DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Northern Arizona VA Health Care System

Prescott, Arizona

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Figure 1. *Northern Arizona VA Health Care System, Prescott, AZ (Source: https://vaww.va.gov/directory/guide/, accessed on June 24, 2019)*

Abbreviations

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

Report Overview

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

CHIP inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus each year.

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

1. Quality, safety, and value;

2. Medical staff privileging;

3. Environment of care;

4. Medication management (specifically the controlled substances inspection program);

5. Mental health (focusing on military sexual trauma follow-up and staff training);

6. Geriatric care (spotlighting antidepressant use for elderly veterans);

7. Women's health (particularly abnormal cervical pathology result notification and follow-up); and

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

This unannounced visit was conducted during the week of February 11, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, chief of staff, associate director for Patient Care Services (ADPCS), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure, with the Executive Leadership Council having oversight for several working groups and being responsible for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning.

Apart from the facility director who was appointed in March 2017, the executive leaders were relatively new to their positions. The chief of staff and associate director were permanently assigned in December 2018 and March 2018, respectively. The acting ADPCS, having been in the role for approximately two months, had recently been selected for the position permanently and was going through the pre-appointment process.

The OIG noted that selected employee satisfaction survey results for the chief of staff and associate director were similar to or above the facility and VHA averages while the results for the director and ADPCS were much lower. However, the OIG understood that the results are not fully representative of the current leadership team, as the director was the only executive team member in place throughout the survey time frame. The director attributed the low scores to the change in leadership and new leaders' efforts to improve organizational culture and operations and was optimistic that future surveys will accurately reflect efforts by the new leadership team. In the selected patient experience survey scores for facility leaders, opportunities exist to improve Patient-Centered Medical Home outpatient experience. The facility leaders seemed actively engaged with employees and patients and were working to improve employee and patient engagement and satisfaction. The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to maintain positive perceptions of the facility through active stakeholder engagement).

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[1] disclosures of adverse patient events, and patient safety indicator data and did not identify any substantial organizational risk factors. At the time of the on-site visit, one recommendation from the most recent Joint Commission survey and two recommendations from the most recent OIG community based outpatient clinics' report had not been closed. Facility staff provided evidence of the submission of a time-limited waiver regarding the open Joint Commission recommendation. The OIG determined that the facility took sufficient actions to address the two

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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."

open recommendations from the OIG community based outpatient clinics' report and closed the recommendations.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[2] Although the leadership team members were knowledgeable within their areas of responsibility about selected SAIL and community living center (CLC) measures, the leaders should continue to take actions to improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL and CLC "2-star" quality ratings.[3]

The OIG noted deficiencies in all eight clinical areas reviewed as well as an incidental finding and issued 20 recommendations that are attributable to the director, ADPCS, 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. However, the OIG identified noncompliance with documentation of physician utilization management (UM) advisors' decisions in the National UM Integration database, participation of all required representatives in the interdisciplinary review of UM data, implementation of root cause analyses action items, and the complete Cardiopulmonary Resuscitation (CPR) committee analysis of resuscitation episodes.[4]

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[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.

[4] The definition of utilization management can be found within VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the "forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria." The January 2018 version of the directive was in effect at the time of the March 2019 review. Subsequently, the directive was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), which expired on July 31, 2019. The utilization management definition remained consistent in both versions of the directive.

Medical Staff Privileging

The facility generally complied with requirements for privileging and focused professional practice evaluations. However, OIG identified a deficiency with the ongoing professional practice evaluation process.[5]

Environment of Care

The facility and Anthem VA Clinic generally complied with cleanliness and safety requirements. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified noncompliance with medication storage at the parent facility.

Medication Management

Overall, the facility complied with requirements for most of the performance indicators evaluated for medication management, including the controlled substances coordinator reports, pharmacy operations, requirements for controlled substances inspectors, and review of override reports. However, the OIG identified noncompliance with controlled substances area inspections and pharmacy inspections.

Mental Health

The OIG team also found the facility complied with some of the mental health performance indicators, including the designation of a military sexual trauma (MST) coordinator and the provision of clinical care. The OIG had concerns, however, with the facility's establishing and monitoring MST-related staff training and informational outreach, communicating MST-related issues with leadership, and tracking MST-related data, and with providers completing MST mandatory training.

Geriatric Care

For geriatric patients, clinicians documented reasons for prescribing medications and ensured patient and/or caregiver understanding when education was provided. However, the OIG

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

identified inadequate patient and/or caregiver education related to newly prescribed medications and medication reconciliation to minimize duplicative medications and adverse drug interactions.

Women's Health

The OIG also noted the facility performed adequately on several indicators related to women's health, including requirements for a designated women veterans program manager and women's health medical director and follow-up care when indicated. However, the OIG noted concerns with Women Veterans Health Committee meetings, reporting to leadership, tracking data related to cervical cancer screenings, and communicating abnormal results to patients within the required time frame.

High-Risk Processes

The OIG inspection revealed that the facility generally complied with many of the performance indicators used to assess the high-risk process of the operations and management of the emergency department. However, the OIG noted a lack of backup call schedules for emergency department providers and social workers.

Incidental Finding: High-Alert Medications

At the time of the OIG visit, the inspection team identified inappropriate storage of highly concentrated opioid oral liquid (narcotics) medications in patient care areas.

Summary

In reviewing key healthcare processes, the OIG issued 20 recommendations for improvement directed to the facility director, ADPCS, 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 77–78, and the responses within the body of the report for the full

text of the directors' comments.) The OIG considers recommendations 1, 2, 4, 5, 6, 7, and 8 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

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

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.[6] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[7] Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

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

1. Leadership and organizational risks

2. Quality, safety, and value (QSV)

3. Medical staff privileging

4. Environment of care

5. Medication management (specifically the controlled substances inspection program)

6. Mental health (focusing on military sexual trauma follow-up and staff training)

7. Geriatric care (spotlighting antidepressant use for elderly veterans)

8. Women's health (particularly abnormal cervical pathology results notification and follow-up)

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

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

9. High-risk processes (specifically the emergency department and urgent care center operations and management).[8]
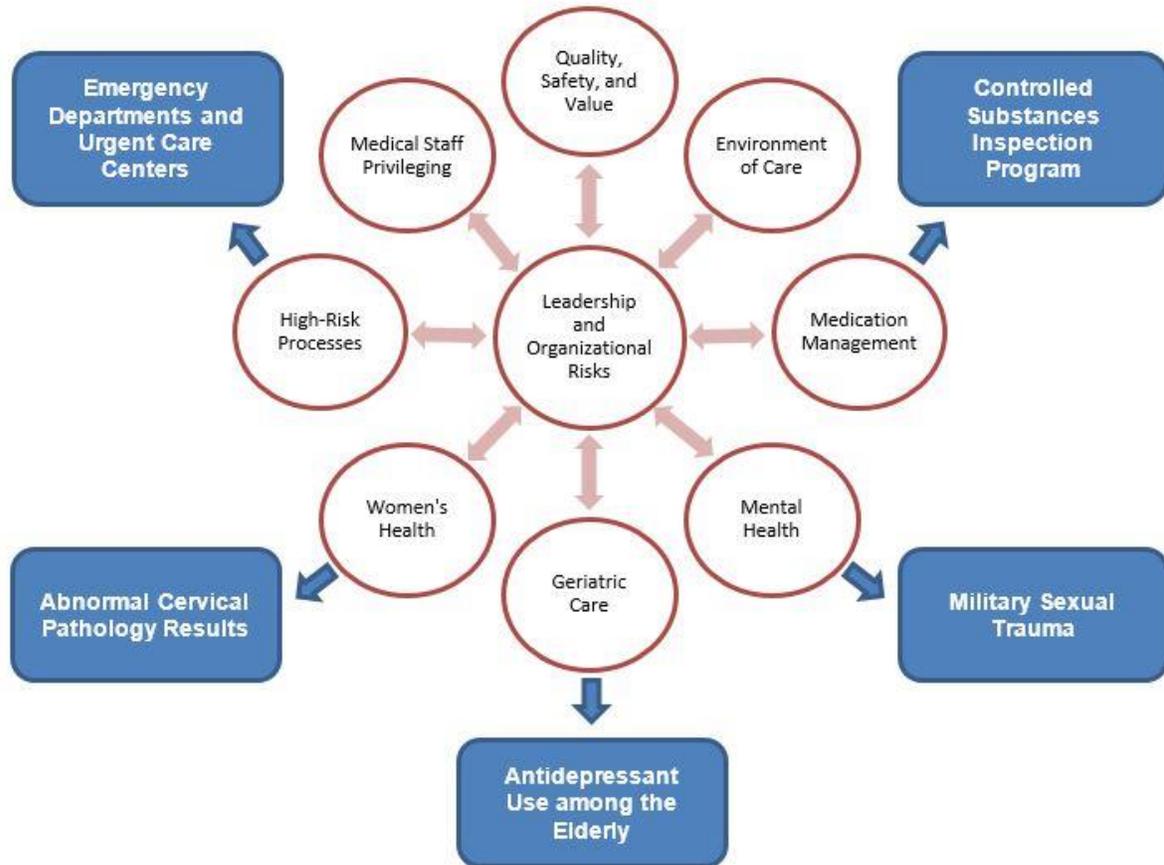
Figure 2. Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

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

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;[9] physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from November 21, 2015, through February 15, 2019, the last day of the unannounced week-long site visit.[10] While on site, the OIG did not receive any complaints beyond the scope of the CHIP review.

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.[11] To assess the facility's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement

2. Employee satisfaction

3. Patient experience

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

5. Factors related to possible lapses in care

6. VHA performance data

Executive Leadership Position Stability and Engagement

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

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[11] L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on February 2, 2017.)
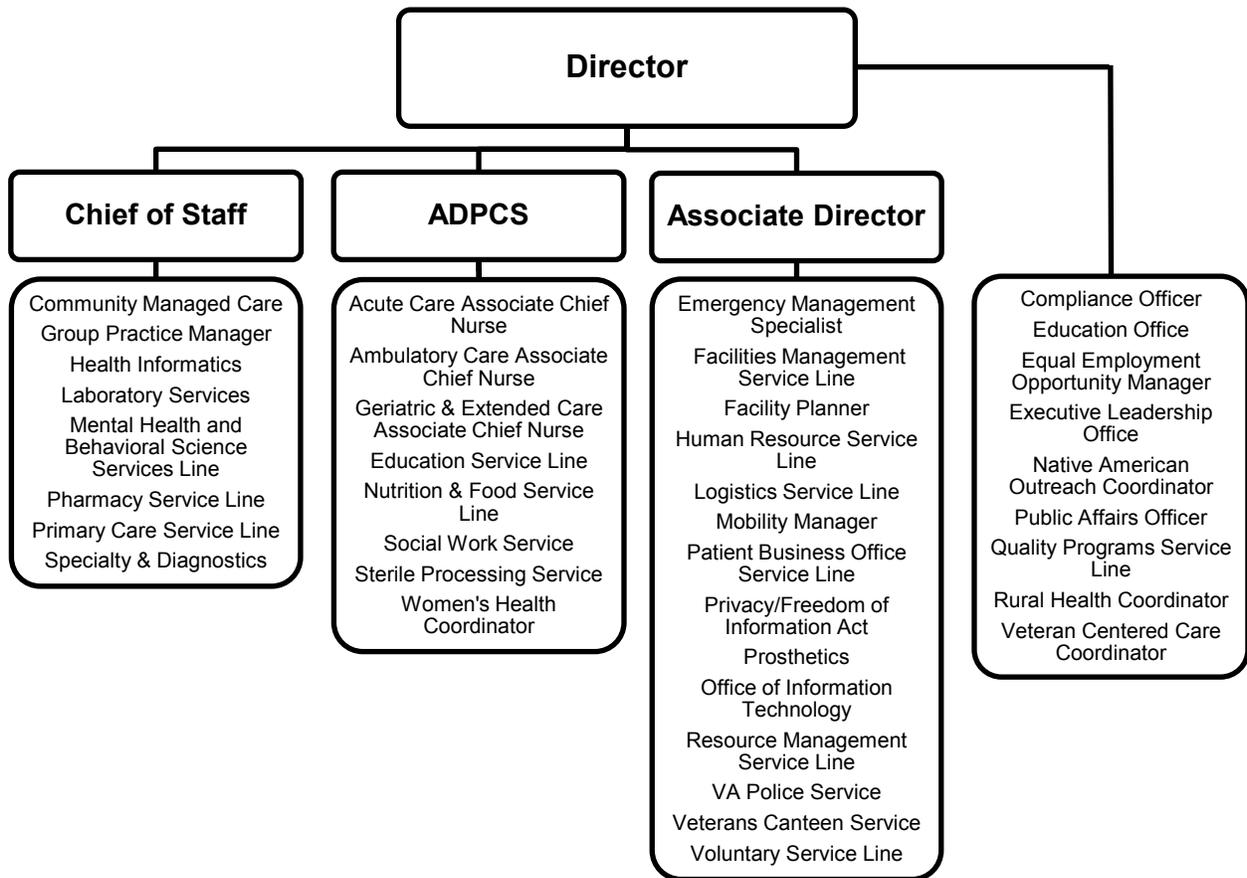
Figure 3. Facility Organizational Chart[12]
Source: Northern Arizona VA Health Care System (received February 11, 2019)

