific competence of the practitioner and document evidence of competently performing the requested privileges of the facility."[64] In 8 of 37 professional practice evaluations (1 FPPE, 7 OPPEs), the OIG found that the evaluations were conducted by a provider who did not have similar training and privileges. This resulted in providers practicing without a comprehensive evaluation of their practice. The chief of staff reported challenges in identifying providers with similar training and privileges at a small facility and that service chiefs have reached out to other facilities for assistance.

Recommendation 6

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

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[64] VHA Memorandum, Requirements for Peer Review of Solo Practitioners, August 29, 2016.

Facility concurred.

Target date for completion: 12/26/2019

Facility response: The recommendation was provided to the chief of staff and credentialing coordinator at the time of OIG visit; credentialing coordinator immediately started verifying correct reviewers for each professional practice evaluation. Service Line Managers are responsible for identifying the peer reviewers for the professional practice evaluations; the credentialing coordinator verifies the reviewers and facilitates reviewers across the VISN if there are not enough peer reviewers. 100% (1/1) of FPPEs completed and 100% (5/5) of FPPEs started since June 2019 have been done by peers with similar privileges and training; it is annotated on the professional practice evaluation worksheet for the record. The worksheet is reviewed and captured in Professional Standards Board and reported to Medical Executive Council, the chief of staff is notified through committee minutes, and the worksheet and notification are recorded in the Medical Executive Council minutes. The Medical Executive Council will continue to review each professional practice evaluation into perpetuity; the six-month case-by-case review will be complete December 26th, 2019, if sustained greater than or equal to 90%. If less than 90%, case-by-case review of each peer assignment will extend until 90% or greater compliance is reached. The Chief of Staff is ultimately responsible for credentialing.

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.[65]

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.[66]

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.[67]

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.[68] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[69]

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[65] VHA Directive 1608, Comprehensive Environment of Care (CEOC Program), February 1, 2016.

[66] 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).

[67] 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.)

[68] VHA Directive 0320.01, Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures, April 6, 2017.

[69] VHA Directive 1028, *Electrical Distribution Systems*, July 25, 2014, TJC. Environment of Care standard EC.02.05.07.

Occupational Safety and Health Administration,[70] and National Fire Protection Association standards.[71] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[72]

In all, the OIG team inspected four areas—the CLC (east), urgent care center, outpatient clinic (Sunapee), and post-anesthesia care unit. The team also inspected the Somersworth VA Outpatient Clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility

  o General safety

  o Environmental cleanliness and infection prevention

  o General privacy

  o Women veterans program

  o Availability of medical equipment and supplies

- Community based outpatient clinic

  o General safety

  o Environmental cleanliness and infection prevention

  o General privacy

  o Women veterans program

  o Availability of medical equipment and supplies

- Locked inpatient mental health unit[73]

  o Mental health environment of care rounds

  o Nursing station security

  o Public area and general unit safety

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[70] 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).

[71] 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).

[72] TJC. Environment of Care standard EC.02.05.07.

[73] The facility did not have an inpatient mental health unit.

- o Patient room safety

- o Infection prevention

- o Availability of medical equipment and supplies

- Emergency management

  - o Hazard vulnerability analysis (HVA)

  - o Emergency operations plan (EOP)

  - o Emergency power testing and availability

Environment of Care Conclusion

Generally, the parent facility and the Somersworth VA Outpatient Clinic met privacy measures. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG team found sterile storage area shelving without a solid surface on the bottom shelf (corrected during the site visit) and built in storage units with bottom shelves less than eight inches above the floor in the UCC. The OIG also identified noncompliance at the parent facility with environmental cleanliness, infection prevention, and safety that warranted a recommendation for improvement.

Specifically, VHA[74] and TJC[75] require hospitals to identify environmental deficiencies, hazards, and unsafe practices and to keep furnishings and equipment safe and in good repair. In the CLC, urgent care center (UCC), and outpatient clinic, the OIG observed dirty/dusty heating, ventilation, and air conditioning grills. The CLC and outpatient clinic also had dirty floors and damaged walls, and the outpatient clinic and the UCC had stained ceiling tiles. The CLC also had dirty light fixtures. These conditions resulted in a lack of assurance of a clean and safe patient care environment. The chief of Facilities reported that communication between end users and facilities' workers had been a challenge in the past. In addition, the only supervisor on the second shift had the responsibility for cleaning and conducting quality control inspections which limited time for oversight.

Recommendation 7

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

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[74] VHA Directive 1608.

[75] TJC. Environment of Care standard EC.02.06.01.

Facility concurred.

Target date for completion: 12/31/2019

Facility response: Medical Facility Environment of Care (EOC) Rounds are completed weekly and as needed. All areas of the facility are visited at least quarterly on a rotating schedule. Since June 2019, the EOC rounds have specifically reviewed items identified by the surveyor to include distal end dust in vents, stained floors and ceiling tiles, and damage to the structures. One hundred and seventy items have been identified since June 6th, they are captured in the EOC tracking system and monitored until closed. The completion rate of open EOC items is monitored at the facility level by the Associate Director (who attends rounds), and at the VISN level by the Deputy Network Director. Attendance, as well as completion of action items or planning for all findings, are reported at the facility and VISN level. Manchester's FY18Q4-FY19Q3 rate of Resolution or Plan of Action rate within fourteen days was 97.7%; 9% over the national average. Facility Senior Attendance tracking is at 95% for the same period; 2% over national average; EOC team member participation was at 98.1% or 7% over the VA average. These metrics—to include issues with action plans, attendance, and resolution—are monitored by the Associate Director during morning huddle and will continue to occur in detail until December 31st, 2019 at which time, if the measure is greater than or equal to 90%, it will be transitioned to quarterly report at Administrative Executive Council.

