DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System

Leeds, Massachusetts

CHIP REPORT | REPORT #19-00038-63 | JANUARY 13, 2020

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Figure 1.*VA Central Western Massachusetts Healthcare System, Leeds, MA (Source: https://vaww.va.gov/directory/guide/, accessed on September 16, 2019)*

Abbreviations

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

Report Overview

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

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

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

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

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

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, chief of staff, associate director for Nursing and Patient Care Services (ADNPCS), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure with the Executive Council of the Governing Body having oversight for several working groups, such as the Executive Committee of the Medical Staff, Administrative Executive Board, Nurse Executive Board, and Performance Improvement Committee. The leaders were engaged in monitoring patient safety and care through the Performance Improvement Committee, the committee responsible for quality, safety, and value functions at the facility; however, the OIG noted that the director was not the chair of this committee.[1]

The facility's leadership team had been working together for 18 months. The director and ADNPCS were permanently assigned September 21, 2014, and May 4, 2014, respectively. Likewise, the chief of staff was permanently assigned April 2, 2017, and the associate director, on December 10, 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 director appears to have opportunities to promote and develop an environment that improves employee engagement, empowerment, and trust. The patient experience survey scores applicable to the facility demonstrated that patients were generally satisfied with the leadership and care provided. Facility leaders appeared to be actively engaged with patients through leadership rounding, where the executive team members interact with patients and staff and solicit feedback. The facility also created a veteran-centered VA television show that airs monthly in different cities and is available on YouTube. The show provides news and resource information to the veteran population and internal and external stakeholders.

The OIG also reviewed accreditation agency findings and noted the facility received a preliminary denial of accreditation following the June 2018 Joint Commission (JC) survey, had closed all but two recommendations, and received full accreditation in August 2018. In addition,

[1] 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.)

the OIG's review of the facility's sentinel events[2] and disclosures identified opportunities for the facility leaders to review the process for evaluating cases for possible institutional disclosure and to ensure accurate data collection and reporting, including but not limited to, documenting, tracking, and completing disclosures for all events that meet criteria.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[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 "5-star" and SAIL CLC "3-star" quality ratings.[4]

The OIG noted deficiencies in all eight clinical areas reviewed and issued 30 recommendations that are attributable to the director, chief of staff, and associate director. These are briefly described below.

Quality, Safety, and Value

The OIG found general compliance with requirements for resuscitative episode reviews. However, the OIG identified concerns with peer review activities, completion of utilization management reviews and analysis of data, root causes analyses, and submission of an annual patient safety report.[5]

[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."

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

Medical Staff Privileging

The facility generally complied with requirements for privileging. However, the OIG identified concerns with the focused, ongoing, and for cause professional practice evaluation processes.[6]

Environment of Care

The facility generally complied with safety requirements. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG found damaged furniture in two locations at the facility. The OIG also identified concerns at the Fitchburg VA Clinic related to cleanliness and a tripping hazard.

Medication Management

Overall, the facility complied with requirements for some of the performance indicators evaluated, including the controlled substances coordinator reports, controlled substances inspectors' completion of annual competency assessments, and pharmacy inspections. The OIG team noted that the staff responsible for conducting the monthly review of balance adjustments were also able to conduct the balance adjustments. This was corrected while the OIG was onsite. However, the OIG identified noncompliance with requirements for controlled substances inspectors' terms of appointment, controlled substances non-pharmacy area inspections, and override reports reviewed by the facility.

Mental Health

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

Geriatric Care

For geriatric patients, clinicians documented reasons for prescribing antidepressant medications. However, the OIG identified inadequate patient and/or caregiver education and assessment of understanding specific to the newly prescribed medication. Additionally, clinicians did not consistently reconcile patients' medications.

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, and provision of follow-up care when indicated. However, the OIG noted concerns with the Women Veterans Health Committee membership, tracking of cervical cancer screening data, and communication of abnormal results to patients within the required time frame.

High-Risk Processes

The OIG inspection determined that the facility generally complied with some of the performance indicators used to assess the operations and management of the urgent care clinic (UCC). The OIG team found that facility managers were operating the UCC 24 hours a day, seven days a week without a waiver and a lack of a minimum of two registered nurses on duty during all hours of operation, a provider backup call schedule, support services during all hours of operation, availability of social work services, development and implementation of patient flow measures, proper UCC signage, availability of a mental health intervention room, and availability of pediatric resuscitation and obstetric equipment.