At the time of the OIG site visit, apart from the director, the executive team members were relatively new to their positions (less than one year). The director, chief of staff, and associate director were permanently assigned. The acting ADPCS, having been in the role for approximately two months, had recently been selected for the position permanently and was going through the pre-appointment process (see Table 1).

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[12] At this facility, the director is responsible for the Compliance Officer, Education Office, Equal Employment Opportunity Manager, Executive Leadership Office, Native American Outreach Coordinator, Public Affairs Officer, Quality Programs Service Line, Rural Health Coordinator, and Veteran Centered Care Coordinator.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	March 5, 2017
Chief of staff	December 17, 2018
Associate director for Patient Care Services	December 16, 2018 (acting)
Associate director	March 18, 2018

Source: Northern Arizona VA Health Care System human resources officer (received February 12, 2019)

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

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months 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 Leadership Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Council oversees various working groups, such as the Nursing Executive, Medical Executive, and Environment of Care/Safety Boards.

These leaders are also engaged in monitoring patient safety and care through the Quality and Performance Board, for which the director and Quality Programs Service Line manager are co-chairs, and the chief of staff, ADPCS, and associate director are members. The Quality and Performance Board is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes, and it reports to the Executive Leadership Council. See Figure 4.

Executive Leadership Council

Employee and Community Relations Board	Veteran Centered Care Board	Nursing Executive Board	Quality and Performance Board	Planning Business Operations Board	Medical Executive Board	Environment of Care/Safety Board	Clinical Informatics Board	
Equal Employment Opportunity Diversity	Community Living Center Culture Change	Advance Practice Nurse	Geriatrics and Extended care Performance Improvement	Commodities Standardi-zation	Blood Bank	Accident Review	Clinical Informatics	Affiliations
Employee Wellness	Customer Satisfaction	Clinical Records Multi-disciplinary	Health Promotion and Disease Prevention	Data Validation/ Veterans Equitable Resource Allocation	Clinical Nutrition	Construction Safety	Clinical Profile Management	Commanders Council
Incentive Awards		Evidence Based Practice	Medical Records	Equipment Safety	Clinical Product Review	Environment of Care Rounds	Information Management	Compliance
VA Voluntary Service		Inter-disciplinary Skin Care	Patient Safety	Operational Planning	Cardio-pulmonary Resuscitation	Emergency Preparedness	Telehealth	Integrated Ethics
Web Editorial Review Board		Nursing Development	System Redesign	Space Management	Dementia Steering	Fall Prevention		Labor Management Alternative Dispute Resolution Forum
			Utilization Management		Disruptive Behavior	GEMS		Resources
					Home Care Equipment	Radiation Safety		
					Home Respiratory	Safe Patient Handling		
					Invasive Procedures	Safety		
					Infection Control			
					Medical Contacts			
					MOVE			
					Operation Enduring Freedom/ Operation Iraqi Freedom			
					Pain Management			
					Peer Review			
					Pharmacy Therapeutics			
					Reusable Medical Equipment			
					Women Veterans			

Figure 4. *Facility Committee Reporting Structure[13]*
Source: Northern Arizona VA Health Care System (February 11, 2019)
GEMS = Green Environmental Management System

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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[13] The Executive Leadership Council directly oversees Affiliations, Commanders Council, Compliance, Integrated Ethics, Labor Management Alternative Dispute Resolution Forum, and Resources.

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.[14] 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 the selected survey leadership questions was generally lower than the VHA average.[15] The chief of staff and associate director were generally higher, while the director and ADPCS were much lower than the facility and VHA averages. These survey results appeared to be congruent with the low-ranking best place to work and registered nurse (RN) turnover metrics shown in Figure 7 of this report. In all, opportunities appear to exist to improve employee satisfaction. During the interview, the director spoke frankly about personnel and perception challenges when first appointed to the position in March 2017 and attributed the low survey results to joining the organization and implementing meaningful changes. The director is optimistic that future surveys will reflect positive outcomes from changes in leadership and operations that have already been or are in the process of being implemented at the time of the OIG inspection.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[16]	0–100 where HIGHER scores are more favorable	71.7	70.9	44.0	80.6	65.3	86.9

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

[15] 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.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.0	2.4	3.1	3.0	3.9
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.3	2.6	3.9	3.2	4.3
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.2	2.7	3.7	3.3	4.2

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

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The facility averages for the selected survey questions were similar to or worse than the VHA averages, while those for the director were notably worse than the VHA and facility averages. The director reported ongoing efforts to improve the culture and communication throughout the organization.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.6	2.9	4.4	3.4	4.4
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	3.6	2.7	4.0	3.5	4.3
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	1.8	4.2	1.8	2.0	2.6

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

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through September 30, 2018. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment

of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.[17]

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward facility leaders (see Table 4). For this facility, three patient survey results reflected higher care ratings than the VHA average. Facility leaders attributed the low survey scores in outpatient Patient-Centered Medical Home primarily to the difficulty in hiring specialty care providers to serve a growing number of patients with chronic problems. In all, patients appeared generally satisfied with the leadership and care provided. Facility leaders appeared to be actively engaged with patients, for example, through veteran town hall meetings and executive leadership rounds.

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?*	The response average is the percent of "Definitely Yes" responses.	66.9	72.3
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	86.3
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	72.1
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	78.6

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28,2018)

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

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 Commission (TJC).[19] During the on-site review, the OIG noted that the most recent TJC report had one open recommendation and the facility had submitted a request to TJC asking for a time-limited waiver to relocate a gas alarm panel.[20] The OIG team also noted that the most recent OIG community based outpatient clinics' report still had two open recommendations and closed these based on the determination that the facility had taken sufficient actions and made sustained improvements.

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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[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.

[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 Northern Arizona VA Health Care System, Prescott, Arizona, Report No. 15-04704-297, May 12, 2016*)	November 2015 December 2015	26	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Northern Arizona VA Health Care System, Prescott, Arizona, Report No. 15-05160-161, March 9, 2016*)	November 2015	18	0
TJC Hospital Accreditation	July 2017	43	1
TJC Behavioral Health Care Accreditation		6	0
TJC Home Care Accreditation		10	0

Sources: OIG and TJC (Inspection/survey results verified with the chief of Quality Management on February 12, 2019)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from November 21, 2015 (the prior comprehensive OIG inspection), through February 15, 2019.[23]

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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 Northern Arizona VA Health Care System is a low complexity (3) affiliated facility as described in Appendix B.)

Table 6. Summary of Selected Organizational Risk Factors (November 21, 2015, through February 15, 2019)

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

Source: Northern Arizona VA Health Care System's risk manager (received February 11, 2019)

The OIG also reviewed patient safety indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[27] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 7 summarizes patient safety indicator data from October 1, 2016, through September 30, 2018.

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[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.)

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

| Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 22	Facility
Pressure ulcer	0.74	0.85	0.00
Death among surgical inpatients with serious treatable conditions	113.42	93.33	0.00
Iatrogenic pneumothorax[28]	0.17	0.14	0.00
Central venous catheter-related bloodstream infection	0.16	0.11	0.00
In-hospital fall with hip fracture	0.09	0.07	0.00
Perioperative hemorrhage or hematoma	2.61	1.62	0.00
Postoperative acute kidney injury requiring dialysis	0.89	1.00	0.00
Postoperative respiratory failure	4.54	4.53	0.00
Perioperative pulmonary embolism or deep vein thrombosis	2.97	3.03	0.00
Postoperative sepsis	3.55	2.40	0.00
Postoperative wound dehiscence (rupture along incision)	0.82	0.60	0.00
Unrecognized abdominopelvic accidental puncture or laceration	1.00	0.70	0.00

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

None of the 12 applicable patient safety indicator measures show a reported rate per 1,000 hospital discharges in excess of the reported rates for VISN 22 and VHA.

The OIG also reviewed patient safety indicator data for FY 2018, quarter 4 (the most recent data), and the previous four quarters to identify any potential trends that may impact patient safety or increase the risk for patient harm. It is important to note that although the data are collected and reported by quarter, each set of quarterly data represents potential complications or patient safety events over an eight-quarter or two-year period. Further, it is possible for a facility measure to exceed the VHA rate due to a single incident and for that measure to vary above or below the VHA rate over time due to differences in the number of patients treated. Figure 5 illustrates the time frames covered by the data reviewed.

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[28] According to Northwestern Memorial Hospital, "A Pneumothorax is a type of lung injury that allows air to leak into the area between the lungs and the chest wall, which causes mild to severe chest pain and shortness of breath. An Iatrogenic Pneumothorax is caused by medical treatment, often as an incidental event during a procedure such as a pacemaker insertion." Northwestern Medicine. http://www.nmh.org/nm/quality-lung-injury-due-to-medical-care. (The website was accessed on March 6, 2019.)
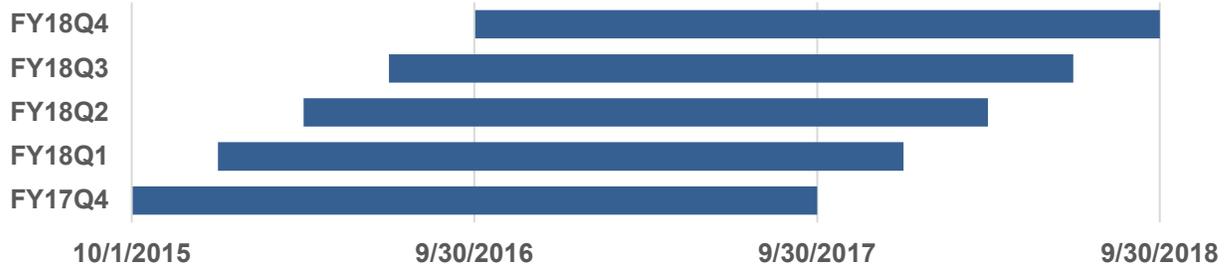
Figure 5. Associated Time Frames for Quarterly Patient Safety Indicator Data
Source: VA OIG
FY18Q4 = fiscal year 2018, quarter 4
FY18Q3 = fiscal year 2018, quarter 3
FY18Q2 = fiscal year 2018, quarter 2
FY18Q1 = fiscal year 2018, quarter 1
FY17Q4 = fiscal year 2017, quarter 4

Table 8 summarizes patient safety indicator data for FY 2017, quarter 4 (FY17Q4), through FY 2018, quarter 4 (FY18Q4), which includes potential complications from October 1, 2015, through September 30, 2018.