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.[76] 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.[77]

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.[78]

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;[79] and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
    - o Monthly summary of findings to the director
    - o Quarterly trend reports to the director
    - o Quality Management Committee's review of monthly and quarterly trend reports
    - o Actions taken to resolve identified problems
- Pharmacy operations
    - o Staff restrictions for monthly review of balance adjustments[80]
- Requirements for controlled substances inspectors

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

[77] 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.

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

[79] The two quarters were from October 1, 2018, through March 31, 2019.

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

- o No conflicts of interest

- o Appointed in writing by the director for a term not to exceed three years

- o Hiatus of one year between any reappointment

- o Completion of required annual competency assessment

- Controlled substances area inspections

  - o Completion of monthly inspections

  - o Rotations of controlled substances inspectors

  - o Patterns of inspections

  - o Completion of inspections on day initiated

  - o Reconciliation of dispensing between pharmacy and each dispensing area

  - o Verification of controlled substances orders

  - o Performance of routine controlled substances inspections

- Pharmacy inspections

  - o Monthly physical counts of the controlled substances in the pharmacy

  - o Completion of inspections on day initiated

  - o Security and verification of drugs held for destruction[81]

  - o Accountability for all prescription pads in pharmacy

  - o Verification of hard copy controlled substances prescriptions

  - o Verification of twice a week (three days apart) inventories of the main vault[82]

  - o Quarterly inspections of emergency drugs

  - o Monthly checks of locks and verification of lock numbers

- Facility review of override reports[83]

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[81] 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."

[82] VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (This handbook was rescinded on May 1, 2019, and replaced by VHA Directive 1108.01, *Controlled Substances Management*.)

[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.

Medication Management Conclusion

Generally, the facility achieved the performance indicators listed above. The OIG noted that the staff responsible for conducting the monthly review of balance adjustments was not a pharmacy staff member as required; this was corrected while the OIG was still on site. The OIG made no recommendations.

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."[84] 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.[85]

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.[86] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[87]

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.[88] Those who screen positive must have access to appropriate MST-related care.[89] 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.[90]

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.[91] All mental health and primary care providers must complete MST mandatory

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

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

[86] VHA Directive 1115.

[87] 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.)

[88] 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."

[89] VHA Directive 1115.

[90] VHA Handbook 1160.01.

[91] 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.[92]

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 48 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

    o Establishes and monitors MST-related staff training

    o Establishes and monitors informational outreach

    o Communicates MST-related issues, services, and initiatives with local leaders

- Evidence of tracking MST-related data

- Provision of clinical care

    o Referral for MST-related care to patients with positive MST screens

    o Initial evaluation within 24 hours of referral for mental health services

    o 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 some of the performance indicators, including the designation of a facility MST coordinator and tracking of MST-related data. However, there were concerns with communication of MST-related issues, services, and initiatives with local leadership; referral for MST-related care to patients with positive MST screens; and completion of MST mandatory training that warranted recommendations for improvement.

Specifically, VHA requires that the MST coordinator communicates MST-related issues, services, and initiatives to facility leadership.[93] The OIG identified that MST issues, services, and initiatives were not communicated to facility leaders. Lack of communication between the

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[92] 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 and Operations and Management, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

[93] VHA Directive 1115.

MST coordinator and facility leaders impacts the latter's awareness of the current status of MST-related services and initiatives. The chief of Mental Health who started in the position March 4, 2019, had identified the lack of communication but did not correct the deficiency prior to the OIG's site visit.

Recommendation 8

8. The facility director ensures that military sexual trauma coordinator communicates the status of military sexual trauma-related information to leadership and monitors coordinator's compliance.

Facility concurred.

Target date for completion: December 31st, 2019

Facility response: The Military Sexual Trauma Coordinator has standing meetings with the Psychotherapy Program Manager, who can escalate issues to the Mental Health service line manager. The Military Sexual Trauma Coordinator also attends the monthly Mental Health Executive Committee (MHEC) for standing attendance and report and for discussing and relaying issues and program wins. The MST Coordinator has been actively participating for four months; issues that exceed the purview of the MHEC will be forwarded to Medical Executive Committee on either the standing quarterly report or more frequently, depending on the severity, scope or urgency of the issue. Attendance of the Military Sexual Trauma Coordinator at Mental Health Executive Committee will be monitored for six months until December 31st, 2019 to ensure greater than 90% attendance or written report. The Mental Health service line manager also reports MST program elements during the regular quarterly report to the Medical Executive Committee. If an issue is not resolved or important information needs to be disseminated at the Medical Executive Committee, it is forwarded to Executive Council for resolution. All four members of the executive leadership team are represented on Executive Council, the notification is also completed by dissemination of the minutes. The Medical Center Director signs the Executive Council minutes. The chief of staff is responsible for the needs, information, and requests of the MST program.

VHA requires a referral for MST-related care be offered to patients with positive MST screens.[94] The OIG estimated that 77 percent of the patients at the facility with positive MST-screens were not offered a referral for MST-related services, based on electronic health records reviewed.[95] This could result in missed opportunities to identify potential patient risks and provide the appropriate counseling, care, and service to patients who experienced MST. The chief of Mental

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[94] VHA Directive 1115.

[95] The OIG is 95 percent confident that the true compliance rate is somewhere between 65.1 and 89.1 percent, which is statistically significantly below the 90 percent benchmark.

Health reported the majority of patients were not offered a referral because the providers believed that documenting "in treatment with Mental Health" negated the need for a referral. Additionally, the chief of Mental Health reported that provider turnover contributed to a lack of training on the MST referral process.

