DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Maryland Health Care System Baltimore, Maryland

CHIP REPORT | REPORT #19-00016-61 | JANUARY 9, 2020

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Figure 1. *Baltimore VA Medical Center, Baltimore, Maryland (Source: https://vaww.va.gov/directory/guide/, accessed on July 8, 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 VA Maryland Health Care System (the facility), a three-division facility comprised of the Baltimore, Loch Raven, and Perry Point VA Medical Centers. 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 March 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 Quality Council being responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.[1] The OIG noted that the director did not chair the Executive Quality Council.

The facility's leadership team had been working together for greater than a year, although several had served in their position for years. The director was assigned August 14, 2015, and the chief of staff on March 6, 2016. The ADPCS and associate director for Operations were permanently assigned July 1, 2012, and October 21, 2012, respectively. The associate director for Finance was assigned October 1, 2017.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders were engaged and promoted a culture where employees felt safe bringing forward issues and concerns. However, the associate director for Finance had a worse score related to moral distress at work when compared to the VHA average and those for other leaders. The selected patient experience survey scores for facility leaders were worse than the VHA average for three of the four scores, and facility leaders had implemented processes and plans to improve positive patient experiences.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[2] disclosures of adverse patient events, and patient safety indicator data and did not identify any substantial organizational risk factors. At the time of the on-site visit, all recommendations from previous OIG and Joint Commission surveys were closed.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities

[1] At the time of OIG's visit in March 2019, the Executive Quality Council was known as the Executive Performance Improvement Council.

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

and differences between the top and bottom performers" within VHA.[3] Although the leadership team members were knowledgeable within their areas of responsibility about selected SAIL metrics and SAIL community living center (CLC) measures, the leaders should continue to take actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "3-star" and SAIL CLC "1-star" quality ratings.[4]

The OIG noted deficiencies in six of the eight clinical areas reviewed and issued 23 recommendations that are attributable to the director, associate directors, and chief of staff. These are briefly described below.

Quality, Safety, and Value

The OIG identified concerns with reporting peer review data to the Executive Committee of the Medical Staff, timely peer review completion, peer review of applicable deaths, interdisciplinary review of utilization management data, patient safety root cause analysis content, feedback to the reporting individuals or departments, responsible committee review of resuscitative episodes, and resuscitative care in accordance with life-sustaining treatment orders.[5]

[3] VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star rating" system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 6, 2019, but is not accessible by the public.)

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

[5] The definition of utilization management can be found within VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the "forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria." 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. However, the OIG identified concerns in the focused and ongoing professional practice evaluation processes.[6] The OIG had also identified noncompliance with ongoing professional practice evaluation processes in the 2016 OIG Combined Assessment Program Review.

Environment of Care

The facility generally complied with requirements for privacy, women veterans program, and emergency management. The OIG did not note any issues with the availability of medical equipment or supplies. However, the OIG identified noncompliance with safety, environmental cleanliness, environment of care rounds, and infection prevention at the facility and safety at the Glen Burnie VA clinic.

Medication Management

Overall, the facility complied with requirements for most of the performance indicators evaluated, including the controlled substances coordinator reports, pharmacy operations, and requirements for controlled substances inspectors. The OIG found that there were inconsistent practices between the Baltimore and the Perry Point facilities related to controlled substances inspector appointments and competencies. The OIG identified noncompliance with verification of controlled substances orders, reconciliation of dispensing between pharmacy and each dispensing area, and monthly checks of cache locks with verification of lock numbers.

Mental Health

The OIG team also found the facility complied with many of the mental health performance indicators, including the designation of a Military Sexual Trauma (MST) coordinator and tracking of MST-related data. The OIG noted a concern, however, with deficiencies in clinical staff training.

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

Women's Health

The OIG also noted the facility performed adequately on indicators related to women's health, including requirements for a designated women veterans program manager, clinical oversight of the women's health program, communication of results to patients within the required time frame, and follow-up care when indicated. However, the Women Veterans Health Committee lacked representation from medical and/or surgical subspecialties, quality management, and executive leadership; and the facility did not track cervical cancer screenings data.

Summary

In reviewing key healthcare processes, the OIG issued 23 recommendations for improvement directed to the facility director, associate directors, 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 86–87, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

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

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

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility:[9]

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)

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

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

[9] 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.

8. Women's health (particularly abnormal cervical pathology results notification and follow-up)
9. High-risk processes (specifically the emergency department and urgent care center operations and management).

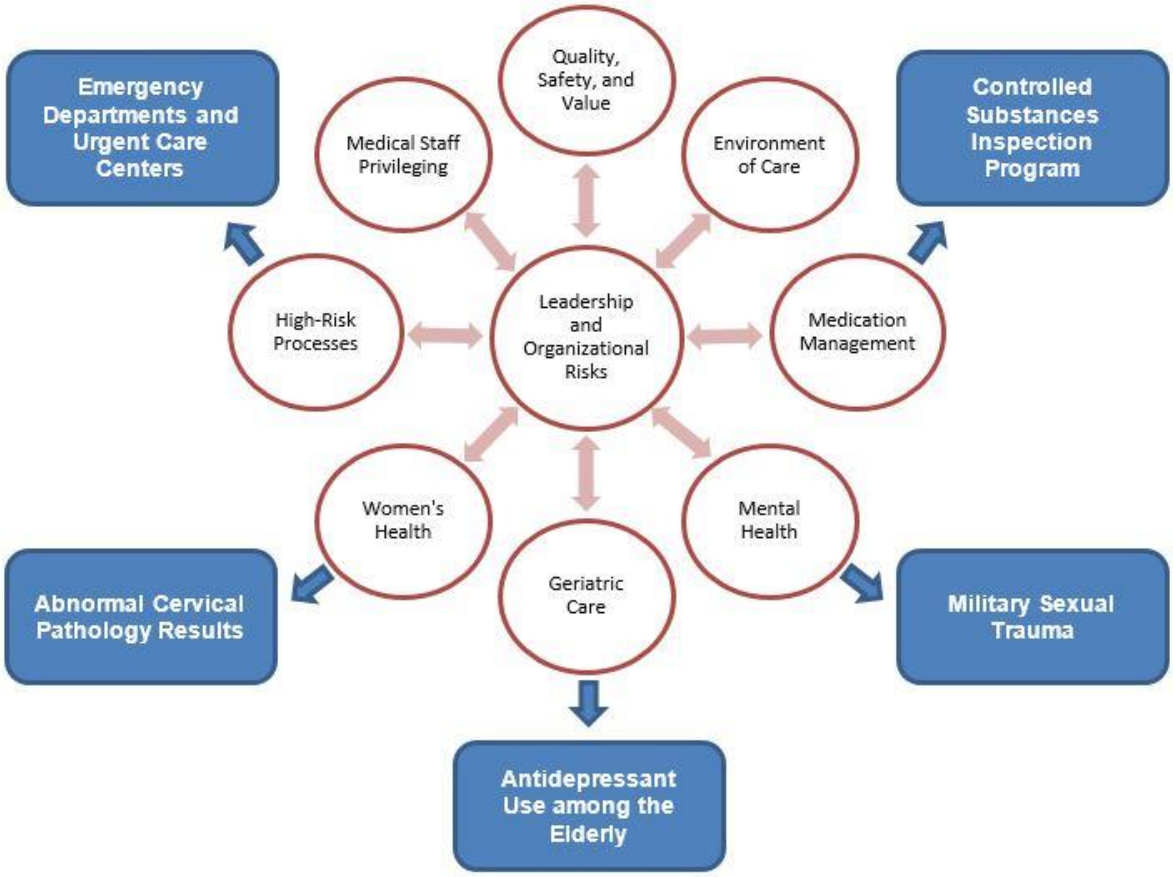

Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

Methodology

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

The inspection period examined operations from December 12, 2015, through March 15, 2019, the last day of the unannounced week-long site visit.[11] 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.

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

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

Results and Recommendations

Leadership and Organizational Risks

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

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

Executive Leadership Position Stability and Engagement

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

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

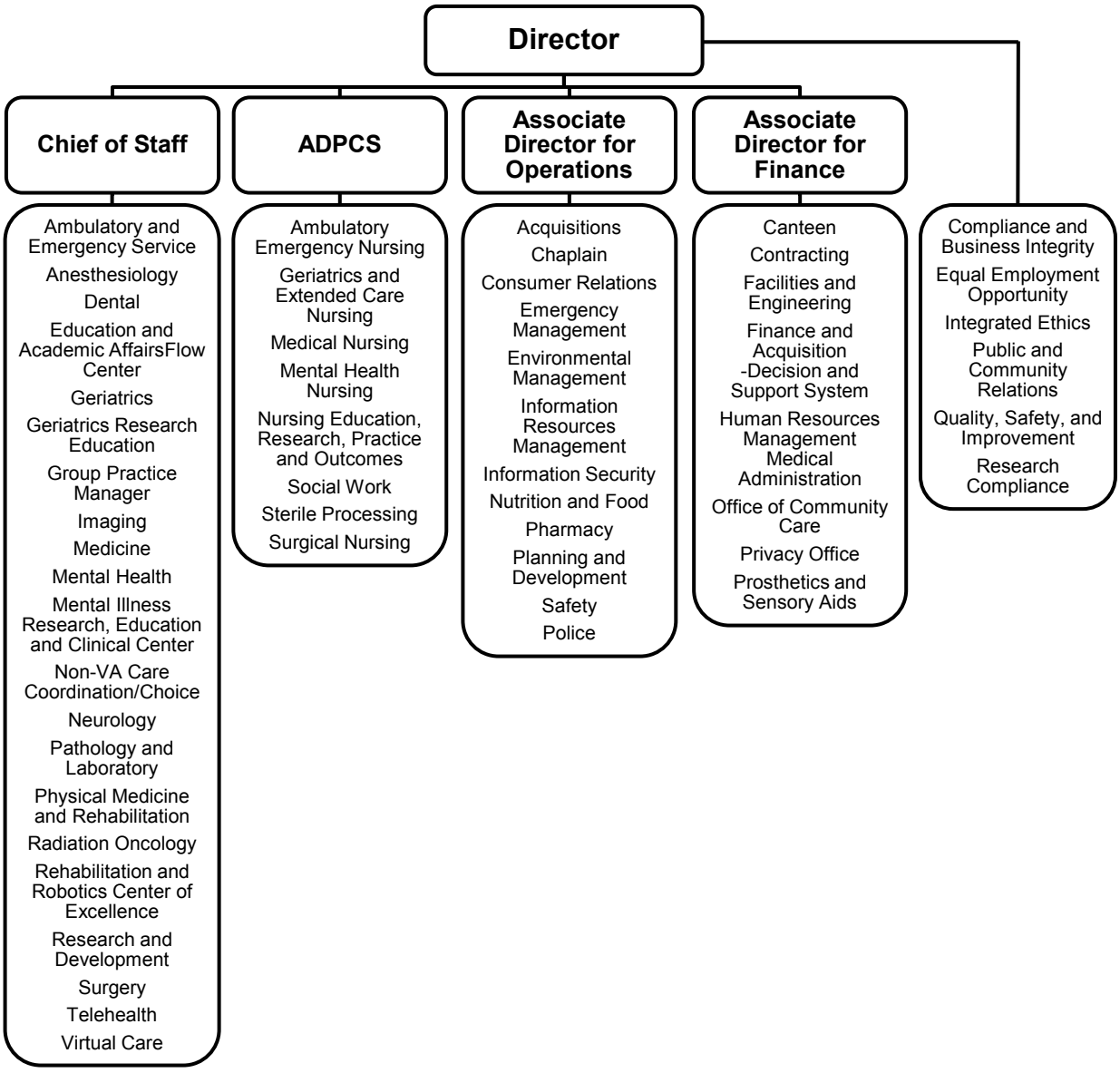

Figure 3. *Facility Organizational Chart*[13]
Source: VA Maryland Health Care System (received March 13, 2019)

At the time of the OIG site visit, the executive team had been working together for more than one year, although several team members have been in their position for many years (see Table 1).