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

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY17Q4	**FY18Q1**	**FY18Q2**	**FY18Q3**	**FY18Q4**
Pressure ulcer	VHA	0.60	0.88	—[29]	0.76	0.74
	Facility	0.00	0.00	—	0.00	0.00
Death among surgical inpatients with serious treatable conditions	VHA	100.97	118.96	113.92	114.89	113.42
	Facility	n/a	0.00	0.00	0.00	0.00
Iatrogenic pneumothorax	VHA	0.19	0.19	0.17	0.15	0.17
	Facility	0.00	0.00	0.00	0.00	0.00
Central venous catheter-related bloodstream infection	VHA	0.15	0.14	0.15	0.16	0.16
	Facility	0.00	0.00	0.00	0.00	0.00
In-hospital fall with hip fracture	VHA	0.08	0.09	0.08	0.09	0.09
	Facility	0.00	0.00	0.00	0.00	0.00
Perioperative hemorrhage or hematoma	VHA	1.94	2.58	2.62	2.59	2.61
	Facility	n/a	0.00	0.00	0.00	0.00
	VHA	0.88	0.80	0.65	0.96	0.89

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

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
Postoperative acute kidney injury requiring dialysis	Facility	n/a	0.00	0.00	0.00	0.00
Postoperative respiratory failure	VHA	5.55	5.34	5.11	4.88	4.54
	Facility	n/a	0.00	0.00	0.00	0.00
Perioperative pulmonary embolism or deep vein thrombosis	VHA	3.29	3.26	3.09	3.05	2.97
	Facility	n/a	0.00	0.00	0.00	0.00
Postoperative sepsis	VHA	4.00	3.96	3.72	3.70	3.55
	Facility	n/a	0.00	0.00	0.00	0.00
Postoperative wound dehiscence (rupture along incision)	VHA	0.52	1.04	1.00	0.93	0.82
	Facility	0.00	0.00	0.00	0.00	0.00
Unrecognized abdominopelvic accidental puncture or laceration	VHA	0.53	1.21	1.02	1.07	1.00
	Facility	0.00	0.00	0.00	0.00	0.00

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
n/a = Not applicable because during the review period, there were no discharges for patients who underwent an applicable surgical procedure.

None of the 12 applicable patient safety indicator data for FY 2018, quarter 4 (the most recent data), and the previous four quarters show a reported rate per 1,000 hospital discharges in excess of the reported rates for VHA. No trends impacting patient safety were identified.

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." 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.[30]

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

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[30] 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.)

facilities. Figure 6 describes the distribution of facilities by star rating.[31] As of June 30, 2018, the facility was rated as "2-star" for overall quality.
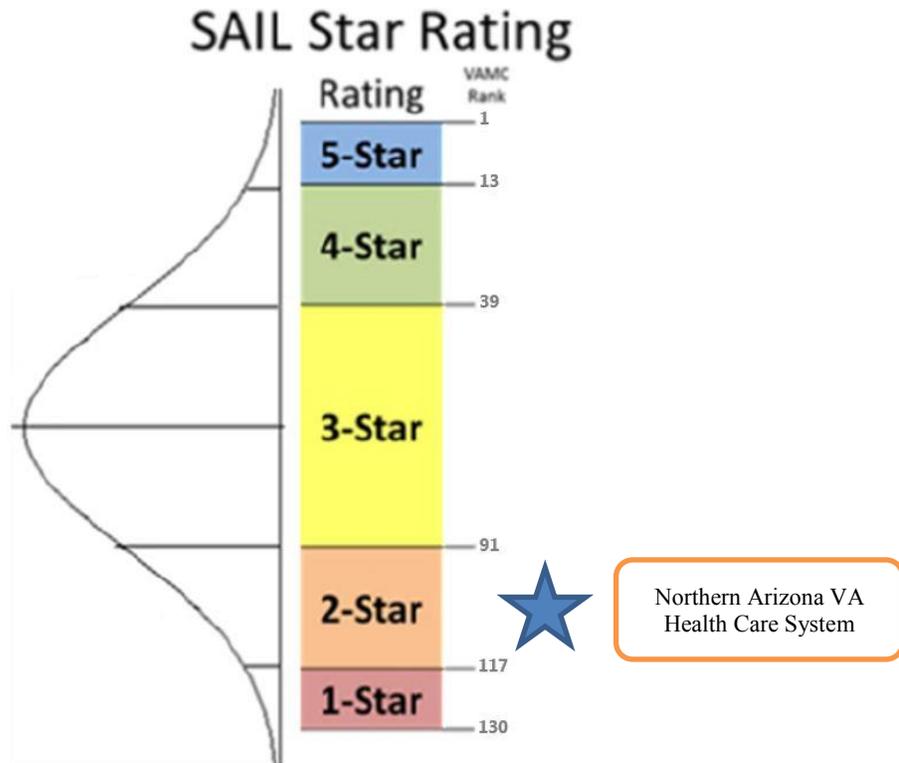
Figure 6. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed January 11, 2019)

Figure 7 illustrates the facility's quality of care and efficiency metric rankings and performance compared with other VA facilities as of September 30, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of health care (HC) associated (Assoc) infections, acute care in-hospital standardized mortality ratio (SMR), and admission (Admit) reviews met). Metrics that need improvement are denoted in orange and red (for example, rating (of) primary care (PC) provider, physician capacity, call responsiveness, best place to work, and registered nurse (RN) turnover).[32]

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[31] 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.

[32] For information on the acronyms in the SAIL metrics, please see Appendix D.
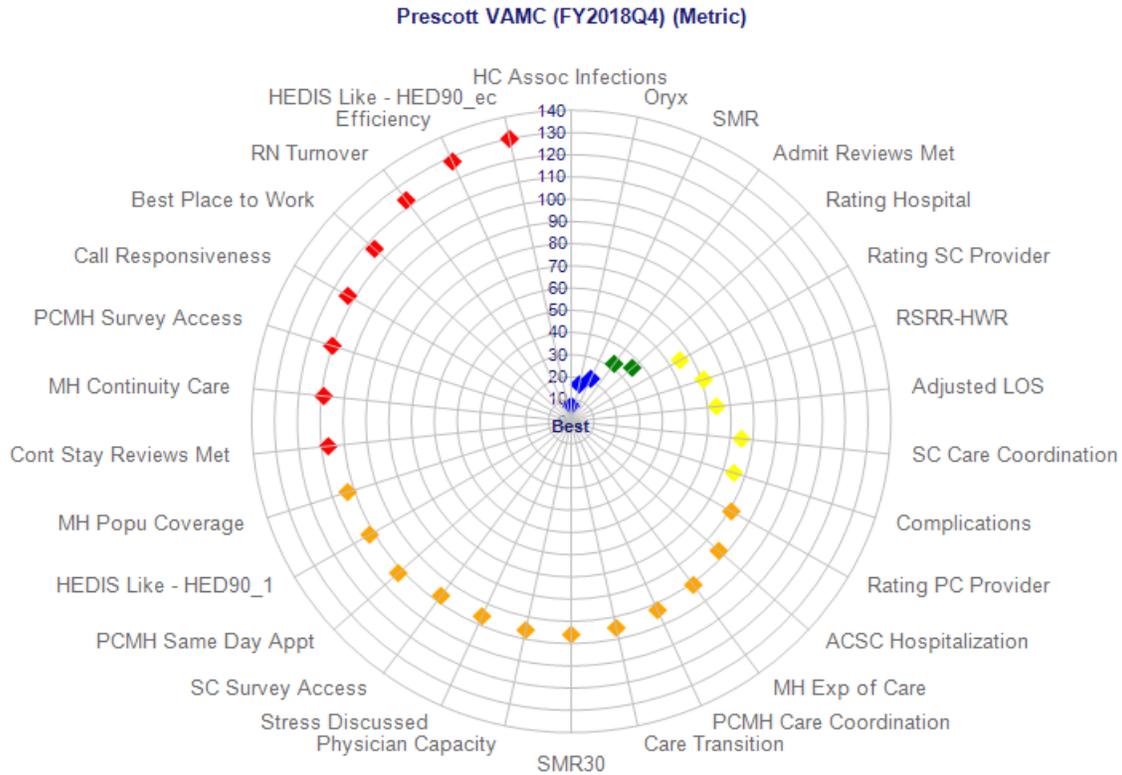
Figure 7. *Facility Quality of Care and Efficiency Metric Rankings (as of September 30, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

The SAIL Value Model also includes "SAIL CLC," which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in The Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare*.[33] The SAIL CLC provides a single resource to review quality measures and health inspection results. It

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[33] 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 unannounced survey, staffing, quality, and overall results.[34] Table 9 summarizes the rating results for the facility's CLC as of September 30, 2018. The facility has an overall "2-star" rating, and its rating for quality is also a "2-star."

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

Domain	Star Rating
Unannounced Survey	1
Staffing	5
Quality	2
Overall	2

Source: VHA Support Service Center

In exploring the reasons for the "2-star" quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 8 illustrates the facility's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of physical restraints–long stay (LS) and moderate-severe pain–short stay (SS)). Metrics that need improvement and were likely the reasons why the facility had a "2-star" for quality are denoted in orange and red (for example, catheter in bladder (LS), help with activities of daily living (ADL) (LS), and ability to move independently worsened (LS)).[35]

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[34] *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.)