Recommendation 9

9. The chief of staff ensures providers offer referrals for military sexual trauma-related services for patients with a positive screen and monitors providers' compliance.

Facility concurred.

Target date for completion: 12/26/2019

Facility response: The Mental Health Service Line Manager is responsible for ensuring that the service line conducts audits of positive MST-screens for compliance with a referral for MST-related care. These audits are reviewed by the Mental Health Service Line Manager and are reported to Medical Executive Committee as part of the standing quarterly report, additionally, it is reported directly to the chief of staff if the threshold (90% completion of referral) is not met. The notifications would be captured in the Medical Executive Committee minutes. Changes to the national MST template were requested to facilitate compliance; the Office of Mental Health and Suicide Prevention (OMHSP) has been tasked to complete the revision. Additionally, clinical service line managers provided education to their providers for referrals specific to MST care. The subsequent four-month audit showed 100% of all positive screens have received a referral for follow-on MST-specific care. Compliance is reached when 90% or greater of positive MST-screens received an MST-specific care referral for six months. Completion of the compliance period should occur by December 26th, 2019. The chief of staff is ultimately responsible for this program.

For mandatory MST-related staff training, VHA requires that all primary care and mental health providers complete MST mandatory training; for those hired after July 1, 2012, training must be completed no later than 90 days after assuming their position.[96] The OIG found that 5 of 12 providers hired after July 1, 2012, did not complete the required training within 90 days and one of the five had not completed the training at the time of OIG visit. This could potentially prevent clinicians from providing a consistent level of counseling, care, and service to patients who experienced MST. The chief of Mental Health and the acting chief of Primary Care reported that turnover in supervisors led to a lack of oversight and training.

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[96] VHA Directive 1115.01; Acting Deputy Under Secretary for Health and Operations and Management, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

Recommendation 10

10. The facility director 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: 4/30/2020

Facility response: Maintenance of the electronic learning system, where Military Sexual Trauma training is housed is being updated by the Talent Management System program. While that is being addressed, the facility education department is pulling the list of new employees and manually assigning the training to them. Due to historic assignment issues, the electronic learning system coordinator will report this information monthly to the MST Coordinator; compliance rates will be reported to Mental Health Executive Committee and failing to maintain 90% will be reported through Medical Executive Council to the Executive Committee. The chief of staff is the chair of the Medical Executive Council; they are also responsible for signing the minutes. The medical center director is the chair of the Executive Council; notification is documented in the minutes and they are signed by the director. Documentation will be captured in the minutes of each committee. Reporting will continue until the goal of 90% of compliance is met for 6 months. Reporting will extend to April 30th, 2020; if compliance issues still exist, reporting will extend until 90% compliance is reached. After compliance is reached, reporting will move to the quarterly Mental Health Service Line report to Medical Executive Committee. The Medical Center Director has ultimate responsibility to ensure completion of required training.

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."[97] 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.[98]

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 antidepression drugs, psychotherapy, or a combination of both."[99]

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.[100] 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."[101] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[102] 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.[103] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[97] 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.)

[98] *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.)

[99] 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.)

[100] 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.sigot.org/allegato_docs/1057_Beers-Criteria.pdf. (The website was accessed on March 22, 2018.)

[101] TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

[102] VHA Directive 1164, Essential Medication Information Standards, June 26, 2015.

[103] TJC. National Patient Safety Goal standard NPSG.03.06.01.

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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.[104]

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 32 patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[105] The OIG evaluated the following performance indicators:

- Justification for medication initiation

- Evidence of patient and/or caregiver education specific to the medication prescribed

- Clinician evaluation of patient and/or caregiver understanding of the education provided

- Medication reconciliation

Geriatric Care Conclusion

The OIG team found a lack of providers documenting justification (clinical indication) for medication initiation, patient and/or caregiver education, providers evaluating patient and/or caregiver understanding of education, and medication reconciliation. These findings warranted recommendations for improvement.

TJC requires that the patient's clinical record contain "initial diagnosis, diagnostic impression(s), or condition(s)" and "any diagnoses or conditions established during the patient's course of care, treatment, or services."[106] The OIG determined that providers justified the reason for initiating the medication in 63 percent of the electronic health records reviewed.[107] Without a justification of the reason for the medication, the clinical record lacks information that reflects the patient's care or treatment. The chief of Medicine reported recent turnover of both providers and leaders have led to compromised continuity of training, monitoring, and oversight.

Recommendation 11

11. The chief of staff ensures providers document indication for use for newly prescribed medications in patients' electronic health records and monitors providers' compliance.

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[104] VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

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

[106] TJC. Record of Care, Treatment, and Services standard RC.02.01.01.

[107] Confidence intervals are not included because the data represents every patient in the study population.

Facility concurred.

Target date for completion: 4/20/2020

Facility response: Electronic Health Record (EHR) audits have been completed on a sample of EHRs from June-August. 93% (23/25) of audited charts demonstrate an indication for new medication initiation. As a sustainment action, clinical indication for medication initiation has been added to all prescriber's EHR routine audits and education will be provided by the service chiefs to their prescribers before November 30th, 2019. EHR audits will be reported from Electronic Health Record Committee (EHRC) to the Medical Executive Committee for this metric. The chief of staff is the chair of Medical Executive Council; they are also responsible for signing the minutes. Compliance will be considered met when 90% of all EHR Committee audits demonstrate indication for new medication initiation (if applicable) for greater than six months (April 20th, 2020). Service Line Managers are responsible for developing action plans for each quarter out of compliance, which is also reported to EHRC. When compliance is sustained, reporting will become part of the EHRC's quarterly report. Deficiencies will be provided to the service chiefs and addressed with the prescribers as appropriate. The chief of staff is responsible for documentation compliance.