[13] At this facility, the director is responsible for the Compliance and Business Integrity; Equal Employment Opportunity; Integrated Ethics; Public and Community Relations; Quality, Safety, and Improvement; and Research Compliance committees.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	August 14, 2015
Chief of staff	March 6, 2016
Associate director for Patient Care Services	July 1, 2012
Associate director (Operations)	October 21, 2012
Associate director (Finance)	October 1, 2017

Source: VA Maryland Health Care System human resources officer (received March 12, 2019)

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

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable within their scope of responsibility about selected Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL community living center (CLC) measures for Loch Raven and Perry Point CLCs. These are discussed in greater detail below.

The director serves as the chairperson of the Executive Leadership Board,[14] with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Board oversees various working groups, such as the Executive Council of the Medical Staff, Executive Council for Patient Care Services, and Executive Environment of Care Council.

These leaders are also engaged in monitoring patient safety and care through the Executive Quality Council.[15] The director is noted in the minutes and the governance structure policy as the chairperson of this council;[16] however, the director acknowledged that he does not chair the council. The Executive Quality Council is responsible for tracking and identifying trends and

[14] At the time of OIG's visit in March 2019, the Executive Leadership Board was known as the Executive Committee of the Governing Board.

[15] At the time of OIG's visit in March 2019, the Executive Quality Council was known as the Executive Performance Improvement Council.

[16] According to VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, And Value,* August 2, 2013, "the standing committee must: be chaired or co-chaired by the Medical Facility Director." (This VHA directive was scheduled for recertification on or before the last working day of August 2018 but was rescinded on October 24, 2019.)

monitoring quality of care and patient outcomes and reports to the Executive Leadership Board. See Figure 4.

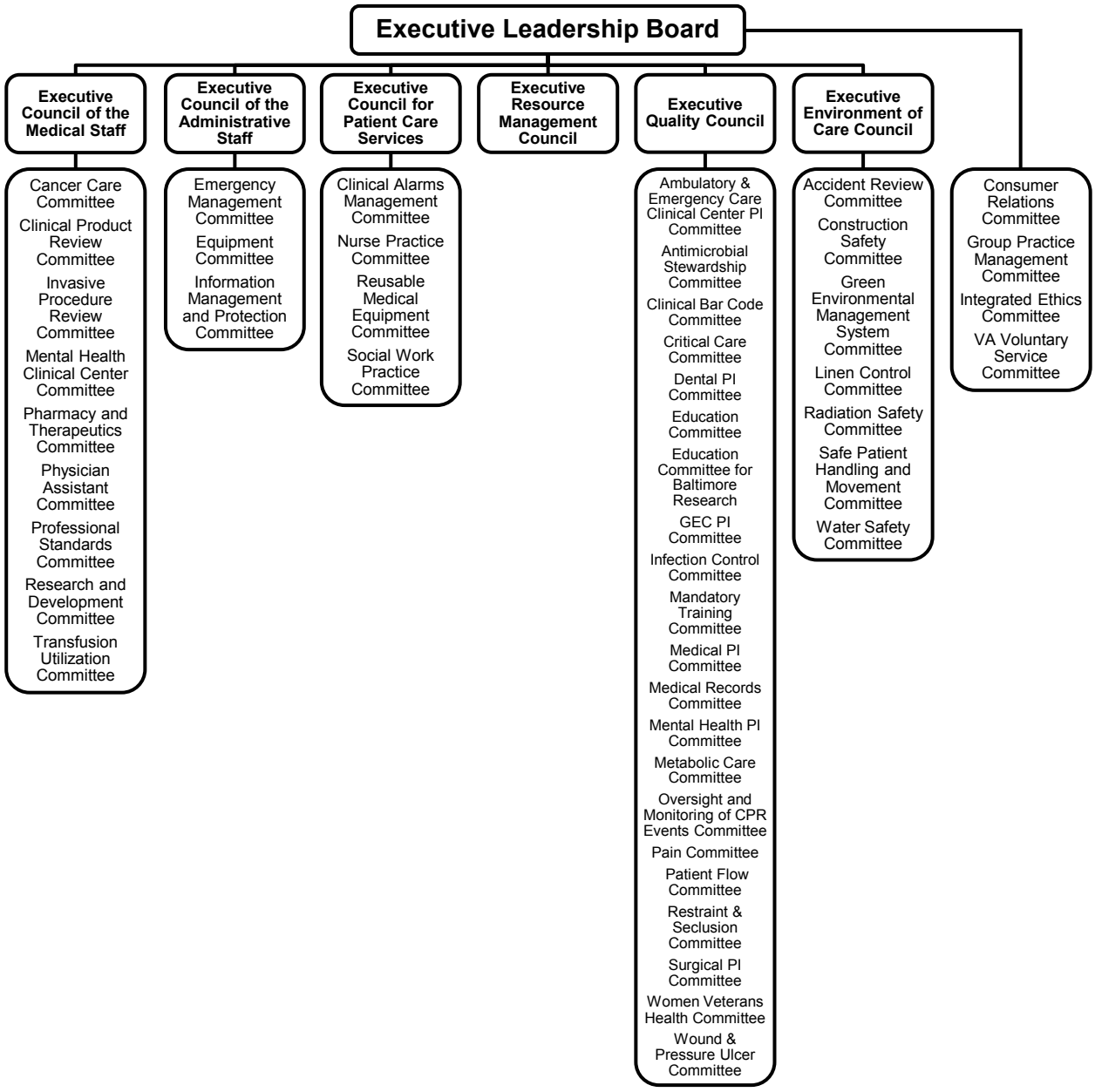

Figure 4. *Facility Committee Reporting Structure*[17]
Source: VA Maryland Health Care System (March 21, 2019, and December 11, 2019)
CPR = cardiopulmonary resuscitation
GEC = Geriatrics and Extended Care
PI = performance improvement

[17] The Executive Leadership Board directly oversees the Consumer Relations Committee, Group Practice Management Committee, Integrated Ethics Committee, and VA Voluntary Service Committee.

Employee Satisfaction

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

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2017, through September 30, 2018.[18] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for several selected survey leadership questions was similar to or higher than the VHA average.[19] The same trend was noted for the members of the executive leadership team. In all, employees appear generally satisfied with facility leaders.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Operations	Assoc. Director Finance Average
All Employee Survey: *Servant Leader Index Composite*[20]	0–100 where HIGHER scores are more favorable	71.7	72.7	79.6	72.8	75.4	95.0	80.0

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

[19] 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.

[20] 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 Operations	Assoc. Director Finance 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	3.4	3.9	3.5	4.0	4.7	4.0
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.6	4.0	3.7	3.9	4.7	4.0
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.7	4.0	3.7	4.2	4.9	4.2

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

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility and executive leadership team averages for the selected survey questions were similar to or better than the VHA average with the exception of the associate director for Finance. For the survey question, "in the past year, how often did you experience moral distress at work," the associate director for Finance score was worse than the VHA average and those for the other facility leaders. Of note, the OIG did not interview the associate director for Finance during the on-site visit, but the associate director should review the All Employee Survey scores and comments to identify opportunities for improvement. In general, facility leaders appear to be maintaining an environment where employees feel safe bringing forth issues and concerns.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc Director Operations Average	Assoc. Director Finance Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	4.3	3.9	4.1	4.9	4.3
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	3.8	3.8	4.1	4.4	3.5

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc Director Operations Average	Assoc. Director Finance Average
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	1.4	1.2	1.3	1.5	0.8	2.0

Source: VA All Employee Survey (accessed February 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.[21]

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 of the four patient survey results reflected lower care ratings than the VHA average. Patients were generally less satisfied with the leadership and care provided compared to VHA patients overall. However, facility leaders appeared to be actively engaged with patients, for example, through leadership rounding, contacting patients for input, and reviewing SHEP data to identify opportunities to improve.

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

Table 4. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.9	54.0
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	79.4
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	76.6
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	74.0

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 9, 2018)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[22] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[23] At the time of the OIG visit, the facility had closed all recommendations

[22] 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.

[23] 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."

for improvement from TJC recommendations, however four improvement actions from a previous OIG Hotline report were still in progress.[24]

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.[25] Additional results included the Long Term Care Institute's inspection of the facility's CLC.[26]

[24] 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.

[25] 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.

[26] 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 VA Maryland Health Care System, Baltimore, MD*, Report No. 15-05497-132, February 23, 2016)	December 2015	26	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Maryland Health Care System, Baltimore, MD*, Report No.15-05164-139, February 23, 2016)	December 2015	5	0
OIG (*Healthcare Inspection Patient Flow, Quality of Care, and Administrative Concerns in the Emergency Department, VA Maryland Health Care System, Baltimore, MD*, Report No. 15-03418-350, August 23, 2017)	May 2015	11	4
OIG (*Healthcare Inspection Opioid Agonist Treatment Program Concerns, VA Maryland Health Care System, Baltimore, MD*, Report No. 16-01091-06, October 19, 2017)	April 2016	5	0
TJC Hospital Accreditation	December 2017	46	0
TJC Behavioral Health Care Accreditation		7	0
TJC Home Care Accreditation		2	0
TJC Opioid Treatment Program	September 2017	8	0

Source: OIG and TJC (inspection/survey results verified with the Quality Improvement accreditation specialist on March 14, 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.

The facility's risk manager provided a list of institutional disclosures as requested; and OIG determined that, based on the documentation provided, institutional disclosure—which may have been appropriate—had not been conducted for four patient safety events. The OIG also noted

delays in conducting the disclosures, and facility leaders could not provide consistent explanations. Table 6 lists the reported patient safety events from December 12, 2015 (the prior comprehensive OIG inspection), through March 15, 2019.[27]

Table 6. Summary of Selected Organizational Risk Factors (December 12, 2015, through March 15, 2019)

Factor	Number of Occurrences
Sentinel Events[28]	21
Institutional Disclosures[29]	28
Large-Scale Disclosures[30]	0

Source: VA Maryland Health Care System's risk manager and patient safety manager (received March 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.[31] 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.

[27] 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 VA Maryland Health Care System is a high complexity (1b) affiliated facility as described in Appendix B.)

[28] 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."

[29] 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."

[30] According to VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

[31] 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 5	Baltimore	Perry Point
Pressure ulcer	0.74	0.88	1.62	0.00
Death among surgical inpatients with serious treatable conditions	113.42	140.74	88.89	n/a
Iatrogenic pneumothorax[32]	0.17	0.14	0.12	0.00
Central venous catheter-related bloodstream infection	0.16	0.14	0.00	0.00
In-hospital fall with hip fracture	0.09	0.16	0.14	0.00
Perioperative hemorrhage or hematoma	2.61	1.41	2.97	0.00
Postoperative acute kidney injury requiring dialysis	0.89	0.64	0.00	n/a
Postoperative respiratory failure	4.54	3.76	4.30	n/a
Perioperative pulmonary embolism or deep vein thrombosis	2.97	4.60	5.68	0.00
Postoperative sepsis	3.55	4.24	4.50	n/a
Postoperative wound dehiscence (rupture along incision)	0.82	0.66	2.03	n/a
Unrecognized abdominopelvic accidental puncture or laceration	1.00	1.30	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 surgical discharges with serious treatable complications (deep vein thrombosis/pulmonary embolism, pneumonia, sepsis, shock/cardiac arrest, or gastrointestinal hemorrhage/acute ulcer); no elective surgical discharges applicable to the acute kidney failure, postoperative respiratory failure, and postoperative sepsis measures; and no abdominopelvic surgery discharges applicable to the postoperative wound dehiscence measure.

All 12 patient safety indicator measures were applicable to the facility during this review period, however, seven had rates greater than VHA and/or VISN 5. Of those seven, in-hospital fall with hip fracture showed a higher rate than VHA, and postoperative respiratory failure showed a higher rate than VISN 5. The other five metrics (pressure ulcer, perioperative hemorrhage or hematoma, perioperative pulmonary embolism or deep vein thrombosis, postoperative sepsis, and postoperative wound dehiscence) had a higher rate than VHA and VISN 5. Of note, Perry

[32] 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.)