[35] For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.
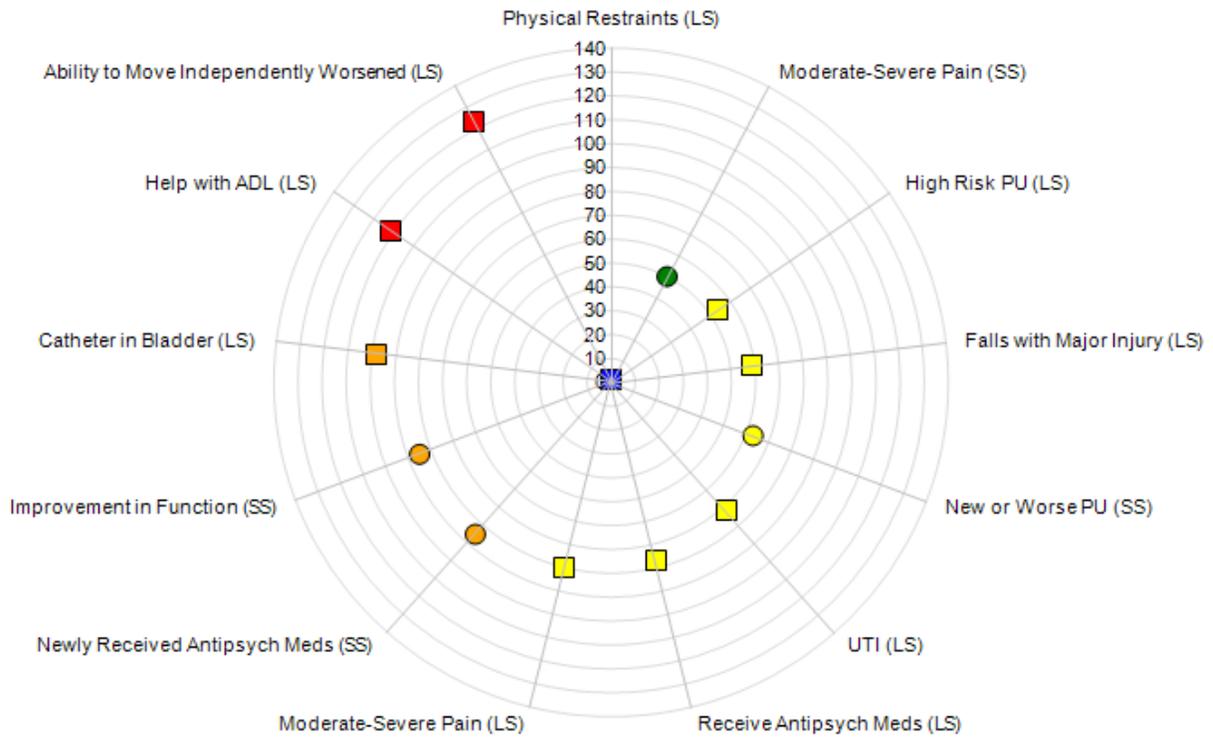
Figure 8. *Facility CLC Quality Measure Rankings (as of September 30, 2018)*
LS = Long-Stay Measure   SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team was relatively new to their positions and the facility. The director, appointed in March 2017, was the most tenured team member. The associate director and chief of staff were permanently assigned in March 2018 and December 2018, respectively. The acting ADPCS, having been in the role for approximately two months, had recently been selected for the position permanently and was going through the pre-appointment process. Except for the director and ADPCS, selected survey scores related to employees' satisfaction with the facility executive leaders were similar to or better than the facility and VHA averages. In all, opportunities exist to improve employee satisfaction. The facility leaders attributed the low scores to the change in leadership and efforts made to improve organizational culture and operations. The director was optimistic that future surveys will accurately reflect efforts by the new leadership team. Patient experience survey data revealed opportunities exist to improve the Patient-Centered Medical Home outpatient experience. The facility leaders appeared actively engaged with employees and patients and were working to improve employee and patient engagement and satisfaction. The leaders appeared to support efforts to improve and

maintain patient safety, quality care, and other positive outcomes (such as initiating plans to maintain positive perceptions of the facility through active stakeholder engagement). The OIG's review of the facility's accreditation findings, sentinel events, disclosures, and patient safety indicator data did not identify any substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and SAIL CLC metrics but should continue to take actions to sustain and improve performance of measures contributing to the facility SAIL "2-star" and CLC "2-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.[36] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[37] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[38]

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,[39] utilization management (UM) reviews,[40] patient safety incident reporting with related root cause analyses,[41] and cardiopulmonary resuscitation (CPR) episode reviews.[42]

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.[43]

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[36] 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.)

[37] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence,* September 2014.

[38] VHA Directive 1026.

[39] 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.

[40] 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.

[41] The definition of an RCA 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."

[42] VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

[43] 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.[44]

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.[45]

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.[46]

The OIG team 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:[47]

- Protected peer reviews

    o Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)

    o Implementation of improvement actions recommended by the Peer Review Committee

    o Completion of final reviews within 120 calendar days

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

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[44] VHA Directive 1117(2).

[45] VHA Handbook 1050.01.

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

[47] For CHIP reviews, 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

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

- UM

  - 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[49]

  - 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

Quality, Safety, and Value Conclusion

The OIG found general compliance with requirements for protected peer reviews. However, OIG inspectors identified concerns with documentation of physician UM advisors' decisions in the

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[48] VHA Directive 1190.

[49] According to VHA Handbook 1050.01, "the requirement for a total of <u>eight</u> [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]."

National UM Integration database, the interdisciplinary review of UM data, implementation of root cause analysis action items, and analysis of resuscitation episodes that warranted recommendations for improvement.

Specifically, VHA requires that physician UM advisors document their decisions in the National UM Integration database regarding appropriateness of acute inpatient admissions and continued stays for 75 percent of all inpatient stays.[50] From July 1, 2018, through December 31, 2018, physician UM advisors documented only 44 percent of their decisions in the database, falling short of the 75 percent requirement. This resulted in a lack of assurance that the appropriate level of care and treatment was provided to patients. The facility has one full-time physician UM advisor and one hospitalist who acted as backup advisor, leaving insufficient coverage when both were concurrently out of the office. The UM manager and physician UM advisor cited an inadequate number of trained backup physician UM advisors as the reason for noncompliance.

Recommendation 1

1. The chief of staff ensures physician utilization management advisors consistently document their decisions in the National Utilization Management Integration database and monitors the advisors' compliance.[51]

Facility concurred.

Target date for completion: September 2019

Facility response: The Utilization Management Coordinator in collaboration with the physician Utilization Management (UM) advisor ensured the Acute Care Medical Director and an additional Hospitalist completed Physician Utilization Management Advisor (PUMA) training to have additional physician UM advisors for the facility. This was monitored by the UM Coordinator for a minimum of six consecutive months or two quarters with a goal of 75 percent compliance or better. Monitoring is ongoing, and the results are reported by the UM Coordinator in the quarterly UM Committee meeting. The UM Coordinator reports monthly to the Quality and Performance Board. From March 1, 2019 thru September 30, 2019, physician UM advisors documented 94.8 percent of their decisions in the National Utilization Management Integration database, exceeding the 75% requirement for seven consecutive months. We request closure of this recommendation based on evidence provided.

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[50] VHA Directive 1117(2).

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

As to UM data, VHA requires interdisciplinary review of UM data. This process must include, but is not limited to, participation by representatives from UM, medicine, nursing, social work, case management, mental health, and chief business office revenue utilization review (CBO-R-UR).[52] From April 2018 through January 2019, the UM Committee lacked consistent representation from medicine, social work, mental health, and the CBO-R-UR. As a result, the UM Committee performed reviews and analyses of UM data without the perspectives of key medicine, social work, mental health, and utilization review colleagues. The UM manager acknowledged lack of oversight and attributed being new to the position and recently becoming aware of the requirements as reasons for noncompliance.

Recommendation 2

2. The chief of staff makes certain that all required representatives consistently participate in interdisciplinary reviews of utilization management data and monitors representatives' compliance.[53]

Facility concurred.

Target date for completion: October 2019

Facility response: The Utilization Management Coordinator revised the Utilization Management (UM) charter to reflect the required representatives per VHA Directive 1117(2) Utilization Management Program. To ensure an increase in representation from medicine, social work, mental health and the chief business office revenue utilization review (CBO-R-UR), the meeting was changed to a SKYPE (internet/web-based software that enables voice and video phone calls) format and the physical location of the meeting was made more accessible. For members unable to attend the meeting due to patient care, there is a discussion via electronic communication with the UM Coordinator prior to the meeting and documented in the UM minutes under c. Topic: Acute Care Flow Discussions. This was monitored by the UM Coordinator for a minimum of six consecutive months or two quarters with a goal of 100 percent compliance. Monitoring is ongoing, and the results are reported by the UM Coordinator in the quarterly UM Committee meeting. The UM Coordinator reports monthly to the Quality and Performance Board. From March 1, 2019 thru October 31, 2019, quarterly UM committee meetings were held in April 2019, July 2019 and October 2019 with a quorum of 6 or greater members in attendance at each meeting. We request closure of this recommendation based on evidence provided.

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[52] VHA Directive 1117(1).

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

For root cause analyses, VHA requires full implementation and monitoring of recommended improvement actions.[54] The OIG found a total of 14 improvement actions documented in the five FY 2018 root cause analyses reviewed. Twelve of the 14 improvement actions lacked full implementation. This resulted in missed opportunities for communication throughout the organization of potential and actual causes of harm to patients, systems vulnerabilities, and the patient safety improvement processes necessary to prevent future occurrences of similar adverse events. The patient safety manager attributed the noncompliance to heavy turnover of key staff assigned to follow-through with action items.

Recommendation 3

3. The facility director ensures all root cause analyses actions are fully implemented by assigned staff and monitors the assigned staff's compliance.

Facility concurred.

Target date for completion: June 2020

Facility response: The chief of Quality Programs Service Line (referred locally as Chief Quality, Safety and Value (QSV) or Chief QSV) elevated the completion of Root Cause Analysis (RCA) action items to the Executive Leadership Team at the Quality and Performance Board meeting on June 18, 2019. The following day, on June 19, 2019, the Patient Safety Manager notified the respective staff via email of assignments and the timeline to complete RCA actions. The Patient Safety Manager, the Risk Manager, and the Chief QSV have met with and will continue to meet with respective staff as needed. Completion of RCA action items will be monitored by the Patient Safety Manager for a minimum of six consecutive months with a goal of 100 percent compliance. Currently, the Patient Safety Manager reports RCA action completion progress weekly to the Chief QSV and reports monthly to the Quality and Performance Board.

For resuscitation episode reviews, VHA requires that the facility establish a committee to review each resuscitative episode under the facility's responsibility. Each review must include identification of errors or deficiencies in technique or procedures, lack of availability or malfunction of equipment, clinical or patient care issues, and delays in initiating CPR or resuscitation.[55] The CPR Committee chair asserted completion of resuscitation episode reviews but could not provide evidence that committee members reviewed the required elements for each resuscitative episode. This resulted in an incomplete analysis of resuscitation episodes and trends, which may impact patient safety. The CPR Committee chair stated the committee was unaware of the requirements and believed current practice met standards.

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[54] VHA Handbook 1050.01.

[55] VHA Directive 1177.

Recommendation 4

4. The facility director ensures the Cardiopulmonary Resuscitation Committee conducts complete analyses of resuscitative episodes by reviewing required elements and monitors the committee's compliance.[56]

Facility concurred.

Target date for completion: September 2019

Facility response: In March 2019, the nurse manager of the Emergency Department revised the Cardiopulmonary Resuscitation/Rapid Response Team (CPR/RRT) monthly monitor to include the two missing required elements: lack of availability or malfunction of equipment and delays in initiating CPR or resuscitation. This was monitored by the nurse manager for a minimum of six consecutive months or two quarters with a goal of 100 percent compliance. Monitoring is ongoing, and the results are reported by the nurse manager in the monthly Cardiopulmonary Resuscitation (CPR) Committee meeting. The CPR Committee reports quarterly to the Quality and Performance Board. Monthly audits, including the two additional required elements, were initiated and consistently used and monitored for seven consecutive months beginning in March 2019 through September 2019. Results showed 100 percent compliance with all required elements. We request closure of this recommendation based on evidence provided.

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

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).[57]

Clinical privileges need to be specific, based on the individual's clinical competence. They are recommended by service chiefs and the Medical Staff Executive Committee and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to their expiration.[58]

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 (OPPE), is essential to confirm the quality of care delivered."[59]

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.[60] 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.[61]

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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[57] 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.)

[58] VHA Handbook 1100.19.

[59] VHA Handbook 1100.19.

[60] 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).

[61] 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.)

- Five 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[62]

- Four 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
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[63]
  - Approval of privileges for a period of less than, or equal to, two years

- Focused professional practice evaluations
  - Criteria defined in advance
  - Use of required criteria in FPPEs for selected specialty LIPs
  - Results and time frames clearly documented
  - Evaluation by another provider with similar training and privileges
  - Executive Committee of the Medical Staff's consideration of FPPE results in its decision to recommend continuing the initially granted privileges

- Ongoing professional practice evaluations
  - Criteria specific to the service or section
  - Use of required criteria in OPPEs for selected specialty LIPs

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[62] The 18-month period was from August 12, 2017, through February 11, 2019. The 12-month review period covered February 12, 2018 through February 11, 2019; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being fewer than three providers in the facility that are privileged in a particular specialty.