For patient and/or caregiver education, TJC requires that clinicians educate patients and families about safe and effective use of medications, evaluate patient/caregiver understanding of the education provided, and ensure that the patient's "medical record contains information that reflects the patient's care, treatment, and services."[108] The OIG determined that clinicians provided education in 22 percent of the electronic health records reviewed.[109] In addition, the OIG found that clinicians assessed understanding of education provided in 71 percent of the records reviewed.[110] Providing medication education and ensuring it is understood are critical to ensuring that patients have the information they need to manage their health at home.[111] The chief of Medicine reported that education was often discussed with the patients during the visit, however, the discussion was not documented.

Recommendation 12

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

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

[109] Confidence intervals are not included because the data represents every patient in the study population.

[110] Confidence intervals are not included because the data represents every patient in the study population.

[111] TJC. Provision of Care standard PC.02.03.01.

Facility concurred.

Target date for completion: 4/30/2020

Facility response: Electronic Health Record (EHR) audits were completed on a sample of EHRs from June-August 2019. 66% (16/25) of audited charts demonstrated the documentation of education and understanding for patients and caregivers provided for newly prescribed medications. Demonstration of these performance elements have been added to the FY2020 EHR workbooks, and re-education will be provided by the service chiefs to their prescribers by November 30th, 2019. EHR audits are completed for twenty-five EHR per clinical department per month and will be reported from Electronic Health Record Committee (EHRC) to the Medical Executive Committee for this metric. The chief of staff is the chair of Medical Executive Council; they also sign the minutes. Compliance will be considered met when 90% of all EHR Committee audits demonstrate indication for new medication initiation (if applicable) for greater than six months (anticipated April 20th, 2020). Service Line Managers are responsible for developing action plans for each quarter out of compliance, which is also reported to EHRC. When compliance is sustained, reporting will become part of the HERC's quarterly report. Deficiencies will be provided to the service chiefs and addressed with the prescribers as appropriate. The chief of staff is responsible for documentation compliance.

According to TJC, In medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies.[112] Additionally, VHA requires that providers review and reconcile medications relevant to the episode of care.[113] The OIG found that medication reconciliation was performed in 53 percent of the electronic health records reviewed.[114] Failure to maintain and communicate accurate patient medication information and reconcile medications increases the risk that there may be duplications, omissions, and interactions in the patient's actual drug regimen.[115] The chief of Medicine reported that in a short period of time there had been a considerable turnover in both providers and leadership, which resulted in the continuity of training, monitoring, and oversight being compromised.

Recommendation 13

13. The chief of staff ensures providers reconcile medication information and resolve discrepancies and monitors the providers' compliance.

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

[113] VHA Directive 1164.

[114] Confidence intervals are not included because the data represents every patient in the study population.

[115] TJC. National Patient Safety Goal standard NPSG.03.06.01.

Facility concurred.

Target date for completion: 4/30/2020

Facility response: Electronic Health Record (EHR) audits were completed on a sample of EHRs (25) from June 2019-August 2019. Audited records demonstrate uneven completion of the medication reconciliation documentation. Risk Management added this component to the New Employee Orientation starting on October 1st, 2019. Demonstration of these performance elements have been added to the FY2020 EHR workbooks, and re-education will be provided by the service chiefs to their prescribers by November 30th, 2019. EHR audits are completed for twenty-five EHR per clinical department per month and will be reported from Electronic Health Record Committee (EHRC) to the Medical Executive Committee for this metric. EHR audits will be reported from Electronic Health Record Committee (EHRC) to Medical Executive Committee for this metric. The chief of staff is the chair of Medical Executive Council; they are also responsible for signing the minutes. Compliance will be considered met when 90% of all EHR Committee audits demonstrate indication for new medication initiation (if applicable) for greater than six months (anticipated April 20th, 2020). Service Line Managers are responsible for developing action plans for each quarter out of compliance, which is also reported to EHRC. When compliance is sustained, reporting will become part of the EHRC's quarterly report. Deficiencies will be provided to the service chiefs and addressed with the prescribers as appropriate. The chief of staff is ultimately responsible for documentation compliance. For Beers Criteria-specific medications, an interdisciplinary team is completing a clinical-team training module looking specifically at antidepressants in the elderly; anticipated completion is January 7th, 2020 and recommendations will be provided to Medical Executive Committee and Quality, Safety, Value Committee. The chief of staff is responsible for documentation compliance.

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.[116] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[117] 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.[118] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[119]

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.[120]

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.[121]

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

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[116] 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.)

[117] 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.)

[118] 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.)

[119] 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.)

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

[121] VHA Directive 1330.01(2).

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results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.[122]

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 32 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

  o Core membership

  o Quarterly meetings

  o Reports to clinical executive leaders

- Collection and tracking of cervical cancer screening data

  o Notification of patients due for screening

  o Completed screenings

  o Results reporting

  o 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 facility complied with many of the performance indicators, including requirements for a designated women veterans program manager, women veterans medical director, Women Veterans Health Committee, and follow-up care when indicated. However, the team noted noncompliance with the communication of results to patients within the required time frame that warranted a recommendation for improvement.

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[122] VHA Directive 1330.01(2).

Specifically, VHA requires that the ordering provider notify patients of abnormal cervical cancer screening results within seven calendar days from the date the results are available.[123] The OIG determined that ordering providers timely notified patients of abnormal results in 78 percent of the electronic health records reviewed.[124] This may result in delays in follow-up care. The women veterans program manager reported multiple leadership position vacancies, including the women veterans program manager, women's health medical director, and primary care chief, which resulted in a lack of service-level leadership, guidance and oversight to properly manage Women's Health program.