Point had 7 of 12 patient safety indicator measures that were below VHA and VISN 5, and the remaining metrics were not applicable during the review period.

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

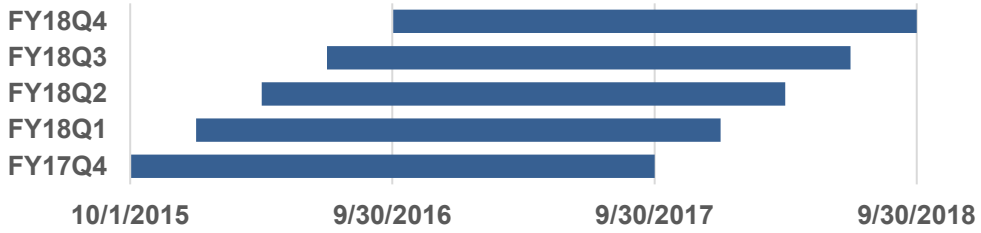

Figure 5. *Associated Time Frames for Quarterly Patient Safety Indicator Data*
Source: VA OIG
FY18Q4 = fiscal year 2018, quarter 4
FY18Q3 = fiscal year 2018, quarter 3
FY18Q2 = fiscal year 2018, quarter 2
FY18Q1 = fiscal year 2018, quarter 1
FY17Q4 = fiscal year 2017, quarter 4

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

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

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
Pressure ulcer	VHA	0.60	0.88	—[33]	0.76	0.74
	Baltimore	2.15	2.78	—	1.82	1.62
	Perry Point	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
	Baltimore	83.33	113.21	106.38	121.95	88.89
	Perry Point	n/a	n/a	n/a	n/a	n/a
Iatrogenic pneumothorax	VHA	0.19	0.19	0.17	0.15	0.17
	Baltimore	0.12	0.11	0.12	0.12	0.12
	Perry Point	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
	Baltimore	0.00	0.00	0.00	0.00	0.00
	Perry Point	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
	Baltimore	0.00	0.00	0.14	0.14	0.14
	Perry Point	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
	Baltimore	1.10	1.51	1.82	1.79	2.97
	Perry Point	n/a	n/a	n/a	0.00	0.00
Postoperative acute kidney injury requiring dialysis	VHA	0.88	0.80	0.65	0.96	0.89
	Baltimore	0.00	0.00	0.00	0.00	0.00
	Perry Point	n/a	n/a	n/a	n/a	n/a
Postoperative respiratory failure	VHA	5.55	5.34	5.11	4.88	4.54
	Baltimore	3.05	5.45	4.59	4.46	4.30
	Perry Point	n/a	n/a	n/a	n/a	n/a
Perioperative pulmonary embolism or deep vein thrombosis	VHA	3.29	3.26	3.09	3.05	2.97
	Baltimore	7.29	7.16	5.18	4.56	5.68
	Perry Point	n/a	n/a	n/a	0.00	0.00

[33] 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 sepsis	VHA	4.00	3.96	3.72	3.70	3.55
	Baltimore	1.12	2.04	3.46	3.43	4.50
	Perry Point	n/a	n/a	n/a	n/a	n/a
Postoperative wound dehiscence (rupture along incision)	VHA	0.52	1.04	1.00	0.93	0.82
	Baltimore	0.00	8.12	6.13	6.12	2.03
	Perry Point	0.00	0.00	0.00	n/a	n/a
Unrecognized abdominopelvic accidental puncture or laceration	VHA	0.53	1.21	1.02	1.07	1.00
	Baltimore	0.00	0.00	0.00	0.00	0.00
	Perry Point	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.

Eight patients were reported to have developed pressure ulcers at the Baltimore facility during FY 2018, quarter 4. Of the eight patients identified by the facility, the risk manager reported that seven were related to coding errors and that the coding department was informed and instructed to make corrections. The one patient who developed a pressure ulcer was reviewed individually by the chief nurse Patient Care Services. As a result, the facility provided nursing staff with education related to use of available pressure ulcer reduction methods (for instance, the proper use of creams and mattresses) and held nursing huddles to identify at-risk patients. The OIG noted the observed pressure ulcer rate has declined at the Baltimore facility since FY 2017, quarter 4.

The facility's in-hospital fall with hip fracture rate (FY 2018, quarter 2) included one patient. The event was reviewed individually through the root cause analysis process. Contributing factors that lead to the fall were identified and corresponding actions were implemented to mitigate risks to prevent future in-hospital falls with hip fracture events.

For FY 2018, five new patients were included in the rate of perioperative hemorrhage or hematoma following a surgical procedure. The risk manager reported two of the five cases were reviewed individually through quality surgical review. Neither of the individually reviewed cases identified trends or system issues. The facility did not provide evidence that the other three cases were reviewed.

Three new patients were included in the postoperative respiratory failure rate in FY 2018, quarter 4. Despite this, Baltimore demonstrated a slight improvement as compared to the prior three quarters. Two of the three cases from FY 2018, quarter 4 were reviewed individually by the chief of Surgery; however, the facility did not provide evidence of an individual or committee review of the remaining case, nor were trends analyzed nor improvement actions recommended for any of the three cases.

There were 10 patients reported as having developed perioperative pulmonary embolism or deep vein thrombosis. Two of these patients were new cases in FY 2018, quarter 4. Of the10 cases the facility provided information on eight, seven were individually reviewed by the chief of Surgery and one case was externally reviewed. The facility did not provide any additional information regarding trends or improvement actions taken to prevent reoccurrences.

Four patients were included in the FY 2018, quarter 4 postoperative sepsis rate. The facility reported that three of the four cases were individually reviewed by the chief of Surgery. The facility did not provide any additional information regarding trends or opportunities for improvement.

The postoperative wound dehiscence rate represents one patient event that occurred in FY 2017, quarter 3. The facility reported the chief of Surgery reviewed the single case at the time of occurrence. There have been no additional events reported since FY 2017, quarter 3.

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.[34]

VA also uses a star rating system where facilities with a "5-star" rating are performing within the top 10 percent of facilities and "1-star" facilities are performing within the bottom 10 percent of facilities. Figure 6 describes the distribution of facilities by star rating.[35] As of June 30, 2018, the facility was rated as "3-star" for overall quality.

[34] 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.)

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

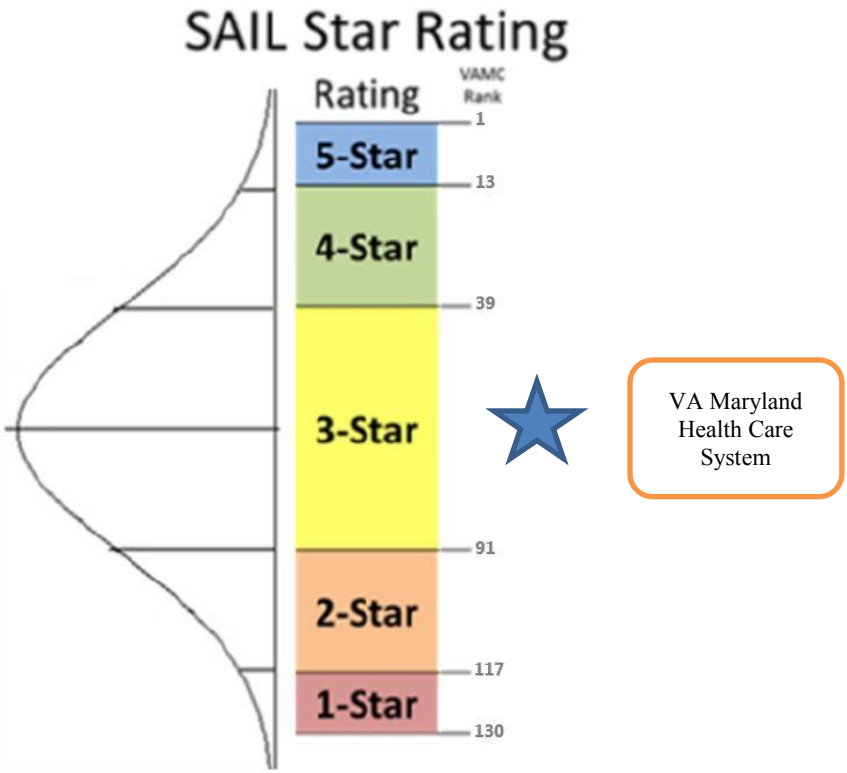

Figure 6. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed February 11, 2019)

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 registered nurse (RN) turnover, mental health (MH) population (Popu) coverage, acute care standardized mortality ratio (SMR), and best place to work). Metrics that need improvement are denoted in orange and red (for example, healthcare (HC) associated infections, care transition, mental health (MH) continuity of care, and physician capacity).[36]

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

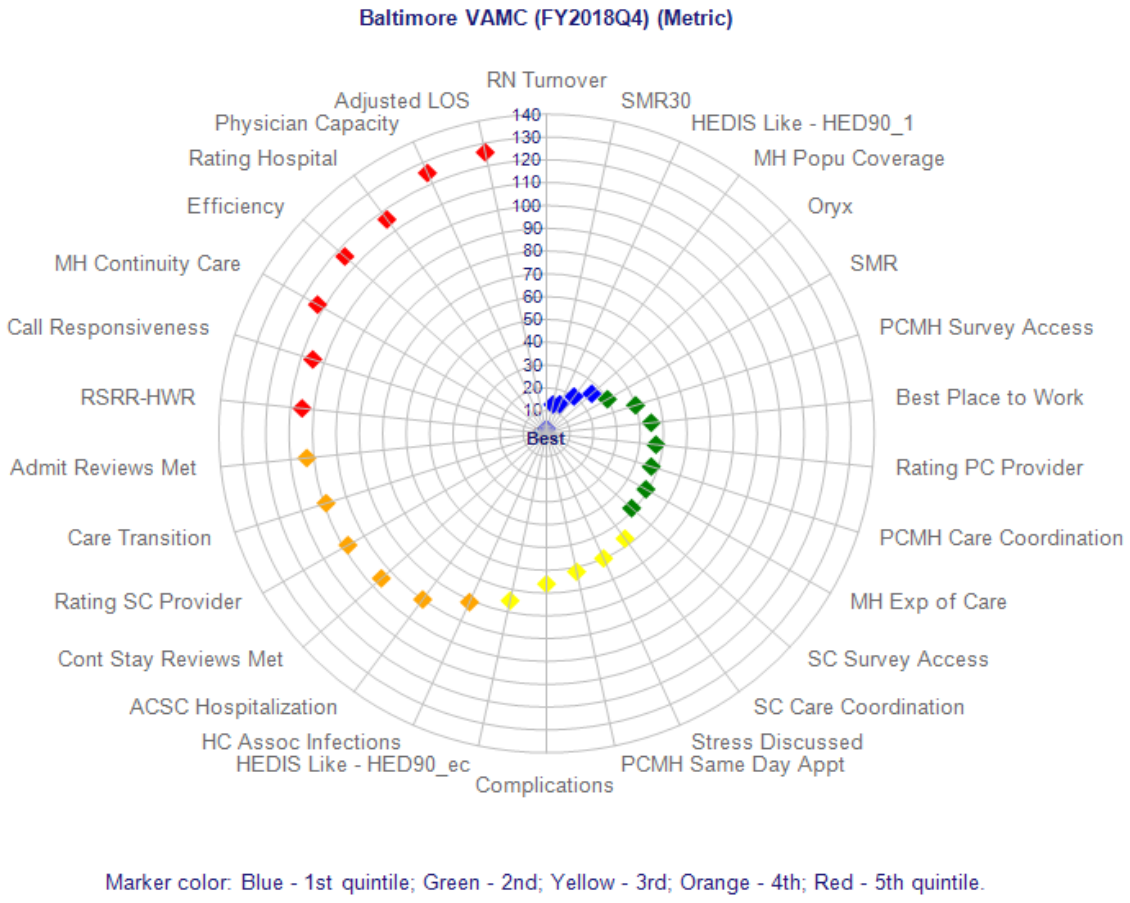

Figure 7. *Facility Quality of Care and Efficiency Metric Rankings (as of September 30, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such 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*.[37] The SAIL CLC provides a single resource to review quality measures and health inspection results. It

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

includes star ratings for an unannounced survey, staffing, quality, and overall results.[38] Table 9 summarizes the rating results for both facility's CLCs as of September 30, 2018. Although the Loch Raven CLC has an overall "2-star" rating, its rating for quality is only a "1-star;" and the Perry Point CLC has an overall "3-star" rating; its rating for quality is only a "1-star."