[63] 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 and FPPEs. However, OIG inspectors identified a deficiency with the OPPE process that warranted a recommendation for improvement.

VHA has defined the specialty-specific elements to be used, where appropriate, for gastroenterology, pathology, nuclear medicine, and radiation oncology OPPEs.[64] This OPPE process ensures a consistent approach to evaluating providers in these specialties and is essential to confirming the quality of care delivered. Of the 20 LIPs reviewed, two were nuclear medicine providers, and the OIG team found no evidence that the clinical managers used nuclear medicine-specific criteria or data in their OPPEs of these providers. As a result, the providers delivered care without a thorough evaluation of their nuclear medicine-specific practice. The new chief of staff and several specialty service chiefs attributed the noncompliance to frequent turnover in key leadership positions.

Recommendation 5

5. The chief of staff makes certain that the Radiology Service chief includes the required nuclear medicine-specific criteria for ongoing professional practice evaluations of nuclear medicine providers and monitors the chief's compliance.[65]

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[64] Acting Deputy Under Secretary for Health for Operations and Management Memorandum, *Requirements for Peer Review of Solo Practitioners,* August 29, 2016.

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

Facility concurred.

Target date for completion: November 2019

Facility response: To ensure a consistent approach in evaluating providers in nuclear medicine, the Chief of Staff, the chief of Quality Programs Service Line, and the Credentialing Lead reviewed and revised the professional practice evaluation forms for solo practitioners in the specialty of Nuclear Medicine in August 2018. The Ongoing Professional Practice Evaluation (OPPE) forms were updated with the required additions of specific criteria under the Patient Care and Procedures section that included nuclear medicine specific criteria for nuclear medicine providers. Completion of OPPEs for nuclear medicine providers will be monitored by the Credentialing Lead for a minimum of six consecutive months with a goal of 100 percent compliance. For the OPPE rating period of January 1, 2019 through June 30, 2019, clinical managers completed OPPE reviews for the two nuclear medicine providers previously reviewed in the February inspection using the nuclear medicine-specific criteria. OPPE reviews are reported by the Credentialing Lead at the monthly Medical Executive Board meetings. For the first six-month OPPE rating period (January 1, 2019-June 30, 2019), clinical managers completed the nuclear medicine specific criteria for two of two nuclear medicine providers for 100 percent compliance. We request closure of this recommendation based on evidence provided.

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.[66]

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 team 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.[67]

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.[68]

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.[69] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[70]

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

[67] 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).

[68] 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.)

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

[70] VHA Directive 1028, *Electrical Power Distribution Systems*, July 25, 2014. (This VHA Directive was scheduled for recertification on or before the last working date of July 2019 and has not been recertified.)

Occupational Safety and Health Administration,[71] and National Fire Protection Association standards.[72] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[73]

In all, the OIG team inspected ten patient care areas—medical/telemetry, one CLC with two units (CLC 1 and CLC 2), domiciliary, emergency department, two primary care clinics (patient aligned care teams 117 and 158), podiatry, spinal cord injury/allergy (Amber), and hematology/cardiology clinics. The OIG team also inspected the Anthem VA Clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. OIG evaluated the following location-specific performance indicators:

- Parent facility
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Community based outpatient clinic
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Locked inpatient mental health unit[74]
  - Mental health environment of care rounds
  - Nursing station security

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[71] 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. (The website was accessed on June 28, 2018.)

[72] 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. (The website was accessed on June 28, 2018.)

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

[74] The facility did not have a locked inpatient mental health unit.

- 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

Environment of Care Conclusion

Generally, the facility and Anthem VA Clinic met cleanliness and safety requirements associated with the above performance indicators. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG team identified noncompliance with medication storage at the parent facility that warranted a recommendation for improvement.

Specifically, VHA requires multi-dose medications to be labeled with an expiration date upon opening.[75] In 2 of the 10 areas inspected, the OIG found 16 open and undated multi-dose medication vials stored with medications available for administration.[76] This resulted in the lack of assurance of safe medication administration practices. The nurse managers acknowledged the deficiency and cited nursing staff's lack of attention to detail as the reason for noncompliance.

Recommendation 6

6. The associate director for Patient Care Services ensures that nursing staff label multi-dose medication vials with an expiration date upon opening and monitors staff compliance.[77]

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[75] VHA Directive 1108.06, *Inpatient Pharmacy Services*, February 8, 2017.

[76] Patient aligned care team 117 and spinal cord injury/allergy (Amber) clinics.

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

Facility concurred.

Target date for completion: October 2019

Facility response: On March 20, 2019 and March 27, 2019 the Clinical Nurse Leader (CNL) of Primary Care (PC) conducted education /training at PC staff meetings on labeling multi-use vials with the open/expiration date and staff initials. The PC nurse manager and the CNL revised the Environment of Care (EOC) Checklist to include "Multi Dose Vial open/exp written on bottle." The EOC checklist is completed daily by nursing staff. The PC nurse manager and CNL created a flyer posted in medication rooms reminding staff to label multi-use vials with the open/ expiration date and staff initials, posted a calculation sheet for the expiration date for medications discarded 28 days after opening and posted a Memorandum for All Allergy/Immunization Clinics dated January 1, 2018 on the subject of 'Allergen Extract Vaccine Stability, Expiration Dating and Sterility." The dating of multi-dose medication vials stored in the medication refrigerators is monitored weekly by nursing staff from the two respective PC areas and reported to the Continuous Readiness Coordinator who reviews, if necessary, at PC staff meetings. Nursing staff will monitor until 100 percent compliance is demonstrated for six consecutive months or two quarters.

Monitoring of the two respective areas in Primary Care began in March 2019 and continued through October 31, 2019 for 8 consecutive months with the medication refrigerator in the Spinal Cord Clinic having 100 percent compliance for the 8 consecutive months and the Medication refrigerator for the PC clinics in building 117 having 100 percent compliance from April 2019 through October 31, 2019 – seven consecutive months.

We request closure of this recommendation based on evidence provided.

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.[78] 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.[79]

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.[80]

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;[81] 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[82]
- Requirements for controlled substances inspectors

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

[79] 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.

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

[81] The two quarters were from July 1, 2018, through December 31, 2018.

[82] 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[83]
  - o Accountability for all prescription pads in pharmacy
  - o Verification of hard copy controlled substances prescriptions
  - o Verification of 72-hour inventories of the main vault
  - o Quarterly inspections of emergency drugs
  - o Monthly checks of locks and verification of lock numbers
- Facility review of override reports[84]

Medication Management Conclusion

The OIG team found general compliance with requirements for most of the performance indicators evaluated, including the controlled substances coordinator reports, pharmacy

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[83] 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."

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

operations, requirements for controlled substances inspectors, and review of override reports. The OIG identified noncompliance with controlled substances non-pharmacy (patient care areas) and pharmacy inspections that warranted recommendations for improvement.

Specifically, VHA requires controlled substances program staff to conduct monthly inspections of controlled substances storage in non-pharmacy and pharmacy areas, which includes conducting physical inventories and reconciling one random day's dispensing and return of stock activities for automated dispensing cabinets.[85] The OIG found that all 10 non-pharmacy areas reviewed lacked consistent evidence of reconciliation of one random day's return of stock to pharmacy from automated dispensing cabinet. Missed reconciliations may cause delays in identifying potential drug diversion activities. The controlled substances coordinator misunderstood the requirement and believed the current reconciliation process met standard.

Recommendation 7

7. The facility director makes certain that controlled substances program staff complete reconciliation of one random day's return of stock to pharmacy from every automated dispensing cabinet during inspections and monitors controlled substances program staff compliance.[86]

Facility concurred.

Target date for completion: September 2019

Facility response: The Controlled Substance Inspection (CSI) Coordinator ensures that CSI staff complete reconciliation of one random day's return of stock to pharmacy from every automated dispensing cabinet during inspections and monitors controlled substances program staff compliance. The facility has 10 non-pharmacy areas. This is monitored by the CSI Coordinator until 100 percent compliance is demonstrated for a minimum of six consecutive months or two quarters. Monitoring will be ongoing and reported via a quarterly report to the facility Director and to the Quality and Performance Board. The CSI coordinator monitored the monthly inspections of the 10 non-pharmacy areas from February 2019 through September 2019, for eight consecutive months with 100 percent compliance. We request closure of this recommendation based on evidence provided.

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[85] VHA Directive 1108.02(1).

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

Additionally, VHA requires controlled substances inspectors to complete a quarterly physical inventory of the controlled substances in the emergency cache by breaking the locks and physically counting all controlled substances.[87] In each of the two months of the quarter when the physical inventory does not occur, the controlled substances inspector must check the locks for any evidence of tampering and verify the lock number. The OIG team found that controlled substances inspectors did not check the emergency drug cache locks for any evidence of tampering or verify the lock numbers for two of the six months reviewed. Failure to perform required inspections may delay the replacement of expired controlled substances and compromise the facility's emergency preparedness. The controlled substances coordinator acknowledged a lack of oversight as the reason for noncompliance.

Recommendation 8

8. The facility director ensures controlled substances inspectors complete emergency drug cache inspections and monitors inspectors' compliance.[88]

Facility concurred.

Target date for completion: September 2019

Facility response: The Controlled Substance Inspection (CSI) Coordinator ensures that CSI staff complete emergency drug cache inspections and monitors controlled substances program staff compliance. Since February 2019, the CSI program has inspected the emergency drug cache monthly. This is monitored by the CSI Coordinator until 100 percent compliance is demonstrated for a minimum of six consecutive months or two quarters. Monitoring will be ongoing and reported via a quarterly report to the facility Director and to the Quality and Performance Board. The CSI coordinator monitored the inspections of the emergency drug cache monthly from February 2019 through September 2019, for eight consecutive months with 100 percent compliance. We request closure of this recommendation based on evidence provided.

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[87] VHA Directive 1108.02(1).

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

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."[89] 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.[90]

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.[91] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[92]

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.[93] Those who screen positive must have access to appropriate MST-related care.[94] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. All new 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.[95]

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

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

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

[91] VHA Directive 1115.

[92] 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.)

[93] 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."

[94] VHA Directive 1115.

[95] VHA Handbook 1160.01.

[96] 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.[97]

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

- Designated facility MST coordinator

    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 many of the performance indicators, including the designation of an MST coordinator and the provision of clinical care. The OIG noted concerns, however, with establishing and monitoring MST-related staff training and informational outreach, communicating MST-related issues with local leaders, tracking MST-related data, and providers completing MST mandatory training that warranted recommendations for improvement.

Specifically, VHA requires MST coordinators to establish and monitor MST-related staff training and informational outreach and communicate the status of MST services and initiatives

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

with local leaders.[98] The OIG team determined that the MST coordinator did not establish and monitor MST-related staff training and informational outreach or communicate MST services and initiatives with leaders. This hinders accomplishment of program goals and facility leaders' ability to identify and address improvement opportunities. The MST coordinator and interim Mental Health and Behavioral Science Services chief attributed the lack of compliance to the need to prioritize clinical care over administrative duties due to significant vacancies in Mental Health and Behavioral Science Services.

Recommendation 9

9. The facility director ensures that the military sexual trauma coordinator establishes and monitors military sexual trauma-related staff training.