Summary

In reviewing key healthcare processes, the OIG issued 30 recommendations for improvement directed to the facility director, chief of staff, and the associate director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issue 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 interim facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 84–85, and the responses within the body of the report for the

full text of the directors' comments.) The OIG considers recommendation 28 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

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Purpose and Scope

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

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.[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)
8. Women's health (particularly abnormal cervical pathology results notification and follow-up)

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

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

[9] 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.

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

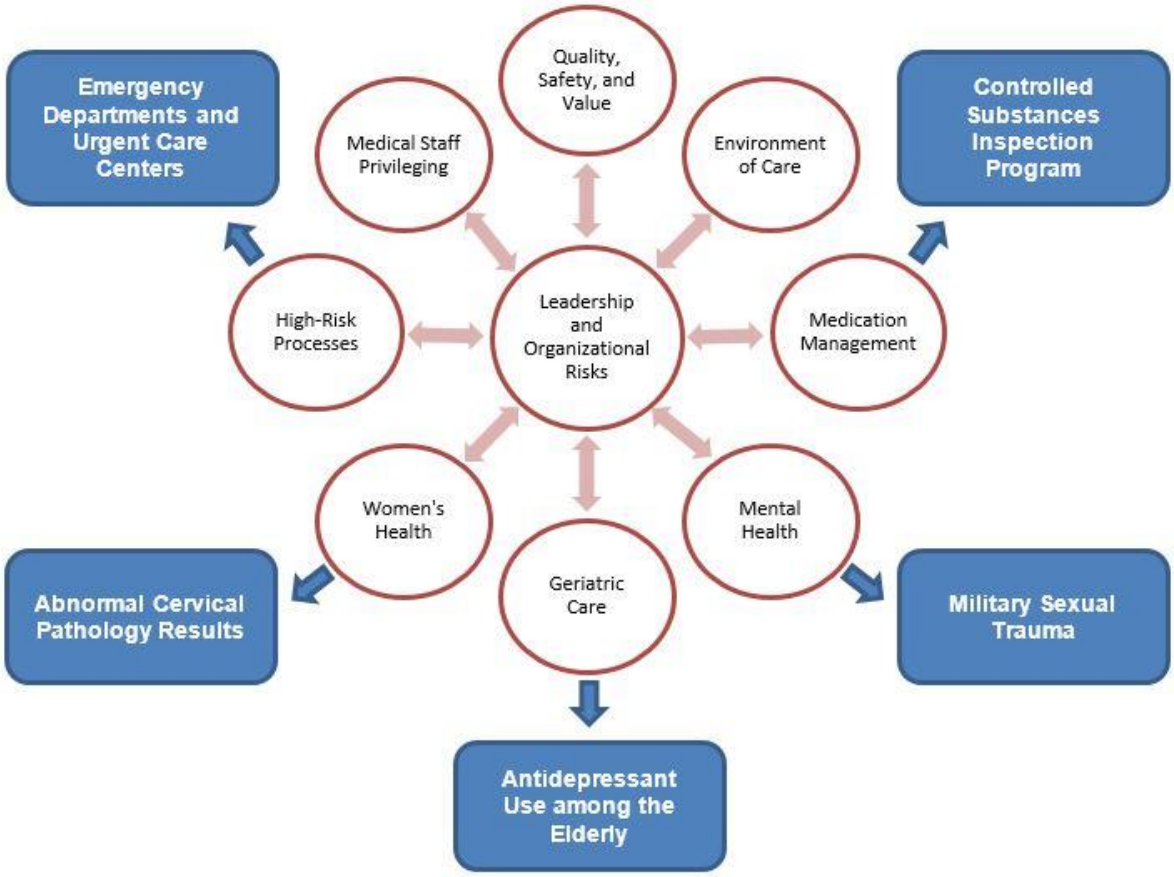

Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

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 6, 2014, through June 6, 2019, the last day of the unannounced week-long site visit.[11] While on site, the OIG referred issues and concerns beyond the scope of the CHIP review to our hotline management team for further evaluation.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The facility director's comments submitted in response to the report recommendations appear within each topic area.

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

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

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

Results and Recommendations

Leadership and Organizational Risks

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

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

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the director, chief of staff, associate director for Nursing and Patient Care Services (ADNPCS), and associate director (primarily nonclinical). The chief of staff and ADNPCS 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.)