Table 9. Baltimore Loch Raven and Perry Point CLC Star Ratings (as of September 30, 2018)

Domain	Loch Raven Star Rating	Perry Point Star Rating
Unannounced Survey	2	3
Staffing	5	5
Quality	1	1
Overall	2	3

Source: VHA Support Service Center

In exploring the reasons for the "1 star" quality ratings for the Loch Raven and Perry Point CLCs, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 8 and 9 illustrates the facility's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2018. Figure 8 uses blue and green data points to indicate high performance for the Loch Raven CLC (for example, in the areas of physical restraints–long stay (LS) and ability to move independently worsened (LS)). Metrics that need improvement and were likely the reasons why the facility had a "1-star" for quality are denoted in orange and red (for example, catheter in bladder (LS) and newly received antipsychotic (Antipsych) meds–short stay (SS)). Figure 9 uses blue and green data points to indicate high performance for the Perry Point CLC (for example, improvement in function (SS) and urinary tract infection (LS)). Metrics that need improvement and were likely the reasons why the facility had a "1-star" for quality are denoted in orange and red (for example, moderate-severe pain (SS), and physical restraints (LS)).[39]

[38] *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.)

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

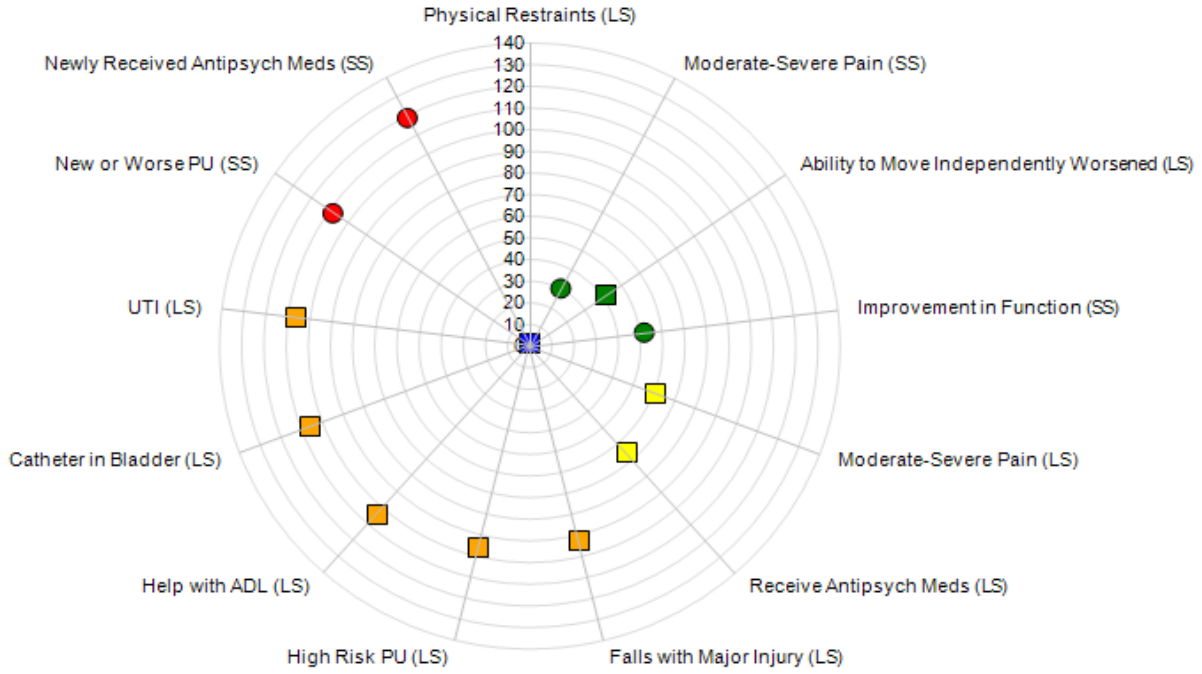

Figure 8. *Loch Raven CLC Quality Measure Rankings (as of September 30, 2018)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

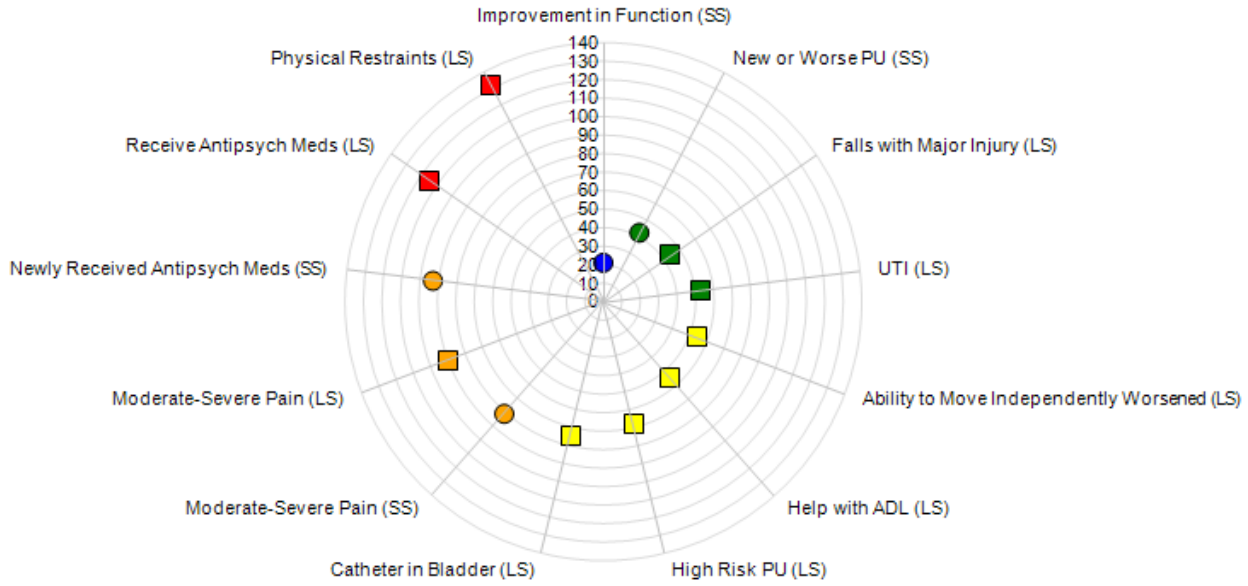

Figure 9. *Perry Point CLC Quality Measure Rankings (as of September 30, 2018)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team appeared relatively stable, with all five positions permanently filled for greater than one year. Selected survey scores related to employees' satisfaction with the facility executive leaders were generally better than VHA averages, except the score regarding moral distress at work for the associate director for Finance. Patient experience survey data related to satisfaction with the facility leadership were below VHA averages for three of the four survey questions. Facility leaders interact with staff and patients during leadership rounds and seek input from patients to sustain and further 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). However, the facility director was not involved as the chair or co-chair role for the committee responsible for quality, safety, and value. The OIG's review of the facility's accreditation findings, sentinel events, and patient safety indicator data did not identify any substantial organizational risk factors. The leaders should continue to strengthen processes for institutional disclosures. The leadership team was generally knowledgeable within their scope of responsibility about selected

SAIL and SAIL CLC metrics. They should, however, continue to take actions to sustain and improve performance of measures contributing to the SAIL "3-star" and Loch Raven and Perry Point CLC "1-star" quality ratings.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.[40] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[41] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[42]

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,[43] utilization management (UM) reviews,[44] patient safety incident reporting with related root cause analyses,[45] and cardiopulmonary resuscitation (CPR) episode reviews.[46]

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

[40] 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.)

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

[42] VHA Directive 1026.

[43] 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.

[44] 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.

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

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

nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[47]

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.[48]

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.[49]

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.[50]

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[51]

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

[47] VHA Directive 1190.

[48] VHA Directive 1117(1).

[49] VHA Handbook 1050.01.

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

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

  - Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee
  - Peer review of all applicable deaths within 24 hours of admission to the hospital
  - Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[52]
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Annual completion of a minimum of eight root cause analyses[53]
  - Inclusion of required content in root cause analyses (generally)
  - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report to facility leaders
- Resuscitation episode review
  - Evidence of a committee responsible for reviewing resuscitation episodes
  - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
  - Evidence of basic or advanced cardiac life support certification for code team responders
  - Evaluation of each resuscitation episode by the CPR Committee or equivalent

[52] VHA Directive 1190.

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

Quality, Safety, Value Conclusion

The OIG found compliance with few of the requirements. The OIG identified concerns with reporting peer review data to the Executive Committee of the Medical Staff (now known as the Executive Council of the Medical Staff), timely peer review completion, peer review of applicable deaths, interdisciplinary review of utilization management data, patient safety root cause analysis content, feedback to the reporting individuals or departments, responsible committee review of resuscitative episodes, and resuscitative actions in accordance with life-sustaining treatment orders. These concerns warranted recommendations for improvement.

Specifically, VHA requires the completion of final peer reviews within 120 days. An extension beyond 120 days is required to be in writing and approved by the facility director.[54] Of the 20 peer reviews reviewed by the OIG team, three were not completed within 120 calendar days and there was no documentation of a written extension granted by the facility director. When peer reviews are not conducted in a timely manner, the ability to quickly identify and correct issues is negatively impacted. The risk manager was unaware that facility director approval was required for peer reviews that would not be completed within 120 days due to a lack of knowledge of applicable directives.

Recommendation 1

1. The facility director ensures that peer reviews are completed within 120 calendar days or that a written extension is requested and approved by the facility director and monitors peer review coordinator's compliance.

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Director of Risk Management

Facility response: Risk Manager Lead will review 90% of completed peer reviews each month. Compliance rate targeted at 90% for timely completion of peer reviews will begin January 2020.

Sustainability: Compliance of timely peer reviews will be submitted to the Peer Review Committee quarterly and the Executive Council of the Medical Staff (ECMS) monthly and all data will be documented in Committee Minutes.

In addition, VHA requires quarterly reporting of peer review data to the medical executive committee or equivalent.[55] From January 2018 to January 2019, peer review data was not reported to the Executive Committee of the Medical Staff in two of four quarters. When data are not presented regularly, facility leaders may not be aware of trends that could indicate potential

[54] VHA Directive 1190.
[55] VHA Directive 1190.

or actual critical patient care issues. The risk manager was scheduled to present the quarterly data to the Executive Committee of the Medical Staff at just three meetings during the year and believed the intent was being met.

Recommendation 2

2. The chief of staff ensures reporting of peer review data to the Executive Council of the Medical Staff at least quarterly and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Director of Risk Management

Facility response: The Peer Review Committee Report has been added to Executive Council of the Medical Staff (ECMS) reporting schedule as of September 2019.

Sustainability: The Peer Review Committee will report data quarterly to the ECMS and data will be documented in the Minutes.

VHA also requires peer review of applicable deaths occurring within 24 hours of admission.[56] The OIG identified four deaths meeting VHA's criteria for review, but peer reviews had not been conducted. When a peer review is not done, the facility loses the ability to ensure that the clinical decisions and actions taken during the clinical encounter met the standard of care; this may result in missed opportunity to take action that can result in both immediate and long-term improvements in patient care. The risk manager stated a lack of awareness of the requirement.

Recommendation 3

3. The chief of staff ensures that all applicable deaths occurring within 24 hours of admission undergo a peer review and monitors compliance.

[56] VHA Directive 1190.

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Director of Risk Management

Facility response: The Director of Risk Management sends a written request to the Suicide Prevention Team and Utilization Management for submission of any deaths within 24 hours of an acute admission. If applicable a peer review will occur.