Facility concurred.

Target date for completion: June 2020

Facility response: The Military Sexual Trauma (MST) Coordinator will monitor additional MST-related training provided to Mental Health and Primary Care staff in addition to the mandatory Talent Management System Training. This will be monitored by the MST Coordinator for a minimum of six consecutive months with a goal of 90 percent compliance. Monitoring will be ongoing and reported quarterly to the Medical Executive Board.

Recommendation 10

10. The facility director makes certain that the military sexual trauma coordinator establishes and monitors informational outreach and monitors the coordinator's compliance.

Facility concurred.

Target date for completion: June 2020

Facility response: The Military Sexual Trauma (MST) Coordinator will attend at least one informational outreach event per month. This will be monitored by the MST Coordinator for a minimum of six consecutive months with a goal of 90 percent compliance. Monitoring will be ongoing, and data reported quarterly to the Medical Executive Board (MEB). The MEB minutes are reviewed and signed off by the facility director.

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[98] VHA Directive 1115.

Recommendation 11

11. The facility director ensures the military sexual trauma coordinator communicates the status of military sexual trauma services and initiatives with leadership and monitors the coordinator's compliance.

Facility concurred.

Target date for completion: June 2020

Facility response: The Military Sexual Trauma (MST) Coordinator will communicate the status of MST services and initiatives as needed and monthly to the Post Traumatic Stress Disorder Clinical Team Program Manager. The MST Coordinator will also report MST program services and initiatives to leadership quarterly through the Medical Executive Board (MEB). Evidence of reporting will be documented through MEB meeting minutes, which are reviewed and signed by the facility director. Compliance with the requirement will be monitored for a minimum of six consecutive months or two consecutive quarters until a target of 90 percent is achieved and sustained.

VHA also requires that MST-related data are tracked, including monitoring screening, referral, and treatment services provided to veterans.[99] The OIG found that the facility did not have a process to track and monitor MST-related data. This may result in ineffective program evaluation and missed opportunities for improvement. The MST coordinator was unaware of this requirement.

Recommendation 12

12. The facility director makes certain that the military sexual trauma coordinator tracks and monitors military sexual trauma-related data and monitors the coordinator's compliance.

Facility concurred.

Target date for completion: June 2020

Facility response: The Military Sexual Trauma (MST) Coordinator will collaborate with the Mental Health Clinical Operations Social Worker to monitor MST-related data to include screening, referrals and treatment services provided. This will be monitored for a minimum of six consecutive months with a goal of 100 percent compliance. Monitoring will be ongoing, and data reported quarterly to the Medical Executive Board (MEB). The MEB minutes are reviewed and signed off by the facility director.

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[99] VHA Handbook 1160.01.

VHA requires all primary care and mental health providers hired after July 1, 2012 complete MST mandatory training no later than 90 days after entering their position.[100] Of the seven training records reviewed, the OIG found that one provider did not complete the training within 90 days of hire and two providers had not completed the training at all. This could prevent providers from administering appropriate counseling, care, and service to veterans who experienced MST. The MST coordinator and interim Mental Health and Behavioral Science Services chief cited a lack of oversight as the reason for noncompliance.

Recommendation 13

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

Facility concurred.

Target date for completion: June 2020

Facility response: Military Sexual Trauma (MST) mandatory training within the required time frame for Mental Health and Primary Care providers is monitored by the MST Coordinator in collaboration with the Talent Management System (TMS) Domain Manager via monthly TMS reports generated electronically. Any staff delinquent in training receives a reminder email with supervisor notification. This will be monitored for a minimum of six months with a goal of 90 percent compliance. Monitoring will be ongoing and reported quarterly to the Medical Executive Board.

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[100] VHA Memorandum, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers (VAIQ 7663786)*, February 2, 2016, refers to specific MST training requirements for providers assuming their position before or after July 1, 2012.

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."[101] 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.[102]

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."[103]

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.[104] 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."[105] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[106] 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.[107] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[101] 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.)

[102] 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.)

[103] 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.)

[104] 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.)

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

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

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

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.[108]

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 EHRs of 35 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[109] The OIG team 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 found compliance with clinicians justifying the reason for medication initiation and validating general patient and/or caregiver understanding after educating them about newly prescribed medications. However, the OIG team identified that clinicians did not provide adequate patient and/or caregiver education specific to the newly prescribed medications nor did they reconcile patients' medications. These latter two findings warranted recommendations for improvement.

Specifically, TJC requires that clinicians educate patients and families about "safe and effective use of medications" and that the patient's "medical record contains information that reflects the patient's care, treatment, and services."[110] The OIG estimated that clinicians provided this education to 49 percent of the patients at the facility, based on electronic health records reviewed.[111] Providing medication education is critical to ensuring that patients or their caregivers have the information they need to manage their own health at home. The interim Mental Health and Behavioral Science Services chief was aware of the requirements and believed education was being provided but cited ineffective oversight and peer review processes

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

[109] The seven selected antidepressant medications are amitriptyline, clomipramine, desipramine, doxepin (>6mg/day), imipramine, nortriptyline, and paroxetine.

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

[111] The OIG is 95 percent confident that the true compliance rate is somewhere between 31.9 and 65.6 percent, which is statistically significantly below the 90 percent benchmark.

resulted in unrecognized gaps in required documentation. The Primary Care chief also cited the absence of a formal process for documenting patient education as the reason for noncompliance.

Recommendation 14

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

Facility concurred.

Target date for completion: June 2020

Facility response: On May 31, 2019, the Veterans Integrated Service Network (VISN) 22 held a meeting which included the facility's Mental Health (MH), Primary Care (PC), Pharmacy and VISN staff to review and discuss antidepressant use among the elderly, use of the Beers's Criteria for anticholinergic antidepressant medications, the importance of MH and PC clinicians providing and documenting patient/caregiver education about the safe and effective use of newly prescribed antidepressant medications, and documenting a follow-up within 30 days. In June 2019, the Clinical Applications Coordinator and the MH pharmacist collaborated to create two templates in the Computerized Patient Record System (CPRS). This was a VISN mandate. The first template titled "Patient Education" is to document patient/caregiver education. The following will be documented in the template: topic, learner and place, method of education and the outcome(s). The second template is titled "Patient Education: Anticholinergic" and gives the provider a choice of documenting the initial use of the medication or the 30-day follow-up. The following will be documented in the template for either the initiation of the medication or the follow-up: justification for the medication initiation, evidence of patient/caregiver education specific to the antidepressant prescribed, clinician evaluation of patient/caregiver understanding of the education, assessment of adverse effects, effectiveness of the antidepressant, adherence to dosing guidelines, and medication reconciliation. The facility is in the process of determining the plan to educate PC and MH providers and the responsibility of monitoring and reviewing progress. This will be monitored for a minimum of six consecutive months or two quarters with a goal of 90 percent compliance.

Regarding medication reconciliation, TJC requires that "a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolve any discrepancies."[112] VHA requires that clinicians review and reconcile medications relevant to the episode of care.[113] TJC also requires patients' "medical records contain information that reflects the patient's care, treatment, and services."[114]

The OIG team estimated that clinicians performed medication reconciliation for 40 percent of the patients at the facility, based on electronic health records reviewed.[115] Failure to maintain and communicate accurate patient medication information and reconcile medications increases the risk of duplications, omissions, and interactions in the patient's actual drug regimen.[116] The interim Mental Health and Behavioral Science Services chief was aware of the requirement and cited insufficient oversight of mental health clinicians in the outpatient settings as the reason for noncompliance.

Recommendation 15

15. The chief of staff ensures clinicians reconcile medication information and maintain and communicate accurate patient medication information in patients' electronic health records and monitors clinicians' compliance.

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

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

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

[115] The OIG is 95 percent confident that the true compliance rate is somewhere between 24.3 and 56.3 percent, which is statistically significantly below the 90 percent benchmark.

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

Facility concurred.

Target date for completion: June 2020

Facility response: Clinicians will reconcile medication information and maintain and communicate accurate patient medication information in patient's electronic health records. Mental health providers will review the current list of all medications in the Computerized Patient Record System CPRS) and discuss possible side effects of psychotropic medications with the patient. Primary Care (PC) will conduct medication reconciliation as follows: At check-in the medical support assistant (MSA) or designee will provide the patient with a printed list of current medications, obtained by accessing CPRS, Reports Tab, Health Summary, Medication Reconciliation – the patient will review and make any changes then give the list to the PC provider or nurse – the PC provider will review the medication list with the patient and update the medication(s) as appropriate in CPRS and counsel the patient on the medications. At the conclusion of the visit the MSA will print out an updated medication list and give to the patient. The facility is in the process of determining the plan to educate PC and MH providers and the responsibility of monitoring and reviewing progress. This will be monitored for a minimum of six consecutive months or two quarters with a goal of 90 percent compliance. Results will be reported to executive leadership.

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.[117] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[118] 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.[119] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[120]

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.[121]

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.[122]

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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[117] 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.)

[118] 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.)

[119] 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.)

[120] 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.)

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

[122] VHA Directive 1330.01(2).

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.[123]

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 11 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 team evaluated the following performance indicators:

- Appointment of a women veterans program manager

- Appointment of a women's health medical director or clinical champion

- Facilitte 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 the required time frame

- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women's Health Conclusion

Generally, the OIG found compliance with several of the performance indicators, including the designation of a women veterans program manager and women's health medical director and the provision of follow-up care. However, the OIG team identified noncompliance with the facility Women Veterans Health Committee, tracking of cervical cancer screening data, and communication of abnormal results to patients within the required time frame that warranted recommendations for improvement.

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[123] VHA Directive 1330.01(2).

Specifically, VHA requires the Women Veterans Health Committee must maintain an active charter, meet at least quarterly, and report to executive leadership with signed minutes.[124] At the time of the inspection, the OIG team found that the Women Veterans Health Committee held its last meeting in April 2017 and had not met or reported to leadership for 22 months. As a result, the women veterans program lacked the required guidance and oversight to ensure high-quality equitable care for women veterans.[125] The acting ADPCS, Quality Management chief, and women veterans program manager reported that core committee members were not held accountable for attending meetings and recent key leadership turnover caused ineffective oversight and instability for primary care representatives and other core committee members.

Recommendation 16

16. The facility director ensures the Women Veterans Health Committee maintains an active charter, meets at least quarterly, and reports to executive leaders with signed minutes and monitors the committee's compliance.

Facility concurred.

Target date for completion: June 2020

Facility Response: The Women Veterans Program Manager revised the Women Veterans Health Committee Charter and it was signed by the Chief of Staff on May 24, 2019. The Women Veterans Health Committee meets quarterly and has met for two consecutive quarters, in FY19 Q3 in April 2019 and in FY19 Q4 in July 2019. Signed meeting minutes are complete for April 2019. The Women Veteran Program Manager (WVPM) reports quarterly to the Medical Executive Board. The WVPM will monitor until 90 percent compliance is maintained for a minimum of two consecutive quarters with the requirement for the Women Veterans' Health Committee to meet quarterly and reports to the Medical Executive Board.

VHA also requires that each facility have a process to track data, "including notification of patients who are due for screening, tracking of completion of screening, results reports, and follow-up care" related to abnormal cervical cancer screenings.[126] The OIG team identified that the facility did not have a systematic process for collating, trending, and analyzing cervical cancer screening data for quality assurance purposes. The women veterans program manager reported tracking abnormal cervical cancer screening data; however, the results were not collated, analyzed, or reported in a manner consistent with other quality improvement activities. Lack of a systematic quality assurance process for tracking cervical cancer screening results reporting and follow-up care data may cause delays in identifying and addressing problem areas

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[124] VHA Directive 1330.01(2).
[125] VHA Directive 1330.01(2).
[126] VHA Directive 1330.01(2).

and implementing appropriate action plans. The women veterans program manager stated the reasons for noncompliance included a lack of awareness of the requirements and an absence of formal data management training.