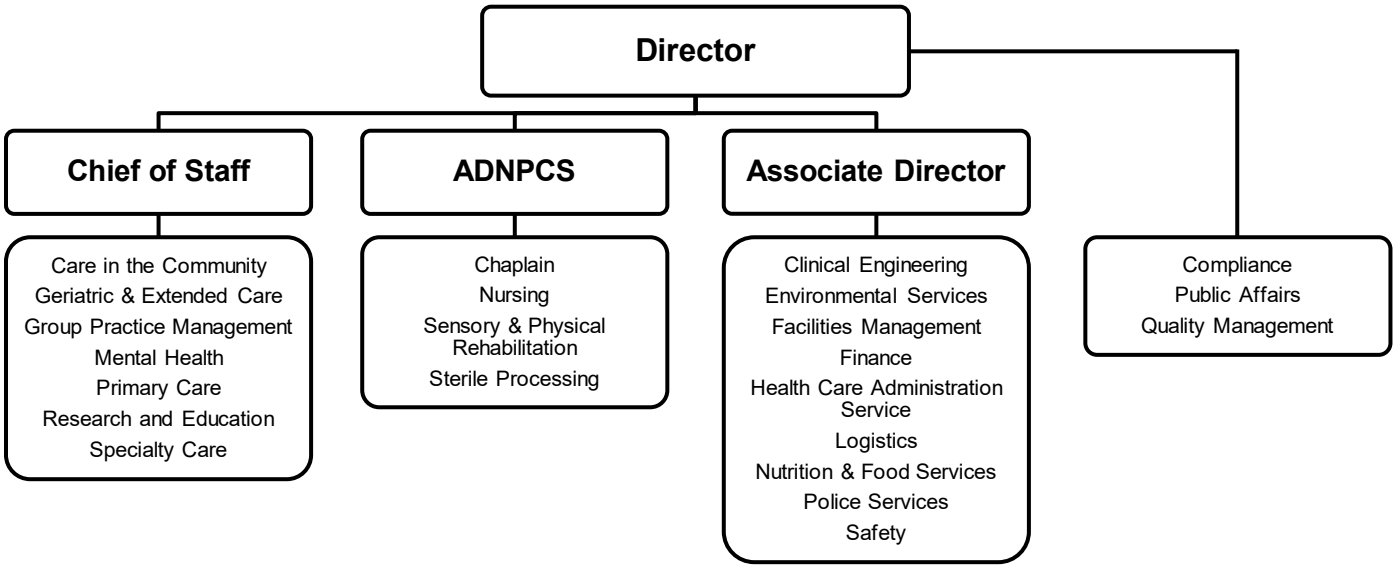

Figure 3. *Facility Organizational Chart*
Source: VA Central Western Massachusetts Healthcare System (received June 4, 2019, and December 16, 2019)[13]

At the time of the OIG site visit, the executive team had been working together for 18 months, with the associate director being the most recently appointed (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	September 21, 2014
Chief of staff	April 2, 2017
Associate director for Nursing and Patient Care Services	May 4, 2014
Associate director	December 10, 2017

Source: VA Central Western Massachusetts Healthcare System human resources officer (received June 4, 2019)

To help assess facility executive leaders' engagement, the OIG interviewed the director, chief of staff, ADNPCS, and associate director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance. In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable within their scope of responsibilities about selected

[13] The facility provided an updated organizational chart on December 16, 2019. The ADNPCS is now identified as ADPCS. At this facility, the director is responsible for the Compliance, Public Affairs, and Quality Management.

Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL community living center (CLC) measures. These are discussed in greater detail below.

The director serves as the chairperson of the Executive Council of the Governing Body, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Council of the Governing Body oversees various working groups, such as the Executive Committee of the Medical Staff, Administrative Executive Board, Nurse Executive Board, and Education Committee.

These leaders are also engaged in monitoring patient safety and care through the Performance Improvement Committee, for which the chief of Quality Management served as the committee chair.[14] The Performance Improvement Committee is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes and reports to the Executive Council of the Governing Body. See Figure 4. Of note, the OIG found that the Performance Improvement Committee minutes did not include consistent documentation of implementation of actions, monitoring, or discussion of the information presented.