Sustainability: The Director of Risk Management will have Clinical Informatics run a report on all deaths within 24 hours of an acute admission. The deaths will be audited monthly to compare data. Compliance rate targeted at 90%. Monthly data will be reported bi-weekly for six consecutive months to the Chief of Staff's Executive Council of the Medical Staff (ECMS) meeting and Peer Review Committee and all data will be documented in the Minutes.

As to UM data, VHA requires interdisciplinary review of UM data.[57] This group must include representatives from UM, medicine, nursing, social work, case management, mental health, and the chief of business office revenue utilization reviewer (CBO R-UR).[58] From January 2018 through December 2018, the Patient Flow/Utilization Review Committee lacked representation from social work, case management, mental health, and CBO R-UR. As a result, the UM committee performed reviews and analyses of UM data without the perspectives of key social work, case management, mental health, and utilization review colleagues. The program manager stated noncompliance was due to a lack of awareness of the requirement despite being familiar with the directive.

Recommendation 4

4. The facility director ensures that all required representatives consistently participate in interdisciplinary reviews of utilization management data and monitors compliance.

[57] VHA Directive 1117(1).
[58] VHA Directive 1117(1).

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: FLOW Program Manager

Facility response: All required representatives were added to the Patient Flow Committee as of April 2019. All required members will have a substitute identified to serve as a replacement, if needed at the monthly meetings.

Sustainability: The Patient Flow Committee will track all required members attendance using monthly committee attendance sheet for six consecutive months. Compliance of 90% will be achieved for each required member. Monthly attendance data will be reported to the Executive Quality Council and data will be documented in the minutes.

Additionally, when root causes analyses are performed, VHA requires inclusion of specific content and adherence to procedures to ensure the quality and consistency of the review. Feedback from the root cause analysis must be provided to the individual or department who reported the incident.[59] The five root cause analyses reviewed by the OIG did not include the required content and for three of these, and feedback was not given to the individual or department reporting the event.[60] This resulted in incomplete and unreliable reviews and potential misidentification of the root cause(s), resulting in missed opportunities to mitigate risk and prevent future adverse patient events. The acting patient safety manager stated that the staff involved in the reviews did not receive adequate training on how to conduct root cause analyses and that the management review process, conducted by leaders after the RCA team makes conclusions and recommendations, impacted the final content of the root cause analyses. In addition, the acting patient safety manager stated the National Center for Patient Safety accepts the submitted root cause analyses with incomplete components, leading the acting patient safety manager to believe that all root cause analyses met criteria. Additionally, the acting patient safety manager thought the intent of providing feedback of the analysis was met by discussing the issues in the root cause analysis subcommittee meetings.

Recommendation 5

5. The facility director ensures the patient safety manager or designee includes all required components in each root cause analysis to ensure quality and consistency of reviews and monitors the patient safety manager's compliance.

[59] VHA Handbook 1050.01.

[60] All five root cause analyses lacked an analysis of the underlying systems through a series of "why" questions; four lacked a determination of human or other factors or did not identify at least one root cause with corresponding action and outcome measure; three did not identify system vulnerabilities or risks, review of relevant literature, or evidence of individual or department feedback; and two did not have a determination of potential improvement in processes or systems to decrease the likelihood of future events.

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Director of Patient Safety

Facility response: To ensure quality and consistency of all Root Cause Analysis (RCA), as of September 11, 2019 patient safety leaders have implemented an RCA checklist that includes all components of the RCA criteria. The checklist will be used to validate that all completed RCAs each month contain all required elements to be considered a quality review.

Sustainability: Target compliance of 90% will be achieved and sustainment monitored for six consecutive months utilizing the checklist. RCA data will be reported to the Patient Safety Committee monthly which reports to the Executive Quality Council and data will be documented in the minutes.

Recommendation 6

6. The facility director ensures the patient safety manager or designee provides feedback about root cause analysis actions to the reporting individuals or departments and monitors patient safety manager's compliance.

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Director of Patient Safety

Facility response: To ensure RCA follow-up and dissemination of information reaches the reporting individuals and/or departments; an RCA Feedback Form was developed in March 2019.

Sustainability: A monthly audit of all completed RCAs with a compliance target of 90% will have the completed Feedback Form. RCAs are reported monthly to through the Patient Safety Committee which reports to the Executive Quality Council and will be documented in the Minutes.

VHA also requires its practitioners to honor patients' wishes and refrain from initiating life-sustaining treatment for those with a Do Not Resuscitate (DNR)/Do Not Attempt Resuscitation order, even in case of a medical emergency, unless there is evidence that the order no longer represents the patient's preferences.[61] The OIG found that 1 of 10 resuscitative attempts reviewed involved a patient with an existing DNR order. Failure to comply with documented life-sustaining treatment orders dishonors the veteran's preference and has the potential to

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

increase patient harm and decrease quality of life. The Resuscitation Committee co-chair cited lack of a standardized process for documenting patient code status which resulted in difficulties in identifying DNR patients.

Recommendation 7

7. The chief of staff ensures that resuscitative actions performed by staff are in accordance with life-sustaining treatment orders and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Director of Quality, Safety and Improvement

Facility response: All Code Blue events are audited for accurate Life Sustained Treatment Decisions Initiative (LSTDI) orders and life sustaining treatment that was performed. The Quality Department reviews all Code Blues with the second review to the Chair (MD) of the Cardio Pulmonary Resuscitation Committee.

Sustainability: All code blue events will be audited with a compliance target of 90% including accurate LSTDI orders and life sustaining treatment that was performed per month by the committee and results will be reflected within the Cardio Pulmonary Resuscitation committee minutes which reports monthly Executive Quality Council and documented in minutes.

VHA requires that the facility establish a committee to review each resuscitative episode under the facility's responsibility and that the reviews include an assessment to determine if "errors or deficiencies in technique or procedures, lack of availability or malfunction of equipment, clinical issues or patient care issues."[62] Of the 10 resuscitation episodes reviewed by the OIG, seven lacked evidence of committee review. Of the three resuscitation episodes reviewed by the Resuscitation Committee, the OIG found no evidence that the reviews included the required elements. This likely resulted in missed opportunities to identify errors or deficiencies in technique or procedures, lack of availability or malfunction of equipment, and clinical or patient care issues such as failure to rescue. The Resuscitation Committee co-chair reported a lack of a formal review tool to document what was reviewed.

Additionally, in the 10 selected resuscitative events reviewed by OIG, there were four cases where a medical resident[63] functioned as the code leader but was not supervised during the

[62] VHA Directive 1177.

[63] VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012 (This VHA handbook was scheduled for recertification on or before the last working day of December 2017 and has not been recertified): "the term 'resident' refers to an individual who is engaged in an accredited graduate training program for physicians, dentists, optometrists, and podiatrists, and who participates in patient care under the direction of supervising practitioners."

resuscitative event. There was no evidence of a supervising practitioner present during the code event, nor were the corresponding notes co-signed by a supervising practitioner.

Recommendation 8

8. The facility director ensures that the Resuscitation Committee reviews each resuscitative episode under the facility's responsibility and the reviews include required elements and monitors committee's compliance.

Facility concurred.

Target date for completion: June 30,2020

Responsible Person: Director of Quality, Safety and Improvement

Facility response: The Quality, Safety and Improvement division took over the responsibility of the Cardio Pulmonary Resuscitation Committee as of June 2019. The Committee now completes a monthly review of all Code Blue "errors or deficiencies in technique or procedures," "lack of availability or malfunction of equipment," "clinical issues or patient care issues," and/or "delay in care or delay in beginning CPR."

Sustainability: Target of 90% compliance will be achieved for six consecutive months. Cardio Pulmonary Resuscitation Committee Minutes are now uploaded, and the Committee findings are presented in the monthly Executive Quality Council and documented in minutes.

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).[64]

Clinical privileges need to be specific, based on the individual's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to their expiration.[65]

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."[66]

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.[67] 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.[68]

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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[64] 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.)

[65] VHA Handbook 1100.19.

[66] VHA Handbook 1100.19.

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

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

- No solo/few (less than two in a specialty) practitioners were hired within 18 months before the site visit or were privileged within the prior 12 months[69]
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs re-privileged within 12 months before the visit
- No providers underwent a FPPE for cause within 12 months prior to the visit.

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[70]
  - 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

[69] The 18-month period was from September 11, 2017, through March 11, 2019. The 12-month review period covered March 11, 2018, through March 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.

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

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

Medical Staff Privileging Conclusion

The OIG found general compliance with requirements for privileging. However, the OIG identified concerns with focused and ongoing professional practice evaluations which warranted recommendations for improvement. It should be noted that the 2016 Combined Assessment Program Review of the facility also identified concerns with the OPPE process.[71]

VHA requires documentation of all FPPE results in the practitioner's profile. In addition, VHA requires that the Executive Committee of the Medical Staff meeting minutes reflect the decision to recommend privileges based on results of FPPE and OPPE evaluations.[72]

For 2 of 10 LIP FPPE profiles reviewed, the OIG did not find evidence that FPPE results were documented in the provider's profile. When evaluation results are not documented in the provider's profile, it is difficult to determine if the provider is practicing to the required standard of care. The facility managers stated the reasons for noncompliance were lack of attention to detail and oversight at the service chiefs' level.

Of the 30 practitioner profiles reviewed (10 FPPEs and 20 OPPEs), the Executive Committee of the Medical Staff Professional Standards Board's decision to recommend privileges for 21 providers was not based in part on focused or ongoing evaluations This resulted in providers delivering care without thorough documentation of the evaluation of their professional practice. The credentialing supervisor stated the FPPEs were incomplete and not presented for review in a

[71] VA Office of Inspector General, *Combined Assessment Program Review of the VA Maryland Health Care System, Baltimore, Maryland*, Report No. 15-05497-132, February 23, 2016.
[72] VHA Handbook 1100.19.

timely manner. In addition, the OPPE information was documented in a system separate from the committee minutes.

Recommendation 9

9. The chief of staff ensures the service chiefs document the focused professional practice evaluation results in the provider's profile and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Chief of Staff

Facility response: Service Chiefs are required to document focused professional practice evaluation (FPPE) activity results in the provider's profile. All Service Chiefs were re-educated in July 2019 and a Credentialing Database was implemented in July 2019.

Sustainability: Monthly random audits to commence in January 2020 of five (5) Licensed Independent Providers (LIP) profiles to ensure the results of FPPE activities are included/documented until a target of 90% is achieved for six consecutive months. Monthly audit data will be reported to the Professional Standards Committee.

Recommendation 10

10. The chief of staff makes certain that the facility's Executive Committee of the Medical Staff Professional Standards Board reviews all data when recommending continuation of provider privileges and monitors the Committee's compliance.

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Chief of Staff

Facility response: The service chiefs were educated on the new Professional Standards Committee Template that was implemented April 2019. The template will be used to ensure documentation of compliance with review of all pertinent data in order to continue re/privileging and re/appointment.

Sustainability: Audits will be reported within the Professional Standards Committee/Executive Council of the Medical Staff (ECMS) Minutes each month. Monthly audits will be conducted on five (5) Licensed Independent Provider (LIP) profiles using the Professional Standards Committee's template to achieve a 90% compliance rate. Compliance data will be monitored for six consecutive months for sustainment. All data will be reflected in the minutes.

Specific to the OPPE process, VHA requires that at the time of reprivileging, service chiefs consider relevant service- and practitioner-specific data with defined criteria when determining and recommending the continuation of LIPs' privileges to the executive level committee of the medical staff.[73] Of the 20 provider OPPE profiles reviewed, the OIG did not find evidence of service chiefs' determination to continue privileges for 10 LIPs; eight of these also lacked criteria specific to the service/section. This resulted in providers delivering care without thorough documentation of the evaluation of their professional practice. The facility managers stated reasons for noncompliance were lack of attention to detail and oversight at the service chiefs' level.

Recommendation 11

11. The chief of staff ensures that service chiefs include reviews of relevant data in professional practice evaluations when determining continuation of provider's privileges and monitors service chiefs' compliance.