Recommendation 14

14. The chief of staff ensures that ordering providers communicate abnormal results to patients within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: 4/30/2020

Facility response: Electronic Health Record (EHR) audits of all cervical pathology specimens demonstrated 93.7% (136/145) compliance; 6.2% (9/145) results and notifications still in progress; 1% (3/145) were completed but not timely. There were no critically abnormal results without patient notifications; two of 146 were abnormal, were notified, but had a late notification. Women's Health Providers were re-educated on October 10th, 2019 on the need for notification following all pathology results; reviews and reports are managed by the Women's Health Nurse Navigator and the Women Veterans Program Manager. Cervical Pathology and timely reported is document in the Women's Health Program Tracker and are reported to WVAC monthly, a leadership member or designee is present during the meeting and meeting minutes are signed by the chief of staff. Any concerns are addressed directly with Chief of PC and chief of staff. Compliance is reached when a complete audit of cervical pathology-related electronic health records demonstrate timeliness of patient notification in 90% of records for six months. The results are provided to the Primary Care leadership meeting on a monthly basis. When sustained compliance is met, the report will move to a standing reporting item from the Primary Care leadership team to Medical Executive Committee. Compliance is ultimately the responsibility of the chief of staff.

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[123] VHA Directive 1330.01(2).

[124] Confidence intervals are not included because the data represents every patient in the study population.

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]

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[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 UCC area 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 UCC 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[134]
  - 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

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[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).

[134] The facility does not have inpatient beds.

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

  - o Telephone message system during non-operational hours

  - o Inpatient provider available for patients requiring admission

- Patient flow

  - o EDIS tracking program

  - o Emergency department patient flow evaluation

  - o Diversion policy

  - o Designated bed flow coordinator

- General safety

  - o Directional signage to after-hours emergency care

  - o Fast tracks[135]

- 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

  - o Capability and equipment for gynecologic examinations

- Life support equipment

High-Risk Processes Conclusion

Generally, the OIG noted compliance with some of the performance indicators for the operations and management of the UCC. However, the OIG identified deficiencies with required nurse staffing, backup call schedules for UCC providers, and availability of support services that warranted recommendations for improvement.

As previously mentioned, VHA requires that VA UCCs have appropriately educated and qualified emergency care professionals physically present in the UCC during all hours of operation. This includes a licensed physician and a minimum of two registered nurses.[136] The

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

[136] VHA Directive 1101.05(2).

OIG found that the UCC was open 24 hours a day, 7 days a week, and one licensed physician and a minimum of two registered nurses were scheduled for all hours of operation; however, the UCC provider and one of the registered nurses were required to respond to emergencies outside of the UCC during all hours of the day. This could result in potentially unsafe situations in the UCC when a single registered nurse is the only clinical staff member present in the UCC. The UCC nurse manager stated this requirement had been interpreted to mean at least two registered nurses were assigned to the UCC at all times and that one registered nurse could respond to emergencies within the facility. Per the chief of Quality Management, the staffing was based on consideration of cost and the low volume of UCC patient visits.

Recommendation 15

15. The facility director makes certain that the urgent care center is staffed with at least two registered nurses at all times of operation and monitors compliance.

Facility concurred.

Target date for completion: 12/31/2019

Facility response: The urgent care clinic is now open Monday-Sunday 8a-4:30p, excluding holidays, effective August 31st, 2019. Minimum staffing is now three RNs due to the reduction of hours; processes are in place for routine illnesses or short-staffing. The Urgent Care Clinic Nurse Manager reports directly to the ADPNS during morning huddle. Compliance is reached when six months of nursing assignment always demonstrate staffing with no less than two registered nurses (anticipated December 31st, 2019). Sustainment will be comprised of supervision by the urgent care section chief and associate chief nurse for urgent care.

Adequate staffing during all hours of operation requires an effective backup call process as well. VHA requires that UCCs have a written staffing contingency plan that includes a backup call schedule to address situations when additional providers are needed.[137] The OIG found that the UCC lacked a backup call schedule and determined inadequate compliance with VHA requirements because of potential impact to the facility's ability to provide uninterrupted and timely patient care. The UCC section chief stated the staff call to find assistance when needed, but the OIG observed there was not an actual backup call schedule with designated staff.

Recommendation 16

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

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[137] VHA Directive 1101.05(2).

Facility concurred.

Target date for completion: 12/31/2019

Facility response: Since June 7th, 2019, the Urgent Care Section Chief has created and staffed a provider contingency plan. Compliance is demonstrated by having a backup call schedule for each day per month. The compliance goal is reached when the number of days with backup is 100%. The goal of six months of compliance is met with the December 2019 contingency plan, which has been created and disseminated. Oversight of the process is the responsibility of the Urgent Care Director and ultimately the chief of staff; it is monitored in sustainment through morning huddle.

Additionally, VHA requires that necessary resources, including support services, are provided to the UCC to ensure timely access to care for patients.[138] The OIG found that the facility does not have laboratory, pharmacy, or radiology present or available during all hours of UCC operation. This may result in a lack of needed services for patients presenting for care during all hours of UCC operation. Per the chief of Quality Management, the facility has been operating the support services in this manner prior to 2017 due to low volume of UCC patient visits and consideration of cost.

Recommendation 17

17. The facility director ensures that support services necessary to care for patients are readily available to the urgent care center during all hours of operation and monitors compliance.

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[138] VHA Directive 1101.05(2).

Facility concurred.