[14] According to VHA Directive 1026, *VHA Enterprise Framework For Quality, Safety, And Value,* August 2, 2013, "the standing committee must: be chaired or co-charied 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.)

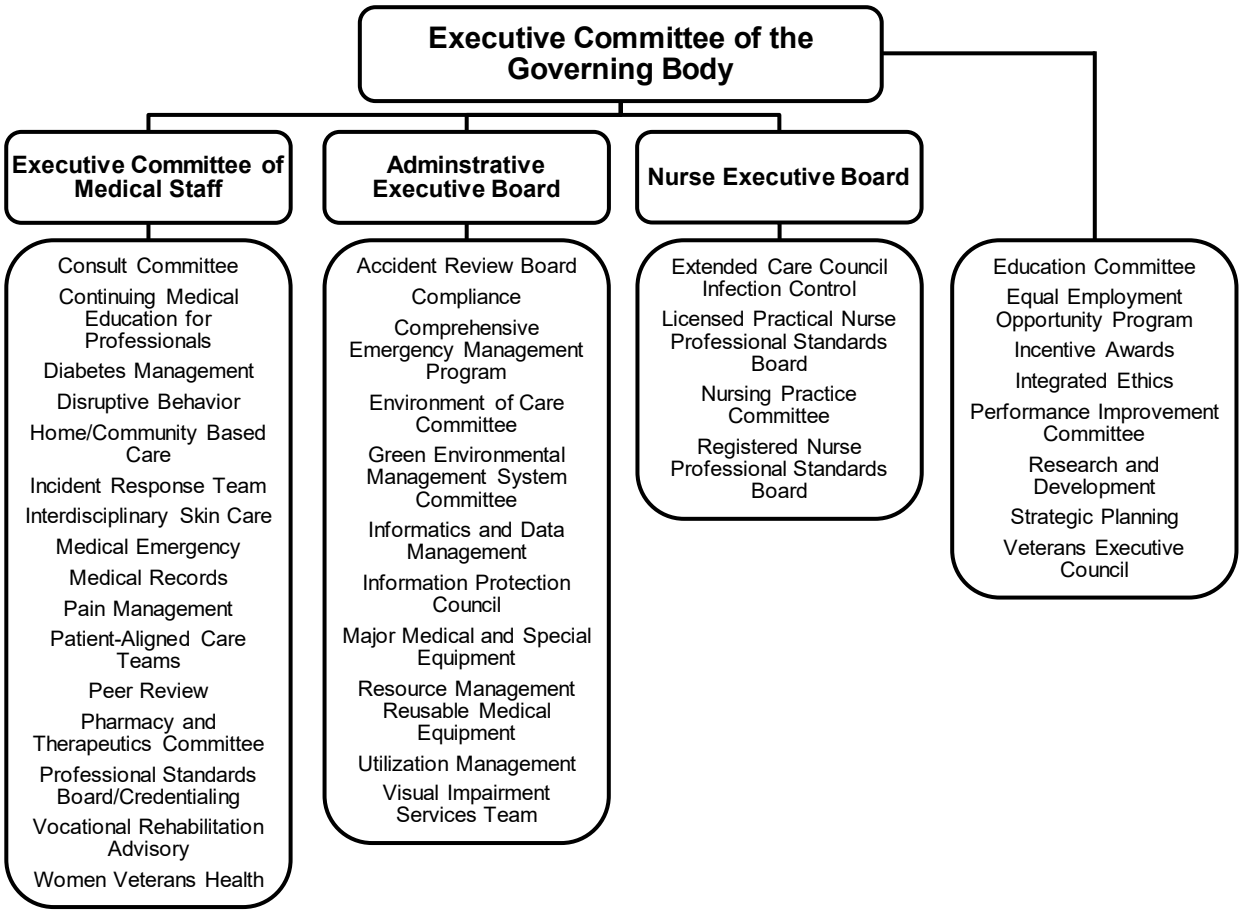

Figure 4. *Facility Committee Reporting Structure*[15]
Source: VA Central Western Massachusetts Healthcare System (received June 4, 2019)

Employee Satisfaction

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

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2017,

[15] At this facility, the Executive Committee of the Governing Body oversees the Education Committee; Equal Employment Opportunity Program; Incentive Awards; Integrated Ethics; Performance Improvement Committee; Research and Development; Strategic Planning; and the Veterans Executive Council.