[73] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Chief of Staff

Facility response: Ongoing Professional Practice Evaluation (OPPE) templates ensure inclusion of relevant practice and quality data to service/section specific privileges in order to continue appointment and privileges (as stated in the VHA directive criteria). A statement was added to OPPE form so that at the semi-annual reviews there is documentation of the decision to continue current privileges based on favorable OPPE review, conduct monthly audits of OPPEs of 5 LIPs (Licensed Independent Providers) who were re-privileged within 12 months of the audit month. Compliance will be achieved at 90%. Each bulleted criteria element will be worth 25 points providing a denominator of 500 with the audit of 5 charts. The service chiefs have revised Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) templates to ensure inclusion of relevant practice and quality data to specialty specific privileges in order to continue appointment and privileges. A statement was added to OPPE form so that at the semi-annual reviews there is documentation of the decision to continue current privileges based on favorable OPPE review.

Sustainability: The audits will commence in January 2020. The result of the audit will be reported monthly during the Professional Standards Committee meetings for a duration of 6 months, or until compliance is met consecutively for 3 months following the initial 6 months of reporting. All reporting will be documented in the minutes of the Professional Standards Board's meeting.

Recommendation 12

12. The chief of staff ensures the service chiefs include service-specific criteria in professional practice evaluations and monitors compliance.

Facility concurred

Target date for completion: June 30, 2020

Responsible Person: Chief of Staff

Facility response: Clinical service staff have updated Ongoing Professional Practice Evaluation (OPPE) criteria in a standard OPPE format to reflect specialty specific data. Target date for approval of the final OPPE form is January 12, 2020.

Sustainability: An audit of five (5) OPPE evaluations will be randomly audited per month for compliance of 90% and compliance sustainment for six consecutive months will be conducted and reported to Executive Council of the Medical Staff (ECMS) and data will be reflected in the minutes.

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.[74]

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.[75]

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.[76]

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.[77] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[78]

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

[75] 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).

[76] 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.)

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

[78] 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,[79] and National Fire Protection Association standards.[80] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[81]

In all, the OIG team inspected 25 areas of the multidivisional facility—Baltimore (emergency department, 5C-surgical intensive care unit, 5B-surgery, 5A-surgical service, 5D-same day surgery, 4C-cardiac intensive care unit, 4C-medical intensive care unit, 4A-speciality clinics, 3A and 3B-medical inpatient units, 2C-oncology, 2C-ear nose and throat, 2D-dental, and 1C-primary care clinics blue and green teams, 6A-inpatient mental health); Perry Point (building 361 outpatient, building 19A hospice and ventilator unit, building 23H Harbor CLC, building 23H 1st floor podiatry and optometry, building 23H 2nd floor geriatrics and extended care, and building 23 dental service); and Loch Raven (hospice; CLC-1; CLC-2; building 6 audiology and radiology; and building 7 research, robotics, and geriatric patient aligned care team). The team also inspected the Glen Burnie VA Clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Community based outpatient clinic
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program

[79] The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA's mission is to assure safe and healthy working conditions "by setting and enforcing standards and by providing training, outreach, education, and assistance." https://www.osha.gov/about.html. (This website was accessed on June 28, 2018.)

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

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

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

Environment of Care Conclusion

Generally, the facility met privacy, the women veterans' program, and emergency management requirements associated with the performance indicators. The OIG did not note a systematic issue with the availability of medical equipment or supplies.

However, the OIG noted that environment of care rounds were only conducted once in fiscal year 2018 at the Baltimore emergency department and the Loch Raven hospice areas when the requirement is twice each fiscal year. Additionally, the OIG identified concerns with safety, environmental cleanliness, and security at the facility which warranted recommendations for improvement.

TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices, and to keep furnishings and equipment safe and in good repair.[82] The OIG noted that six patient care areas had dust throughout,[83] four had dirty ventilation grills[84] and stained and/or missing ceiling

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

[83] Baltimore emergency department, specialty clinics (4A); ear, nose, and throat clinic (2C); inpatient mental health; Loch Raven CLC-2; Perry Point podiatry/optometry clinic (23H).

[84] Baltimore specialty clinics (4A), medical inpatient unit (3A&B), ear nose and throat (2C), Loch Raven CLC-2.

tiles,[85] and three had rolling patient care equipment that was dirty or in need of repair[86] and stained and/or damaged floors.[87]

The OIG found damaged furniture in patient rooms in two inpatient units.[88] Additionally, the OIG found damaged and worn wheelchair padding at the Baltimore and Perry Point facilities. Damaged and worn furniture and wheelchairs cannot be effectively cleaned and sanitized, which may become an infection control issue.

Additionally, at the Perry Point facility, the OIG observed a large pool of water at the lowest part of the tunnel walkway used by staff and visitors. The tunnel also had a black, green, and brown unknown substance coming from the ceiling and walls. Additionally, a sump pump at the end of the tunnel was without a lid cover and mop heads were noted throughout the tunnel. When the facility's physical space has environmental hazards, there is increased risk for patient, visitor, and employee safety events. The site manager stated this is a long standing problem but could not provide a reason why it had not been corrected.

Recommendation 13

13. The associate director ensures that areas used by patients are clean and safe and monitors compliance.

[85] Baltimore specialty clinics (4A), oncology (2C), Perry Point bldg. 361 outpatient, and 23H 1st floor podiatry/optometry.

[86] Baltimore emergency department, primary care (1C), and Perry Point bldg. 361 outpatient.

[87] Baltimore primary care (1C), Perry Point 23H 2nd floor geriatrics and extended care, and the tunnel between bldgs. 19 and 364.

[88] Loch Raven CLC 1 and CLC 2 (old patient furnishings).

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Chief of Environmental Management Service

Facility response: Baltimore and Perry Point both have supervisor housekeepers who complete daily rounds on housekeepers and areas. Baltimore has Environmental Management Service (EMS) supervision 24/7 within the facility and Perry Point has EMS supervision 16 hours and on call.

Sustainability: Both Baltimore and Perry Point have Site Managers who monitor and track all reported deficiencies the compliance goal is for 90% of deficiencies noted in Performance Logic will be closed or have an action plan established within 14 days. This is reported to the Executive Environment of Care (EOC) Council on a monthly basis that has Director oversight all reporting is submitted in the minutes.

Recommendation 14

14. The associate director confirms that damaged furniture and wheelchairs are repaired or removed from service and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Chief of Emergency Management Services/Chief of Voluntary Services (damaged wheelchairs)

Facility response: The Interior Design Team has been placed under the EMS service as of June 2019. Also, the Light Electronic Action Framework (LEAF)[89] has been introduced to track and trend all requests for all damaged furniture and wheelchairs.

Sustainability: The Interior Design manager will provide a monthly report of damaged furniture request to ensure that these requests have been closed or have an action plan 90% of the time within 14 days. This is reported to the Executive Environment of Care (EOC) Council on a monthly basis that has Director oversight all reporting is submitted in the minutes.

[89] Built by VA for VA, LEAF empowers non-technical users to implement workflows and digital forms that allow for fast turnaround, complete transparency, and status tracking.

Recommendation 15

15. The facility director makes certain that the basement tunnel at Perry Point VA is free from water hazards and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2021

Responsible Person: Chief of Facilities and Engineering

Facility response: The design project, #512A5-14-304 Waterproof Tunnel to Building 364, to resolve the water intrusion issue. Construction is on the FY21 plan, (denied for FY20), pending funding availability. Environmental Management Service inspects the corridors on a continuous basis documents floor conditions, promptly clears up any pooled water and maintains a walkable dry tunnel walkway.

Sustainability: Perry Point has a Housekeeper supervisor 16 hours per day and on call 7days a week to monitor and track all incidences. This is reported to the Executive Environment of Care (EOC) Council on a monthly basis that has Director oversight all reporting is submitted in the minutes.

VHA requires facilities to implement, use, and regularly test appropriate physical security precautions and equipment, including panic alarm systems, to ensure the safety of patients and staff.[90] During the OIG inspection of the Glen Burnie VA Clinic, an outpatient site which provided over 4,300 mental health encounters during fiscal year 2018, the nurse manager stated that the clinic did not have a panic alarm system; this was confirmed by the acting Chief of Police. The OIG noted in the previous December 8, 2015, CBOC review that a sister clinic, the Pocomoke VA Clinic, also did not have a panic alarm system,[91] and resolution through the purchase of a portable wireless panic alarm system was reported to the OIG in January 2016 to be operational by March 2016; however, this system was not secured for the Glen Burnie VA Clinic. The Acting chief of Police reported that the facility is currently testing a new security system and had not made a decision to install at other sites.

Recommendation 16

16. The associate director certifies that panic alarms are installed and tested as required and monitors compliance.

[90] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities,* September 27, 2012 (This directive expired on February 28, 2015, and has not been updated)

[91] VA Office of Inspector General, *Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Maryland Health Care System, Baltimore, Maryland*, Report No. 15-05164-139, February 23, 2016.

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Chief of Police

Facility response: Alertus Desktop Notification Panic Alarm system is being installed VA Maryland Health Care Community Based Outpatient Clinics pending Directors Approval.

Sustainability: The panic alarms are tested monthly and documented. The compliance target is 90% of all required panic alarm testing is completed monthly. All data is reported to the Executive Council of Administrative Staff (ECAS) quarterly and data is reflected in the ECAS minutes.

VHA requires testing of panic button and alarm systems in locked mental health units. VA police must periodically test and document their response times to these alerts.[92] Although the alarms systems were tested, the OIG team did not find evidence that police response times to panic alarm testing were documented in the six months prior to the team's site visit. This may result in an unsafe environment for patients, visitors, and staff since timely police responses greatly impact the overall success of police intervention and reduces organizational risks. The acting chief of Police stated that the inpatient mental health unit was not one of the areas selected by the police supervisor to conduct a rapid response test.

Recommendation 17

17. The associate director ensures that panic alarms on the locked mental health unit are tested to include VA police response time and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Responsibility Person: Chief of Police

Facility response: On unit 6A all required panic alarms and response time are tested.

Sustainability: The panic alarms are tested monthly and documented. The test results are filed in Police Service and reported to the Executive Council of Administrative Staff (ECAS) and documented in ECAS minutes. The compliance target is 90% of all required panic alarm testing is completed monthly.

[92] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

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.[93] 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.[94]

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.[95]

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

- Controlled substances coordinator reports
  - Monthly summary of findings to the director
  - Quarterly trend reports to the director
  - Quality Management Committee's review of monthly and quarterly trend reports
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Staff restrictions for monthly review of balance adjustments[97]
- Requirements for controlled substances inspectors

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

[94] 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.

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

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

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

  - No conflicts of interest
  - Appointed in writing by the director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required annual competency assessment
- Controlled substances area inspections
  - Completion of monthly inspections
  - Rotations of controlled substances inspectors
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of controlled substances orders
  - Performance of routine controlled substances inspections
- Pharmacy inspections
  - Monthly physical counts of the controlled substances in the pharmacy
  - Completion of inspections on day initiated
  - Security and verification of drugs held for destruction[98]
  - Accountability for all prescription pads in pharmacy
  - Verification of hard copy controlled substances prescriptions
  - Verification of 72-hour inventories of the main vault
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[99]

Medication Management Conclusion

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

[98] 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."

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

requirements for controlled substances inspectors. However, the OIG found that there were inconsistent practices between the Baltimore and the Perry Point facilities related to controlled substances inspector appointments and competencies. The controlled substances inspectors at Baltimore are appointed and then receive training with the competency completed within four to six months. At Perry Point, the controlled substances inspectors are trained, and competencies are completed at time of appointment. The OIG identified noncompliance with verification of controlled substances orders, reconciliation of dispensing between pharmacy and each dispensing area, and monthly checks of cache locks and verification of lock numbers, all of which warranted recommendations.