Recommendation 17

17. The chief of staff confirms that the women veterans program manager implements a quality assurance process to include tracking of data for cervical cancer screening and results and monitors the manager's compliance.

Facility concurred.

Target date for completion: June 2020

Facility response: The Women Veterans Program Manager will collaborate with Primary Care leadership, and QSV leadership to implement a quality assurance process to include tracking of data for cervical cancer screening. This will be monitored for a minimum of six consecutive months with a goal of 90 percent compliance. Data will be reported quarterly to the Medical Executive Board (MEB).

For communicating abnormal results to patients, VHA requires that providers notify patients with abnormal cervical pathology results within seven calendar days of the report becoming available to the ordering provider.[127] The OIG determined that providers communicated abnormal results in a timely manner to patients in 73 percent of electronic health records reviewed.[128] This resulted in delayed patient notification and initiation of follow-up care. Women Veterans Health Committee members reported lack of stable leadership, including the chief of staff and Primary Care chief, as the reason for noncompliance.

Recommendation 18

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

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[127] VHA Directive 1330.01(2).

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

Facility concurred.

Target date for completion: June 2020

Facility response: The Primary Care Clinical Nurse Leader will conduct a weekly audit to monitor the communication between providers and the patient for abnormal Pap results within the required time frame. This will be monitored for a minimum of 6 consecutive months with a goal of 90% compliance. The monitoring data will be reported monthly to the Medical Executive Board.

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."[129] 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.[130]

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."[131]

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."[132]

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement (EMI) 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.[133]

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

[130] VHA Directive 1101.05(2).

[131] VHA Directive 1101.05(2).

[132] TJC. Leadership standard LD.04.03.11.

[133] 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.[134] Managers must ensure medications are securely stored,[135] a psychiatric intervention room is available,[136] 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.[137]

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

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

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[134] VHA Directive 1101.05(2).

[135] TJC. Medication Management standard MM.03.01.01.

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

[137] VHA Directive 1101.05(2).

- 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[138]

- Medication security and labeling

- Management of patients with mental health disorder

- 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

The facility generally complied with many of the performance indicators used by the OIG team to assess the operations and management of the emergency department. However, the OIG identified deficiencies with the lack of backup call schedules for emergency department providers and social work support services that warranted a recommendation for improvement.

VHA requires that emergency departments have a written staffing contingency plan that includes a backup call schedule to address situations when expedient mobilization of provider resources is needed.[139] The OIG found that the facility lacked a backup call schedule for emergency

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

[139] VHA Directive 1101.05(2).

department providers and social workers. This could impact the facility's ability to provide uninterrupted and timely patient care and/or social work service. The acute care medical director and nurse manager believed that the existing contingency or ad-hoc plan of soliciting volunteers for backup provider coverage met the requirement. The leaders also cited a shortage of social work staff.

Recommendation 19

19. The chief of staff directs the acute care medical director to ensure that a backup call schedule is maintained for emergency department providers and social workers and monitors compliance.

Facility concurred.

Target date for completion: June 2020

Facility response: The Interim Acute Care Medical Director is in the process of developing a staffing contingency plan that includes a back-up call schedule for the Emergency Department to address situations when expedient mobilization of provider resources is needed. The Chief of Social Work is in the process of developing a staffing contingency plan that includes a back-up call schedule for social work when needed in the Emergency Department.

Incidental Finding: High-Alert Medications

Patient Safety: Storage of Highly Concentrated Opioid Oral Liquids in Patient Care Areas

TJC requires special safeguards for high-alert medications, including opioids, that bear a heightened risk of causing significant patient harm when used in error.[140] The OIG noted concerns with highly concentrated oral liquid opioid (narcotics) medications stored in patient care areas that required measurement of miniscule amounts. This increases the risk of medication errors related to calculation and administration of incorrect doses, resulting in patient harm.[141] The recently hired chief of Pharmacy was unaware of this issue and had not yet reviewed all aspects of pharmacy processes. While the OIG was still on site, the chief of Pharmacy reported placing an order for lower concentration opioid liquid medications in single doses to replace the highly concentrated forms and stated that two facility committees (Pain Management and Pharmacy and Therapeutics) will provide required oversight.

Recommendation 20

20. The facility director makes certain that the chief of Pharmacy ensures highly concentrated oral liquid opioid medications are not stored in patient care areas for patient safety and monitors the chief's compliance.

Facility concurred.

Target date for completion: June 2020

Facility response: The Pharmacy Department has ordered less concentrated dosage forms in unit dose cups, which were loaded in patient care area automated medication dispensing systems (Pyxis) throughout the hospital. The more highly concentrated forms are restricted to the hospice Pyxis only as those Veterans often have swallowing issues and are unable to swallow enough liquid to receive the high doses required to treat their pain at the end of life. In February 2019, Pharmacy staff were educated on the change in process to restrict those higher concentration formulations to the one population of Veterans with difficulty swallowing and in hospice care. Pharmacy and Therapeutics and Pain Management Committee will review the "Hospital Wide Med Summary" report for each of those meds at each monthly meeting. This report lists where the medications are available throughout the hospital. This will be monitored for six consecutive months or two quarters for a 90 percent compliance rate.

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[140] TJC. Medication Management standard MM.01.01.03.

[141] TJC. Glossary, *Medication Error.*

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	Twenty 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, ADPCS, 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	- All root cause analyses actions are fully implemented by assigned staff. - The CPR Committee conducts complete analyses of resuscitative episodes by reviewing required elements.	- Physician UM advisors consistently document their decisions in the National UM Integration database. - All required representatives consistently participate in interdisciplinary reviews of UM data.
Medical Staff Privileging	- Privileging - FPPEs - OPPEs - FPPEs for cause - Reporting of privileging actions to National Practitioner Data Bank	The Radiology Service chief includes required nuclear medicine-specific criteria in OPPEs of nuclear medicine providers.	None

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 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
		• Nursing staff label multi-dose medication vials with an expiration date upon opening.	• None

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	• Controlled substances program staff reconcile one random day's return of stock to pharmacy from every automated dispensing cabinet. • Controlled substances inspectors complete emergency drug cache inspections.
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	• None	• The MST coordinator establishes and monitors MST-related staff training. • The MST coordinator establishes and monitors informational outreach. • The MST coordinator communicates the status of MST services and initiatives with leaders. • The MST coordinator tracks and monitors MST-related data. • Providers complete MST mandatory training within the required time frame.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
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	• Clinicians provide and document patient and/or caregiver education about the safe and effective use of newly prescribed medications. • Clinicians reconcile medication information and maintain and communicate accurate patient medication information in patients' electronic health records.	• None
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data • Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated	• Ordering providers communicate abnormal results to patients within the required time frame.	• The Women Veterans Health Committee maintains an active charter, meets at least quarterly, and reports to executive leadership with signed minutes. • The women veterans program manager implements a quality assurance process to include tracking of data for cervical cancer screening and results.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
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	None	The emergency department maintains a backup call schedule for providers and social workers.
Incidental Finding Patient Safety: Storage of Highly Concentrated Opioid Oral Liquids in Patient Care Areas	Storage of high-alert medications (opioids)	Highly concentrated oral liquid opioid medications are not stored in patient care areas.	None

Appendix B: Facility Profile and
VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) affiliated[142] facility reporting to VISN 22.[143]

Table B.1. Facility Profile for Northern Arizona VA Health Care System (649)
(October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[144]	Facility Data FY 2017[145]	Facility Data FY 2018[146]
Total medical care budget in dollars	$174,454,129	$188,608,511	$218,925,719
Number of:			
• Unique patients	26,851	27,802	28,690
• Outpatient visits	278,994	287,451	289,149
• Unique employees[147]	919	989	875
Type and number of operating beds:			
• Community living center	85	85	85
• Domiciliary	120	120	120
• Medicine	21	21	21
Average daily census:			
• Community living center	52	68	65
• Domiciliary	79	89	70
• Medicine	10	9	8

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

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[142] Associated with a medical residency program.

[143] 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."

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

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

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

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

VA Outpatient Clinic Profiles[148]

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)[149]**

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[150] Provided	Diagnostic Services[151] Provided	Ancillary Services[152] Provided
Kingman, AZ	649GA	7,978	2,689	Cardiology Dermatology Endocrinology Pulmonary/ Respiratory disease	n/a	Pharmacy Social work Weight management
Flagstaff, AZ	649GB	4,206	1,656	Cardiology Dermatology	n/a	Pharmacy Social work

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

[149] 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."

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

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

[152] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.
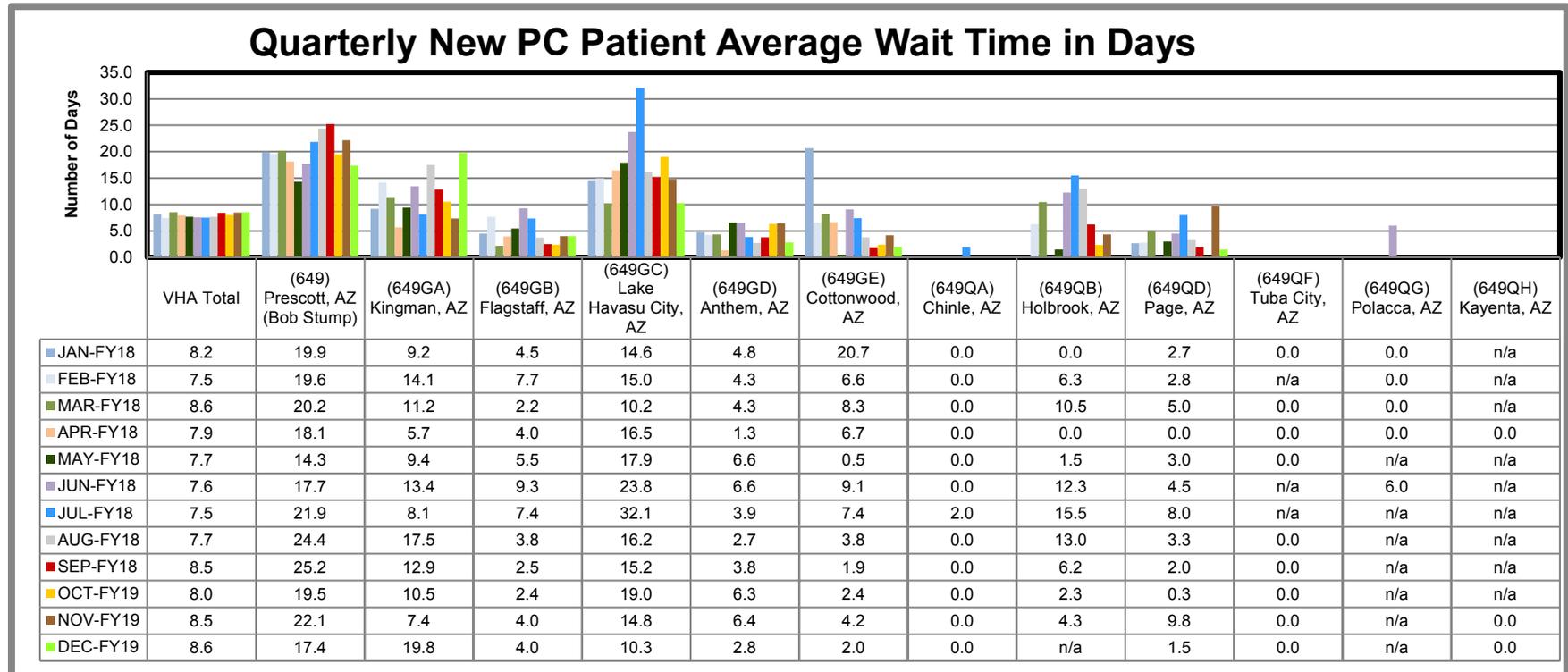
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[150] Provided	Diagnostic Services[151] Provided	Ancillary Services[152] Provided
Lake Havasu City, AZ	649GC	7,765	1,338	Cardiology Dermatology Poly-trauma Vascular	EKG	Pharmacy Social work Weight management
Anthem, AZ	649GD	3,311	1,687	Cardiology Dermatology Endocrinology Poly-trauma	n/a	Social work Weight management
Cottonwood, AZ	649GE	6,239	1,778	Cardiology Dermatology	n/a	Pharmacy
Chinle, AZ	649QA	228	248	n/a	n/a	Pharmacy Weight management
Holbrook, AZ	649QB	438	103	n/a	n/a	Pharmacy
Page, AZ	649QD	401	117	n/a	n/a	Pharmacy
Tuba City, AZ	649QF	148	58	n/a	n/a	n/a
Polacca, AZ	649QG	69	12	n/a	n/a	n/a
Kayenta, AZ	649QH	48	185	n/a	n/a	n/a