through September 30, 2018.[16] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for the selected survey leadership questions was similar to the VHA average.[17] For three of the four selected survey questions, the members of the executive leadership team had survey averages similar to or higher than VHA. The director's average for the servant leader index composite was lower than VHA, the facility, and the other members of the leadership team. Through servant leadership, leaders develop employees and build trust, which increases job satisfaction and quality of health care.[18] There is an opportunity for the director to promote and develop an environment that improves employee engagement and empowerment. In all, however, 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	ADNPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[19]	0–100 where HIGHER scores are more favorable	71.7	72.7	63.8	81.8	86.9	93.1

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

[17] 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.

[18] T. McCann, D. Graves, and L. Cox, "Servant Leadership, Employee Satisfaction, and Organizational Performance in Rural Community Hospitals," *International Journal of Business and Management* 9, no. 10 (2014): 28, https://pdfs.semanticscholar.org/5a4d/306052867e035b1751833e108657dbffb106.pdf. (The website was accessed on July 3, 2019.)

[19] 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	ADNPCS Average	Assoc. Director Average
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.3	3.6	4.0	4.4	4.5
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.5	3.6	4.1	4.6	4.3
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.4	3.8	3.8	4.4	4.5

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

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The facility and executive leadership team averages for the selected survey questions were similar to or better than the VHA average, except for the director whose averages for two of the three questions were worse than VHA, the facility, and the other members of the leadership team. These lower-than-average scores present opportunities for the director to continue to build trust with facility employees. In general, however, 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	ADNPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.8	3.6	4.1	4.6	4.2
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.7	3.4	4.1	4.5	4.6
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.5	1.5	1.6	1.1	0.6	1.5

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

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through June 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.[20]

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses for two of the four survey questions applicable to this facility that reflect patients' attitudes toward facility leaders (see Table 4). Both of the patient survey results for the facility reflected higher care ratings than the VHA average. Patients were generally satisfied with the leadership and care provided. Facility leaders appeared to be actively engaged with patients through leadership rounding where the executive team members interact with patients and staff and solicit feedback. In addition, the facility created and hosted the only veteran-centered VA television show in the region, which airs monthly in different cities and can also be found on YouTube. The purpose of the show is to provide information related to VA outreach initiatives; and, as a result of the program, the facility has seen a 40 percent increase in community partnerships.

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?*[21]	The response average is the percent of "Definitely Yes" responses.	66.9	n/a
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer*.	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.2	n/a
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.3	83.3

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

[21] The facility does not have inpatient beds.

Questions	Scoring	VHA Average	Facility Average
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	82.8

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

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[22] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[23] The OIG noted that during the facility's TJC triennial hospital review conducted June 2018, TJC reviewers recommended a preliminary denial of accreditation, citing risks to patients because of "significant and pervasive patterns, trends, and/or repeat findings."[24] In July 2018, TJC upheld the preliminary denial of accreditation, but the facility received full accreditation in August 2018. Of note, at the time of the OIG visit in June 2019, the facility had closed all but two of TJC's recommendations (water storage tank high and low water level alarms and fire doors to be replaced/repaired). The chief of Quality Management reported that both recommendations required action by VHA contracting and estimated the date of completion to be July 2019.[25]

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

[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."

[24] TJC accreditation decision, June 19, 2018.

[25] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

Pathologists.[26] Additional results included the Long Term Care Institute's inspection of the facility's CLC.[27]

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 Central Western Massachusetts Healthcare System, Leeds, Massachusetts,* Report No. 14-04228-144, March 4, 2015)	December 2014	13	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts,* Report No. 14-04396-142, March 4, 2015)	December 2014	6	0
TJC Hospital Accreditation	June 2018	49	2
TJC Behavioral Health Care Accreditation		9	0
TJC Home Care Accreditation		5	0
TJC Follow Up	January 2019	0	0

Source: OIG and TJC (*inspection/survey results received with the accreditation specialist on June 4, 2019*)

[26] 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.

[27] 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.)

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.