For each monthly area inspection, VHA requires that controlled substances inspectors "must verify there is a hard copy order (electronic or written) in the patient's medical record, there is documentation of administration, and documentation of 2 signatures for any wasting of partial doses for five randomly selected dispensing activities."[100] The OIG found incomplete order verifications for two of ten areas reviewed. In addition, for controlled substances storage areas with more than one medication dispensing cabinet, the review requirement is to evaluate five orders for each cabinet up to a maximum of 20 orders for the area.[101] The OIG noted that for five of the six months reviewed, seven medication dispensing cabinets within the operating room area had 20 orders reviewed. There was no documentation, however, that the review included orders from all seven cabinets. Failure to verify orders may cause delay in identifying any potential drug diversion activities. The controlled substances coordinator stated there was no process established for the controlled substances inspectors to ensure all medication dispensing cabinets in the operating room were included when reviewing dispensing activities.

Recommendation 18

18. The facility director makes certain that controlled substances inspectors verify controlled substances orders monthly for each medication dispensing cabinet and monitors inspectors' compliance.

[100] VHA Directive 1108.02(1).
[101] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Controlled Substance Inspection Program Coordinator

Facility response: The VA Maryland Health Care System (VAMHCS) Controlled Substance Inspection Program Coordinator modified the inspection forms to capture orders and reconciliation from the Automated Dispensing Cabinet (ADC) for all Operating Rooms. All forms will be reviewed monthly for completion with a compliance rate of 90% reported to the Executive Quality Council during the monthly update.

Additionally, during monthly inspections VHA requires controlled substances inspection program staff to reconcile one random day's stocking/refilling from the pharmacy to every automated dispensing unit and one random day's return of stock to pharmacy from every automated dispensing unit.[102] For the six months reviewed by OIG, all four non-pharmacy areas assessed at Perry Point lacked reconciliation of one day dispensing from the pharmacy to the automated dispensing cabinet and one day's return of stock to the pharmacy from every automated dispensing cabinet. Failure to reconcile dispensing and returns in all controlled substances areas may cause delays in identifying potential drug diversion activities. The OIG observed inconsistent processes used by the controlled substances coordinator at the Baltimore site and the alternate controlled substances coordinator at Perry Point. Per the controlled substances coordinator, the alternate controlled substances coordinator was reviewing a report but not reconciling between the areas.

Recommendation 19

19. The facility director makes certain that monthly reconciliation of one-day dispensing from pharmacy to every automated dispensing cabinet and one day return of stock to pharmacy from every automated dispensing cabinet is performed during controlled substances inspections and monitors compliance.

[102] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Controlled Substance Inspection Program Coordinator

Facility response: The VA Maryland Health Care System (VAMHCS) Controlled Substance Program Coordinator trained and established the review and verification of one day dispensing from pharmacy, and one day return to stock VAMHCS wide on a monthly basis. Compliance of dispensing verification is done as an element of the monthly controlled substance inspections with 90% compliance reported to the Executive Quality Council on a monthly basis.

VHA also requires that controlled substances inspectors complete a monthly review of the controlled substances in the emergency drug cache "once each quarter by breaking the locks and physically counting all controlled substances." During the months where breaking the locks is not required, the controlled substances inspectors "must check the locks for any evidence of tampering and verify the lock numbers."[103] The OIG found that in five of the six months of inspection reports reviewed, controlled substances inspectors did not inspect the emergency drug cache. Failure to assess the emergency cache locks for tampering may cause delay in identifying potential drug diversion activities. The controlled substances coordinator stated that the instructions on the facility form for the controlled substances inspectors described the expectation for the review but did not include a requirement to document verification of lock numbers for the cache.

Recommendation 20

20. The facility director confirms that controlled substances inspectors complete emergency drug cache inspections, including verification of lock numbers, and monitors inspectors' compliance.

[103] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Controlled Substance Program Coordinator

Facility response: The VA Maryland Health Care System (VAMHCS) Controlled Substance Program Coordinator modified its inspection form to capture previous month's Pharmacy Cache serial lock number and current month serial number. This is reviewed and verified monthly in log sheets inside the Cache during inventory and inspection. Reporting of reconciling for the Cache to include serial numbers will be included in the Controlled Substance Inspection monthly and quarterly report to achieve 90% compliance reported to the Executive Quality Council on a monthly basis.

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."[104] 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.[105]

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.[106] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[107]

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.[108] Those who screen positive must have access to appropriate MST-related care.[109] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.[110]

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

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

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

[106] VHA Directive 1115.

[107] 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.)

[108] 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."

[109] VHA Directive 1115.

[110] VHA Handbook 1160.01.

[111] 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.[112]

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

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

Mental Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including the designation of an MST coordinator, tracking of MST-related data, and provision of clinical care. There was a concern noted, however, with MST-related clinical staff training that warranted a recommendation for improvement.

Specifically, VHA requires that all primary care and mental health providers complete the MST mandatory training. For those hired after July 1, 2012, this training must be completed no later than 90 days after entering their position.[113] The OIG found that for those hired after July 1,

[112] 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.

[113] VHA Directive 1115.01; Acting Deputy Under Secretary for Health and Operations and Management, February 2, 2016.

2012, 4 of 11 providers did not complete training within 90 days of hire. This could potentially prevent clinicians from providing a consistent level of counseling, care, and service to veterans who experienced MST. The acting director of Mental Health Clinic Center reported that noncompliance with timely training completion was due to conflicting guidance across multiple policies regarding the time line for training completion.

Recommendation 21

21. The Facility director makes certain that primary care and mental health providers complete mandatory military sexual trauma training within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Director Mental Health

Facility response: Mental Health Clinical Center (MHCC) and Ambulatory and Emergency Care Clinical Center (AECCC) with the Talent Management Systems (TMS) Administrators monitor the Military Sexual Trauma (MST) report due date for all employees MST trainings monthly. Mental Health Providers, AECCC staff and the MST Coordinator are electronically notified when courses are pending. As of 11/06/19, the MST Dashboard reflects the following data: 399/401 (99.5%) of MH staff completed the MST training within 90 days of hire and 255/256 (99.6%) primary care employees completed the MST training within 90 days of hire in FY18-FY19. These rates are above the target benchmark of >=98.4% for MH providers and >=97.4% for Primary Care Providers.

Sustainability: Will continue to pull the MST report monthly to track all pending trainings with a compliance rate of 90% for six consecutive months. This report will be reflected in the monthly MH and AECCC PI Councils and reported quarterly in the Executive Quality Council. All data reflected in the minutes.

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."[114] 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.[115]

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."[116]

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.[117] 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."[118] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[119] 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.[120] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[114] 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.)

[115] 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.)

[116] 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.)

[117] 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.)

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

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

[120] 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.[121]

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 44 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.[122] The OIG evaluated the following performance indicators:

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

Geriatric Care Conclusion

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

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

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

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.[123] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[124] 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.[125] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[126]

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.[127]

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 leaders 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.[128]

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

[123] 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.)
[124] 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.)
[125] 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.)
[126] 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.)
[127] VHA Directive 1330.01(2), *Health Care Services for Women Veterans,* February 15, 2017 (amended July 24, 2018).
[128] 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.[129]

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 44 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

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

Women's Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including requirements for a designated women veterans program manager and women's health medical director, clinical oversight of the women's health program, communication of results to patients within the required time frame, and follow-up care when indicated. The OIG noted a concern with the Women Veterans Health Committee membership and the tracking of data related to cervical cancer screenings that warranted recommendations for improvement.

Specifically, VHA requires that the Women Veterans Health Committee includes a women veterans program manager; a women's health medical director; "representatives from primary

[129] VHA Directive 1330.01(2).

care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care; and a member from executive leadership."[130] From April 2018 through January 2019, the committee lacked representation from medical and/or surgical subspecialties, quality management, and executive leadership. This resulted in a lack of expertise in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans. The women veterans program manager stated the facility believed having most of the required members met the intent.

Recommendation 22

22. The facility director confirms that the Women Veterans Health Committee is comprised of required core members and monitors committee's compliance.

Facility concurred.

Target date for completion: September 30, 2020

Responsible Person: Women's Veteran's Program Manager

Facility response: The Women Veteran's Program Manager (WVPM) has updated the Women Veterans Health Committee Charter (WVHC) as of June 2019 to include required core membership as outlined in VHA Directive 1330.01(2). The first meeting under the new charter was held November 2019.

Sustainability: To ensure compliance, core members are required to send a designee in their absence. Additionally, meeting minutes will reflect attendance, including member titles, and will be reported quarterly to the Executive Quality Council. Compliance will be monitored monthly for the next 4 months and then quarterly. Target compliance rate is 90%.

According to VHA, each facility must assign care coordination responsibilities to specific individuals to ensure "notification of patients who are due for screening, tracking of completion of screening, results reporting, and follow-up care."[131] The OIG found no evidence that cervical cancer screening data were being tracked. When data are not tracked and monitored, patients may not receive timely notification and follow-up care. The women's health medical director stated that the facility believed the intent was met through external peer review process reports and by tracking abnormal results.

[130] VHA Directive 1330.01(2).
[131] VHA Directive 1330.01(2).

Recommendation 23

23. The facility director ensures that there is a defined process in place and designated staff responsible for tracking and monitoring of cervical cancer screenings as required and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Responsible Person: Women's Veteran's Program Manager

Facility response: A nurse has been designated to conduct daily tracking and monitoring of patient notification for cervical cancer screenings using an Excel tracking tool as required. The Theradoc Software Program is also utilized to validate cervical screening results against the Excel tracking tool. Patient Aligned Care Teams (PACT) are also identifying patients who are due for screening and contacting them by telephone, secured messaging or letter.

Sustainability: A random audit of 30 records will be reviewed from the daily tracking sheet to ensure cervical cancer screening data elements are documented. Results will be reported monthly to the Ambulatory and Emergency Care Clinical Center (AECCC) Performance Improvement Council and quarterly at the Women Veterans Health Committee and quarterly to the Executive Quality Council. 90% compliance will be achieved for six consecutive months for sustainment.

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

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

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

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

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

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

[133] VHA Directive 1101.05(2).

[134] VHA Directive 1101.05(2).

[135] TJC. Leadership standard LD.04.03.11.

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

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

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

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

[137] VHA Directive 1101.05(2).

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

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

[140] VHA Directive 1101.05(2).

  - Licensed independent mental health provider available as required for the facility's complexity level
  - Telephone message system during non-operational hours
  - Inpatient provider available for patients requiring admission
- Patient flow
  - EDIS tracking program
  - Emergency department patient flow evaluation
  - Diversion policy
  - Designated bed flow coordinator
- General safety
  - Directional signage to after-hours emergency care
  - Fast tracks[141]
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
  - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

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

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

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-three OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director, associate directors, and chief of staff. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• None	• Peer reviews are completed within 120 calendar days or that a written extension is requested and approved by the facility director. • Peer review data is reported to the Executive Committee of the Medical Staff at least quarterly. • Peer review is conducted for applicable deaths occurring within 24 hours of admission. • All required representatives consistently participate in interdisciplinary review or utilization management data. • Patient safety manager or designee includes all required characteristics and components in each root cause analysis. • Patient safety manager or designee provides feedback about root cause analysis actions to the reporting individuals or departments. • Resuscitative actions performed by staff are in accordance with life-sustaining treatment orders. • Resuscitation Committee reviews each resuscitative episode under the facility's responsibility.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• Service chiefs document FPPE results in the provider profiles. • Executive Committee of the Medical Staff Professional Standards Board reviews all data when recommending continuation of privileges. • Service chiefs collect and review of relevant data in professional practice evaluations. • Service chiefs include service-specific criteria in professional practice evaluations.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent facility
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Community based outpatient clinic
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Locked inpatient mental health unit
	  ○ Mental health environment of care rounds
	  ○ Nursing station security
	  ○ Public area and general unit safety
	  ○ Patient room safety
	  ○ Infection prevention
	  ○ Availability of medical equipment and supplies
	• Emergency management
	  ○ Hazard vulnerability analysis (HVA)
	  ○ Emergency operations plan (EOP)
	  ○ Emergency power testing and availability
		• Areas used by patients are clean.
		• Basement tunnel at Perry Point VA is free from water hazards.
		• Panic alarms are installed and tested as required.
		• Panic alarms on the locked mental health unit are tested to include police response.
			• Damaged furniture is repaired or removed from service.