Target date for completion: 11/1/2019

Facility response: Leveraging the recommendation of the OIG, the Manchester VA Medical Center acted swiftly to close the urgent care during the evening/nights when ancillary services were not available. Following a media campaign and facility project, the Urgent Care Center closed its doors for the first time since 1940 at 4 pm, August 31st, 2019. All impacted medical center policies (76) were updated to reflect the changes. Urgent Care services are now available Monday-Sunday, excluding holidays, 8 am-4:30 pm with Urgent Care staff on site until 6 pm for transitions of care. Laboratory, radiology, and pharmacy services are available for all urgent care clinic hours—on-site Monday-Sunday (excluding holidays) from 8 am-4:30 pm. The Administrator on Duty reviews care options with Veterans requesting care during the off-hours, which includes urgent care and emergency department options through the MISSION act; messages to the primary care team; or returning during open hours. The Veteran's decision is reported via the Administrator on Duty log to the Associate Director, and the other leaders, and discussed as needed at director's daily huddle. The Medical Center Director is ultimately responsible for this action.

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	- Executive leadership position stability and engagement - Employee satisfaction - Patient experience - Accreditation and/or for-cause surveys and oversight inspections - Factors related to possible lapses in care - VHA performance data	Seventeen OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director, associate director, and chief of staff. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	- Protected peer reviews - UM reviews - Patient safety - Resuscitation episode review	None	The patient safety manager includes consideration of relevant literature in root cause analyses.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• Professional practice evaluations include service-specific criteria. • Specialty providers' OPPEs include the minimum required specialty criteria. • Professional practice evaluations are completed by a provider with similar training and privileges.	• Clinical managers document in practitioners' profiles the FPPE criteria defined in advance. • The facility's Medical Executive Council reviews the professional practice data in the consideration to continue provider privileges.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent facility
	  o General safety
	  o Environmental cleanliness and infection prevention
	  o General privacy
	  o Women veterans program
	  o Availability of medical equipment and supplies
	• Community based outpatient clinic
	  o General safety
	  o Environmental cleanliness and infection prevention
	  o General privacy
	  o Women veterans program
	  o Availability of medical equipment and supplies
	• Locked inpatient mental health unit
	  o Mental health environment of care rounds
	  o Nursing station security
	  o Public area and general unit safety
	  o Patient room safety
	  o Infection prevention
	  o Availability of medical equipment and supplies
	• Emergency management
	  o Hazard vulnerability analysis (HVA)
	  o Emergency operations plan (EOP)
	  o Emergency power testing and availability
		• None	• A clean and safe environment is maintained throughout the facility.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• None	• None
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• 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	• Providers offer a referral for MST-related services for patients with a positive screen.	• MST-related issues, services, and initiatives are communicated with leadership. • Primary care and mental health providers complete MST mandatory training within the required time frame.
Geriatric Care: Antidepressant Use among the Elderly	• 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	• Providers document clinical indication for medication initiation in patients' electronic health records. • Clinicians provide and document patient/caregiver education and understanding of education provided about the safe and effective use of newly prescribed medications. • Providers reconcile medication information and resolve discrepancies.	• None
Women's Health: Abnormal Cervical	• Appointment of a women veterans program manager	• Ordering providers communicate abnormal results to	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Pathology Results Notification and Follow-Up	• 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	patients within the required time frame.	
High-Risk Processes: Operations and Management of Emergency Departments and UCCs	• 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	• The UCC has at least two registered nurses physically present during all hours of operation. • A backup call schedule is maintained for UCC providers. • Support services necessary to care for patients are readily available to the UCC during all hours of operation.	• None

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) facility reporting to VISN 1.[139]

Table B.1. Facility Profile for Manchester VA Medical Center (608) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[140]	Facility Data FY 2017[141]	Facility Data FY 2018[142]
Total medical care budget dollars	$161,029,921	$173,846,838	$192,933,925
Number of:			
• Unique patients	25,917	26,094	26,530
• Outpatient visits	265,439	261,029	259,240
• Unique employees[143]	633	614	679
Type and number of operating beds:			
• Community living center	112	112	112
Average Daily Census:			
• Community living center	39	33	29

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

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[139] The VHA medical centers are classified according to a facility complexity model; a designation of "3" indicates a facility with "low volume, low-risk patients, few or no complex clinical programs, and small or no research and teaching programs."

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

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

[142] October 1, 2017, through September 30, 2018.

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

VA Outpatient Clinic Profiles[144]

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)[145]**

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[146] Provided	Diagnostic Services[147] Provided	Ancillary Services[148] Provided
Portsmouth, NH	608GA	3,822	1,116	Rheumatology	EKG	Pharmacy Nutrition
Somersworth, NH	608GC	4,769	3,198	Rheumatology Podiatry	EKG	Pharmacy Nutrition
Conway, NH	608GD	2,207	575	Rheumatology	EKG	Pharmacy Nutrition

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[144] Includes all outpatient clinics in the community that were in operation as of February 8, 2019.

[145] 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."