Since the last OIG Combined Assessment Program review, the facility reported the identification of six sentinel events.[28] None of these six sentinel events had documented institutional disclosures even though five of them resulted in patient deaths—three of which were drug overdoses by the patients. Further, although VHA requires disclosure of adverse events that cause death,[29] the chief of staff reported that none of the five events were disclosed to the patients' families or legal guardians. The OIG noted, upon review of the disclosures conducted, one patient had an institutional disclosure note completed, however the event was not identified in the note as required. In addition, the information maintained by facility staff regarding institutional disclosures did not contain all events or associated information such as the dates of incidents, date of disclosure, and any actions taken.

Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from December 6, 2014 (the prior comprehensive OIG inspection), through June 6, 2019.[30]

[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 Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012, (Corrected copy October 12, 2012), "Institutional disclosure is a formal process to inform the patient or the patient's 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." (This VHA directive was scheduled for recertification on or before the last working day of October 2017 and has not been recertified.)

[30] 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 Central Western Massachusetts Healthcare System is a low complexity (3) affiliated facility as described in Appendix B.)

Table 6. Summary of Selected Organizational Risk Factors (December 6, 2014, through June 6, 2019)

Factor	Number of Occurrences
Sentinel Events[31]	6
Institutional Disclosures[32]	5
Large-Scale Disclosures[33]	0

Source: VA Central Western Massachusetts Healthcare System's chief of Quality Management and the risk manager (received June 3, 2019)

Patient safety indicators, developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services, provide information on potential in-hospital complications and adverse events following surgeries and procedures.[34] These data are not applicable since inpatient care is not provided at the facility.

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.[35]

[31] 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."

[32] 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."

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

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

[35] 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.)

VA also uses a star-rating system where facilities with a "5-star" rating are performing within the top 10 percent of facilities and "1-star" facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.[36] As of June 30, 2018, the facility was rated as "5-star" for overall quality.

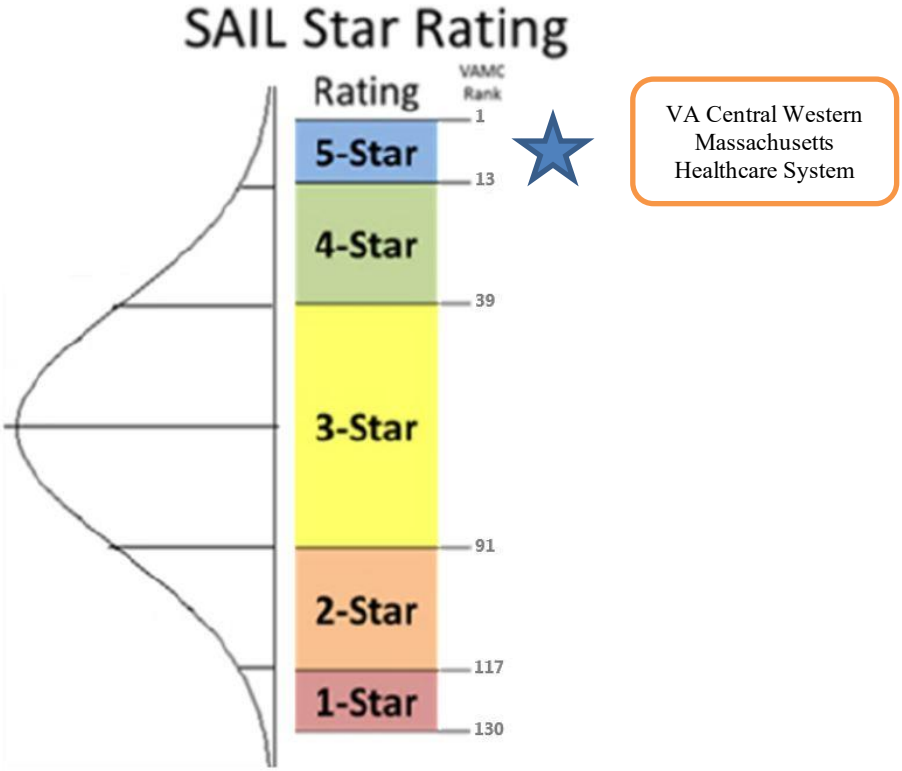

Figure 5. *Strategic Analytics for Improvement and Learning Star-Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed May 5, 2019)

Figure 6 illustrates the facility's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of call responsiveness, mental health (MH) continuity (of) care, registered nurse (RN) turnover, and physician capacity). Metrics that need improvement are denoted in orange and red (for example, stress discussed and best place to work).[37]

[36] 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.