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 inspectors verify controlled substances orders for each medication dispensing cabinet each month. • Monthly reconciliation of one-day dispensing from pharmacy and one day return of stock to pharmacy performed during controlled substances inspections. • Controlled Substances inspectors complete emergency drug cache inspections as required.
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	• Clinicians complete MST mandatory training as required.
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	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
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	• None	• The Women Veterans Health Committee includes required core members. • There is a process and a designated employee responsible for tracking and monitoring of cervical cancer screenings.
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	• None

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this high complexity (1b) affiliated[142] facility reporting to VISN 5.[143]

Table B.1. Facility Profile for VA Maryland Health Care System (512) (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	$646,509,561	$672,239,766	$652,396,797
Number of:			
• Unique patients	55,605	53,539	53,685
• Outpatient visits	728,911	696,426	709,856
• Unique employees[147]	2,981	2,969	2,948
Type and number of operating beds			
• Community living center	263	263	263
• Domiciliary	145	145	163
• Intermediate	22	22	22
• Medicine	83	83	69
• Mental health	98	58	18
• Residential psychology	23	23	23
• Surgery	33	33	33
Average daily census:			
• Community living center	206	175	170
• Domiciliary	120	118	91

[142] Associated with a medical residency program.

[143] The VHA medical centers are classified according to a facility complexity model; a designation of "1b" indicates a facility with "medium-high volume, high-risk patients, many complex clinical programs, and medium-large 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).

Profile Element	Facility Data FY 2016[144]	Facility Data FY 2017[145]	Facility Data FY 2018[146]
• Intermediate	9	7	2
• Medicine	55	58	54
• Mental health	26	15	15
• Neurology	0	0	0
• Residential psychology	15	13	14
• Surgery	21	16	15

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

VA Outpatient Clinic 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
Eastern Baltimore County, MD	512GF	3,722	1,479	n/a	n/a	n/a
Glen Burnie, MD	512GC	10,785	4,393	Endocrinology Pulmonary/ Respiratory disease Eye Podiatry	n/a	Pharmacy Weight management Nutrition

[148] Includes all outpatient clinics in the community that were in operation as of August 15, 2018. *The OIG omitted (512QA) Baltimore-West Fayette, MD, as no data were reported.*

[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.

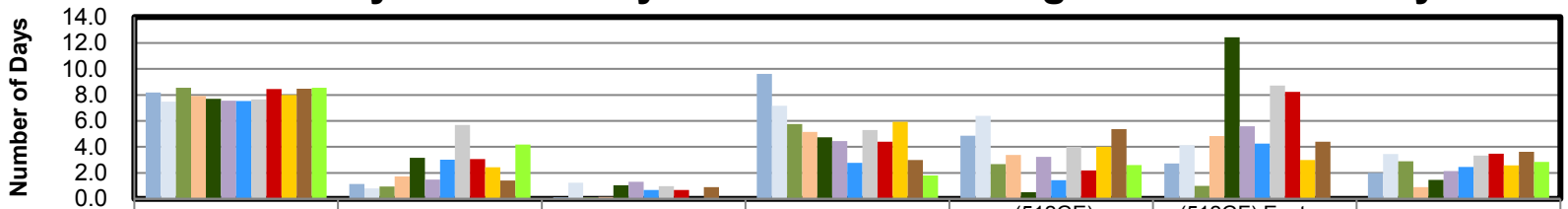
[152] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[150] Provided	Diagnostic Services[151] Provided	Ancillary Services[152] Provided
Cambridge, MD	512GA	11,216	4,896	Dermatology Endocrinology Infectious disease Nephrology Pulmonary/ Respiratory disease Poly-Trauma General surgery Podiatry Urology	EKG	Pharmacy Weight management Nutrition
Pocomoke City, MD	512GE	3,779	1,362	Dermatology Endocrinology Gastroenterology Pulmonary/ Respiratory disease General surgery	n/a	Pharmacy Nutrition
Fort Meade, MD	512GG	9,107	5,335	Gastroenterology Pulmonary/ Respiratory disease Eye	n/a	Pharmacy Nutrition

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

Appendix C: Patient Aligned Care Team Compass Metrics[153]

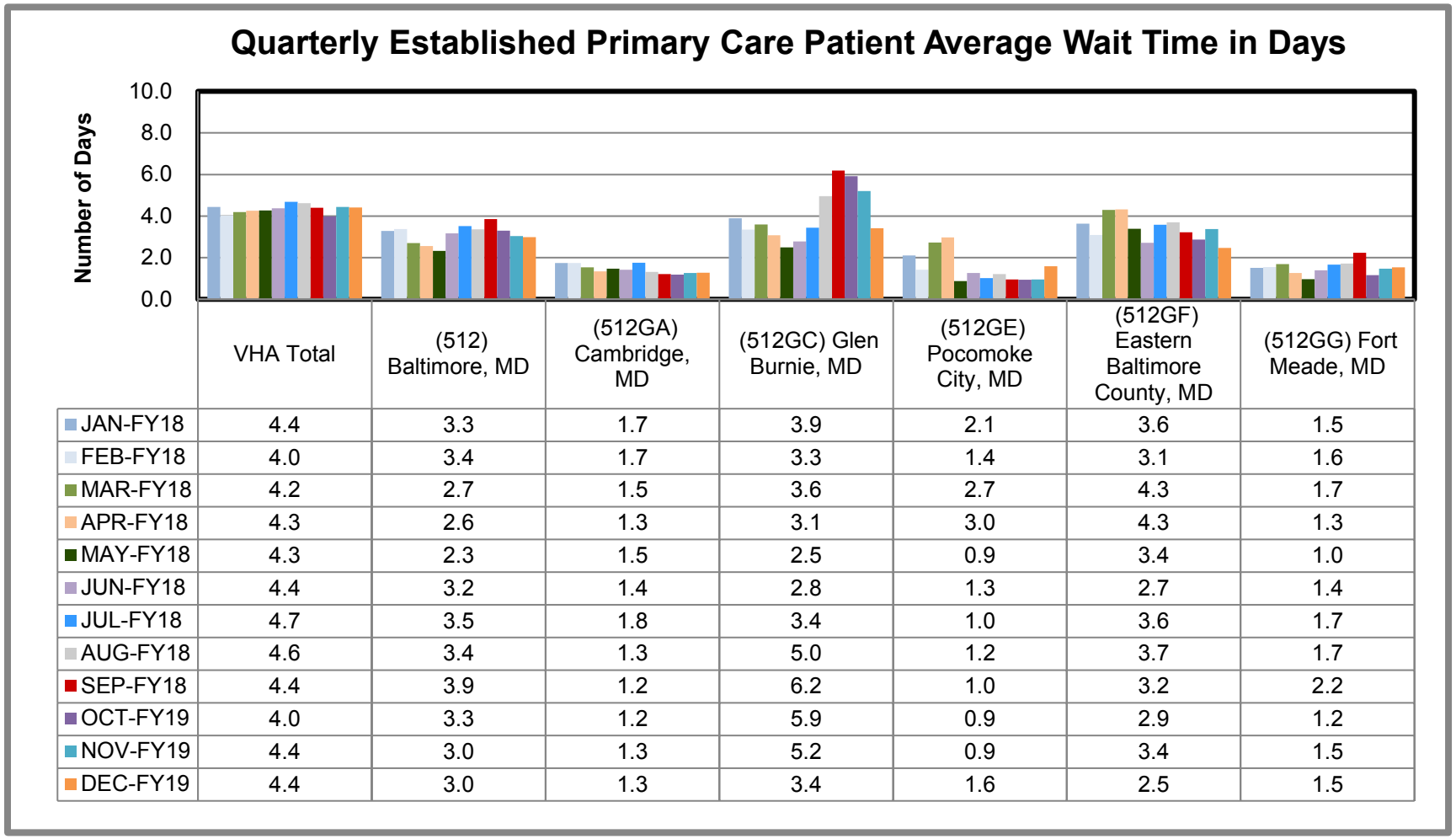
Quarterly New Primary Care Patient Average Wait Time in Days



	VHA Total	(512) Baltimore, MD	(512GA) Cambridge, MD	(512GC) Glen Burnie, MD	(512GE) Pocomoke City, MD	(512GF) Eastern Baltimore County, MD	(512GG) Fort Meade, MD
JAN-FY18	8.2	1.1	0.1	9.6	4.9	2.7	2.0
FEB-FY18	7.5	0.8	1.3	7.2	6.4	4.1	3.5
MAR-FY18	8.6	1.0	0.1	5.8	2.7	1.0	2.9
APR-FY18	7.9	1.7	0.1	5.1	3.4	4.8	0.9
MAY-FY18	7.7	3.2	1.0	4.7	0.5	12.4	1.5
JUN-FY18	7.6	1.5	1.3	4.4	3.2	5.6	2.2
JUL-FY18	7.5	3.0	0.7	2.8	1.4	4.3	2.5
AUG-FY18	7.7	5.7	1.0	5.3	4.0	8.7	3.3
SEP-FY18	8.5	3.1	0.7	4.4	2.2	8.3	3.5
OCT-FY19	8.0	2.4	0.0	5.9	4.0	3.0	2.6
NOV-FY19	8.5	1.4	0.9	3.0	5.4	4.4	3.6
DEC-FY19	8.6	4.2	0.0	1.8	2.6	0.0	2.9

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (512QA) Baltimore-West Fayette, MD as no data were reported. 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 are indicated by "n/a."

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



	VHA Total	(512) Baltimore, MD	(512GA) Cambridge, MD	(512GC) Glen Burnie, MD	(512GE) Pocomoke City, MD	(512GF) Eastern Baltimore County, MD	(512GG) Fort Meade, MD
JAN-FY18	4.4	3.3	1.7	3.9	2.1	3.6	1.5
FEB-FY18	4.0	3.4	1.7	3.3	1.4	3.1	1.6
MAR-FY18	4.2	2.7	1.5	3.6	2.7	4.3	1.7
APR-FY18	4.3	2.6	1.3	3.1	3.0	4.3	1.3
MAY-FY18	4.3	2.3	1.5	2.5	0.9	3.4	1.0
JUN-FY18	4.4	3.2	1.4	2.8	1.3	2.7	1.4
JUL-FY18	4.7	3.5	1.8	3.4	1.0	3.6	1.7
AUG-FY18	4.6	3.4	1.3	5.0	1.2	3.7	1.7
SEP-FY18	4.4	3.9	1.2	6.2	1.0	3.2	2.2
OCT-FY19	4.0	3.3	1.2	5.9	0.9	2.9	1.2
NOV-FY19	4.4	3.0	1.3	5.2	0.9	3.4	1.5
DEC-FY19	4.4	3.0	1.3	3.4	1.6	2.5	1.5

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (512QA) Baltimore-West Fayette, MD, as no data were reported.
Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

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

[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 27, 2019

From: Director, VA Capitol Health Care Network (10N05)

Subj: Comprehensive Healthcare Inspection of the VA Maryland Health Care System, Baltimore, MD

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

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

1. I have reviewed and concur with the findings and recommendations in the Office of Inspector General's (OIG) draft report entitled- Comprehensive Healthcare Inspection of the VA Maryland Health Care System, Baltimore, Maryland.

2. Further, I have reviewed and concur with the VA Maryland HCS, Medical Center Director's response.

(Original signed by:)

Raymond Chung for Robert M. Walton FACHE

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

Appendix G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 26, 2019

From: Director, VA Maryland Health Care System (512/00)

Subj: Comprehensive Healthcare Inspection of the VA Maryland Health Care System, Baltimore, MD

To: Director, VA Capitol Health Care Network (10N05)

1. I would like to express my appreciation to the Office of the Inspector General Comprehensive Healthcare Inspection Program (CHIP) survey team for their professional and thorough review of the VA Maryland Health Care System, Baltimore, Maryland.

2. I have reviewed the draft for the VA Maryland Health Care System, Baltimore, Maryland, and concur with the findings and recommendations.

3. Please express my gratitude to the survey team for their professionalism and assistance to us in our continuing efforts to provide the best care possible to our Veteran patients.

(Original signed by:)

Adam M. Robinson, Jr., M.D.

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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