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

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

[148] 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[146] Provided	Diagnostic Services[147] Provided	Ancillary Services[148] Provided
Tilton, NH	608HA	3,602	1,659	Endocrinology Hematology Urology	EKG	Pharmacy Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.
n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics[149]
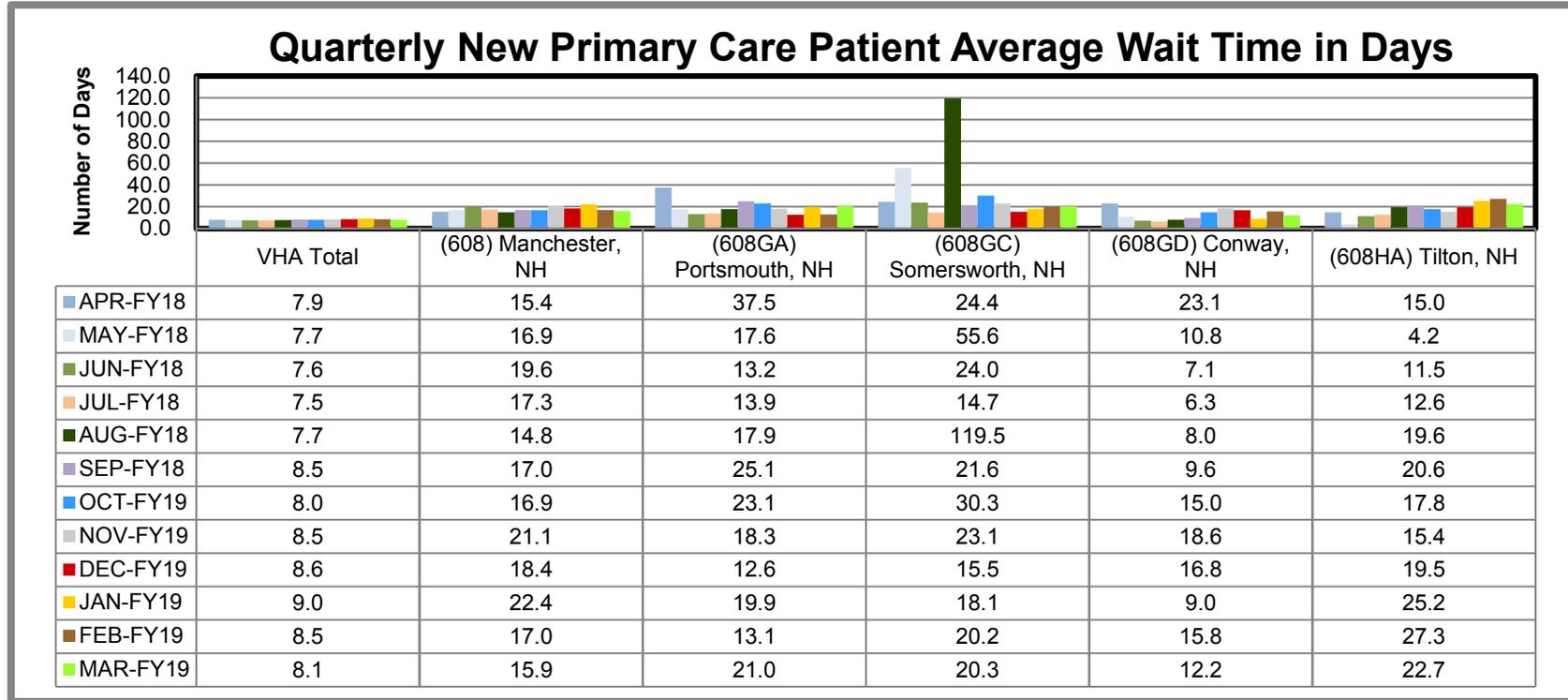
Quarterly New Primary Care Patient Average Wait Time in Days

Number of Days

	VHA Total	(608) Manchester, NH	(608GA) Portsmouth, NH	(608GC) Somersworth, NH	(608GD) Conway, NH	(608HA) Tilton, NH
■ APR-FY18	7.9	15.4	37.5	24.4	23.1	15.0
■ MAY-FY18	7.7	16.9	17.6	55.6	10.8	4.2
■ JUN-FY18	7.6	19.6	13.2	24.0	7.1	11.5
■ JUL-FY18	7.5	17.3	13.9	14.7	6.3	12.6
■ AUG-FY18	7.7	14.8	17.9	119.5	8.0	19.6
■ SEP-FY18	8.5	17.0	25.1	21.6	9.6	20.6
■ OCT-FY19	8.0	16.9	23.1	30.3	15.0	17.8
■ NOV-FY19	8.5	21.1	18.3	23.1	18.6	15.4
■ DEC-FY19	8.6	18.4	12.6	15.5	16.8	19.5
■ JAN-FY19	9.0	22.4	19.9	18.1	9.0	25.2
■ FEB-FY19	8.5	17.0	13.1	20.2	15.8	27.3
■ MAR-FY19	8.1	15.9	21.0	20.3	12.2	22.7

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 (608GA) Portsmouth, NH and (608GC) Somersworth, NH 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.

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[149] 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