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[153]

Quarterly New PC Patient Average Wait Time in Days

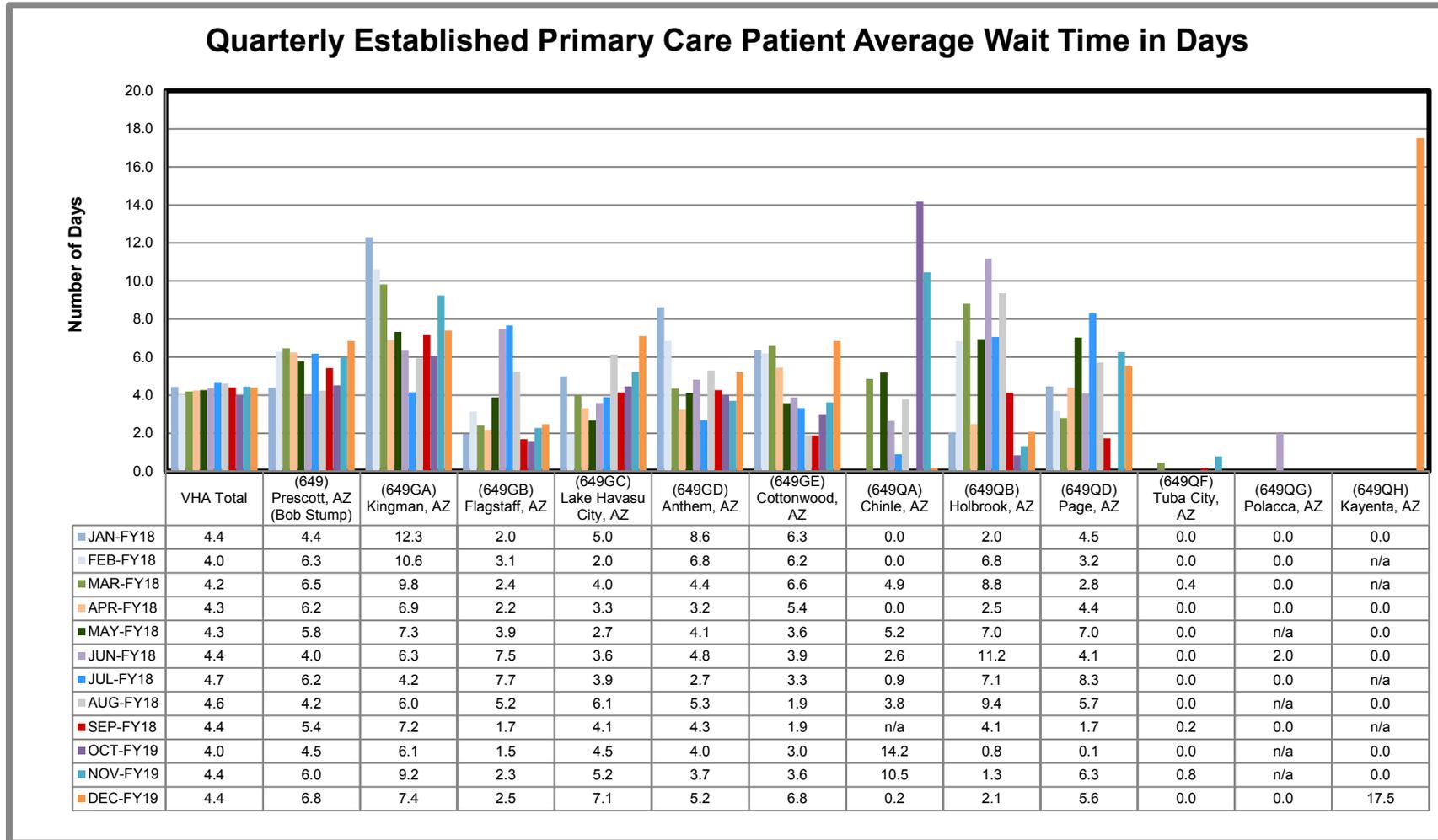|	VHA Total	(649) Prescott, AZ (Bob Stump)	(649GA) Kingman, AZ	(649GB) Flagstaff, AZ	(649GC) Lake Havasu City, AZ	(649GD) Anthem, AZ	(649GE) Cottonwood, AZ	(649QA) Chinle, AZ	(649QB) Holbrook, AZ	(649QD) Page, AZ	(649QF) Tuba City, AZ	(649QG) Polacca, AZ	(649QH) Kayenta, AZ
JAN-FY18	8.2	19.9	9.2	4.5	14.6	4.8	20.7	0.0	0.0	2.7	0.0	0.0	n/a
FEB-FY18	7.5	19.6	14.1	7.7	15.0	4.3	6.6	0.0	6.3	2.8	n/a	0.0	n/a
MAR-FY18	8.6	20.2	11.2	2.2	10.2	4.3	8.3	0.0	10.5	5.0	0.0	0.0	n/a
APR-FY18	7.9	18.1	5.7	4.0	16.5	1.3	6.7	0.0	0.0	0.0	0.0	0.0	0.0
MAY-FY18	7.7	14.3	9.4	5.5	17.9	6.6	0.5	0.0	1.5	3.0	0.0	n/a	n/a
JUN-FY18	7.6	17.7	13.4	9.3	23.8	6.6	9.1	0.0	12.3	4.5	n/a	6.0	n/a
JUL-FY18	7.5	21.9	8.1	7.4	32.1	3.9	7.4	2.0	15.5	8.0	n/a	n/a	n/a
AUG-FY18	7.7	24.4	17.5	3.8	16.2	2.7	3.8	0.0	13.0	3.3	0.0	n/a	n/a
SEP-FY18	8.5	25.2	12.9	2.5	15.2	3.8	1.9	0.0	6.2	2.0	0.0	n/a	n/a
OCT-FY19	8.0	19.5	10.5	2.4	19.0	6.3	2.4	0.0	2.3	0.3	0.0	n/a	n/a
NOV-FY19	8.5	22.1	7.4	4.0	14.8	6.4	4.2	0.0	4.3	9.8	0.0	n/a	0.0
DEC-FY19	8.6	17.4	19.8	4.0	10.3	2.8	2.0	0.0	n/a	1.5	0.0	n/a	0.0

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 Lake Havasu City, AZ, VA Clinic (649GC).

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

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

Quarterly Established Primary Care Patient Average Wait Time in Days

	VHA Total	(649) Prescott, AZ (Bob Stump)	(649GA) Kingman, AZ	(649GB) Flagstaff, AZ	(649GC) Lake Havasu City, AZ	(649GD) Anthem, AZ	(649GE) Cottonwood, AZ	(649QA) Chinle, AZ	(649QB) Holbrook, AZ	(649QD) Page, AZ	(649QF) Tuba City, AZ	(649QG) Polacca, AZ	(649QH) Kayenta, AZ
JAN-FY18	4.4	4.4	12.3	2.0	5.0	8.6	6.3	0.0	2.0	4.5	0.0	0.0	0.0
FEB-FY18	4.0	6.3	10.6	3.1	2.0	6.8	6.2	0.0	6.8	3.2	0.0	0.0	n/a
MAR-FY18	4.2	6.5	9.8	2.4	4.0	4.4	6.6	4.9	8.8	2.8	0.4	0.0	n/a
APR-FY18	4.3	6.2	6.9	2.2	3.3	3.2	5.4	0.0	2.5	4.4	0.0	0.0	0.0
MAY-FY18	4.3	5.8	7.3	3.9	2.7	4.1	3.6	5.2	7.0	7.0	0.0	n/a	0.0
JUN-FY18	4.4	4.0	6.3	7.5	3.6	4.8	3.9	2.6	11.2	4.1	0.0	2.0	0.0
JUL-FY18	4.7	6.2	4.2	7.7	3.9	2.7	3.3	0.9	7.1	8.3	0.0	0.0	n/a
AUG-FY18	4.6	4.2	6.0	5.2	6.1	5.3	1.9	3.8	9.4	5.7	0.0	n/a	0.0
SEP-FY18	4.4	5.4	7.2	1.7	4.1	4.3	1.9	n/a	4.1	1.7	0.2	0.0	n/a
OCT-FY19	4.0	4.5	6.1	1.5	4.5	4.0	3.0	14.2	0.8	0.1	0.0	n/a	0.0
NOV-FY19	4.4	6.0	9.2	2.3	5.2	3.7	3.6	10.5	1.3	6.3	0.8	n/a	0.0
DEC-FY19	4.4	6.8	7.4	2.5	7.1	5.2	6.8	0.2	2.1	5.6	0.0	0.0	17.5

Source: VHA Support Service Center

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

Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." The absence of reported data is indicated by "n/a."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[154]

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

[154] 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[155]

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.

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[155] *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: November 6, 2019

From: Director, Desert Pacific Healthcare Network (10N22)

Subj: Comprehensive Healthcare Inspection of the Northern Arizona VA Health Care System, Prescott, AZ

To: Director, Los Angeles Office of Healthcare Inspections (54CH01)
Director, GAO/OIG Accountability Liaison (VHA 10EG GOAL Action)

1. Thank you for conducting the Comprehensive Health Care Inspection for Northern Arizona VA Health Care System.

2. Northern Arizona VA Health Care System concurs with all recommendations.

3. I have reviewed the documentation and concur with the response as submitted.

(Original signed by:)

Michael W. Fisher
VISN 22 Network Director

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

Appendix G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 4, 2019

From: Director, Northern Arizona VA Health Care System (649/00)

Subj: Comprehensive Healthcare Inspection of the Northern Arizona VA Health Care System, Prescott, AZ

To: Director, Desert Pacific Healthcare Network (10N22)

1. Thank you for conducting the Comprehensive Health Care Inspection for Northern Arizona VA Health Care System.

2. Northern Arizona VA Health Care System concurs with all recommendations. Please see action plans and supporting documentation for recommendations identified in the report.

3. I have reviewed the documentation and concur with the response as submitted.

(Original signed by:)

Barbara A. Oemcke, MBA, FACHE
Medical Center Director

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

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