Number of Days

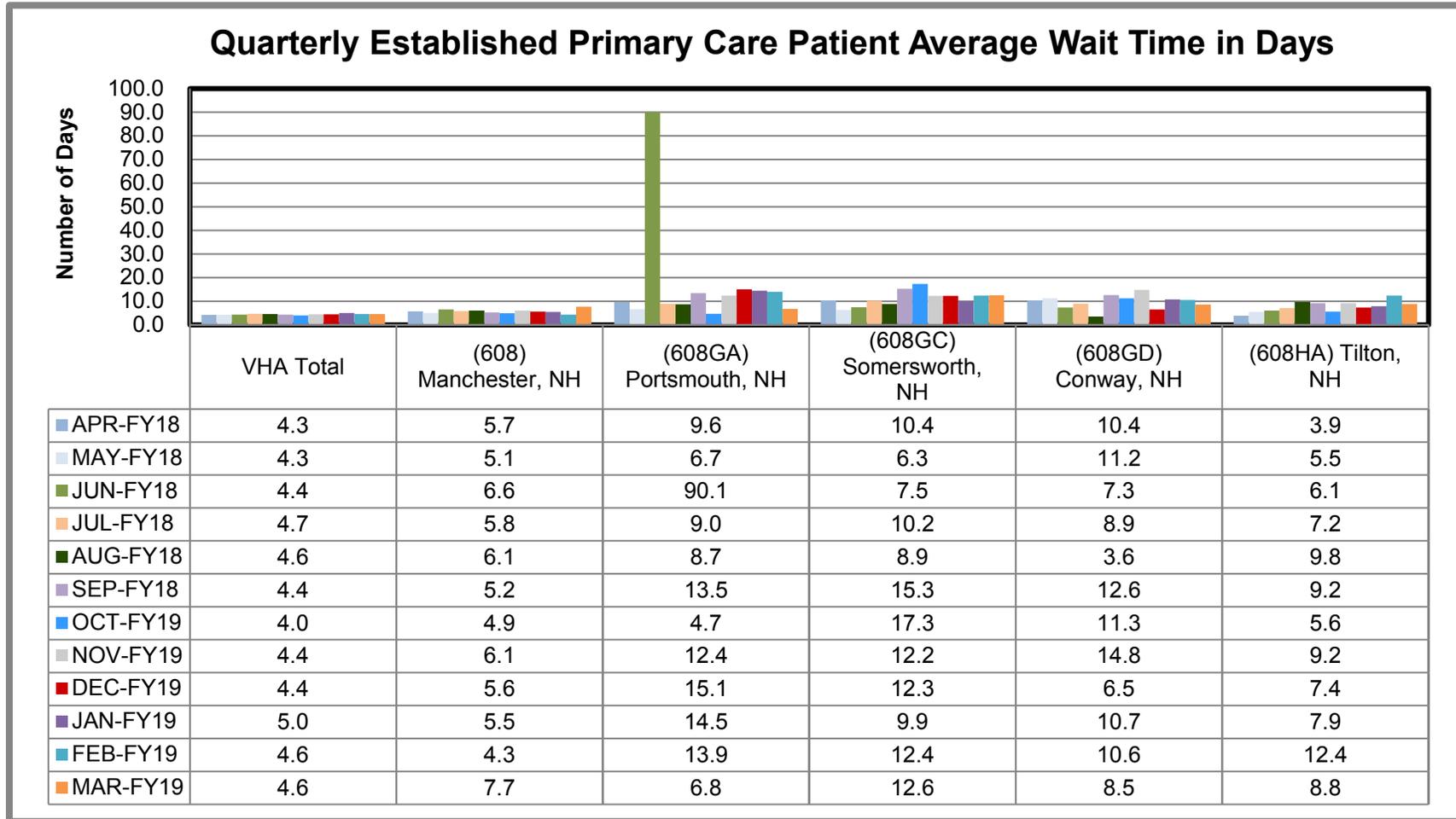|	VHA Total	(608) Manchester, NH	(608GA) Portsmouth, NH	(608GC) Somersworth, NH	(608GD) Conway, NH	(608HA) Tilton, NH
APR-FY18	4.3	5.7	9.6	10.4	10.4	3.9
MAY-FY18	4.3	5.1	6.7	6.3	11.2	5.5
JUN-FY18	4.4	6.6	90.1	7.5	7.3	6.1
JUL-FY18	4.7	5.8	9.0	10.2	8.9	7.2
AUG-FY18	4.6	6.1	8.7	8.9	3.6	9.8
SEP-FY18	4.4	5.2	13.5	15.3	12.6	9.2
OCT-FY19	4.0	4.9	4.7	17.3	11.3	5.6
NOV-FY19	4.4	6.1	12.4	12.2	14.8	9.2
DEC-FY19	4.4	5.6	15.1	12.3	6.5	7.4
JAN-FY19	5.0	5.5	14.5	9.9	10.7	7.9
FEB-FY19	4.6	4.3	13.9	12.4	10.6	12.4
MAR-FY19	4.6	7.7	6.8	12.6	8.5	8.8

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 Portsmouth, NH (608GA) CBOC.

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 Definitions[150]

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

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[150] 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 Definitions[151]

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.

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

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: October 21, 2019

From: Director, VA New England Healthcare System (10N1)

Subj: Comprehensive Healthcare Inspection of the Manchester VA Medical Center, Manchester, NH

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

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Manchester VA Medical Center, Manchester, NH.

2. I concur with the recommendations, findings, and submitted action plans from the Manchester VA Medical Center.

(Original signed by:)

Ryan S. Lilly

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 10, 2019

From: Director, Manchester VA Medical Center (608/00)

Subj: Comprehensive Healthcare Inspection of the Manchester VA Medical Center, Manchester, NH

To: Director, VA New England Healthcare System (10N1)

1. The Manchester VA Medical Center acknowledges the highly consultative nature of the OIG team; we appreciate their dedication to continuous improvement and collaboration. We welcome their input and recommendations in this report; all of these actions have been undertaken as part of our commitment to high reliability.

2. I concur with the recommendations, findings, and submitted action plans from the Manchester team.

(Original signed by:)

Alfred A. Montoya, Jr., MHA, VHA-CM

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

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Myra Brazell, LCSW, Team Leader Charles Cook, MHA Kristie Van Gaalen, BSN, RN Elizabeth Whidden, MS, ARNP Michelle Wilt, MBA, BSN
Other Contributors	Alicia Castillo-Flores, MBA, MPH Limin Clegg, PhD Justin Hanlon, BS LaFonda Henry, MSN, RN-BC Gayle Karamanos, MS, PA-C Yoonhee Kim, PharmD Susan Lott, MSA, CPPS Scott McGrath, BS Larry Ross, Jr., MS Marilyn Stones, BS Erin Stott, MSN, RN April Terenzi, BA, BS Mary Toy, MSN, RN Robert Wallace, ScD, MPH

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