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

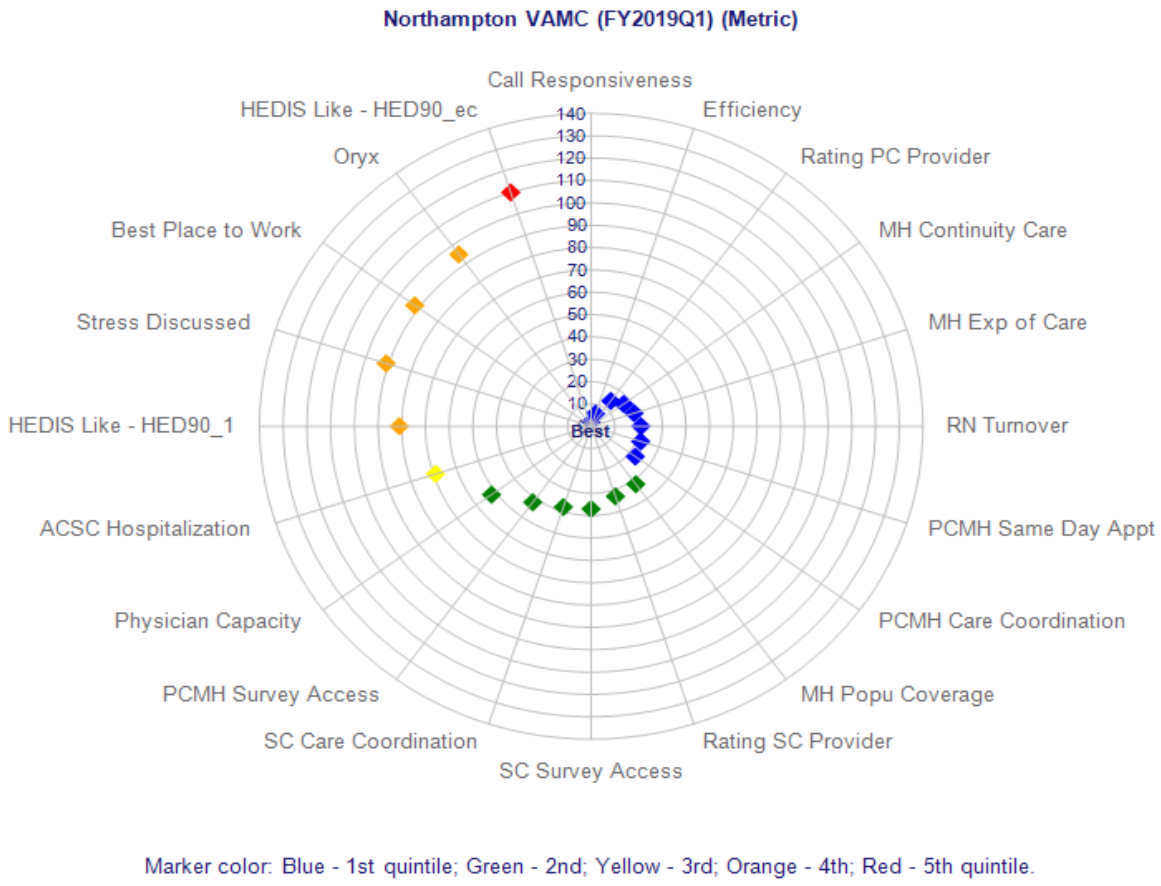

Figure 6. *Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

The SAIL Value Model also includes "SAIL CLC," which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in The Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare*.[38] The SAIL CLC provides a single resource to review quality measures and health inspection results. It

[38] According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, August 22, 2019, "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

includes star ratings for an unannounced survey, staffing, quality, and overall results.[39] Table 7 summarizes the rating results for the facility's CLC as of December 31, 2018. Although the facility has an overall "4-star" rating, its rating for quality is only "3-star."

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

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

Source: VHA Support Service Center

In exploring the reasons for the "3-star" quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 7 illustrates the facility's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of high-risk pressure ulcer (PU)–long stay (LS), physical restraints (LS), and catheter in bladder (LS)). Metrics that need improvement and were likely the reasons why the facility had a "3-star" for quality are denoted in orange and red (for example, moderate-severe pain–short stay (SS), falls with major injury (LS), and receive antipsychotic (antipsych) medications (meds) (LS)).[40]

[39] *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.)

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

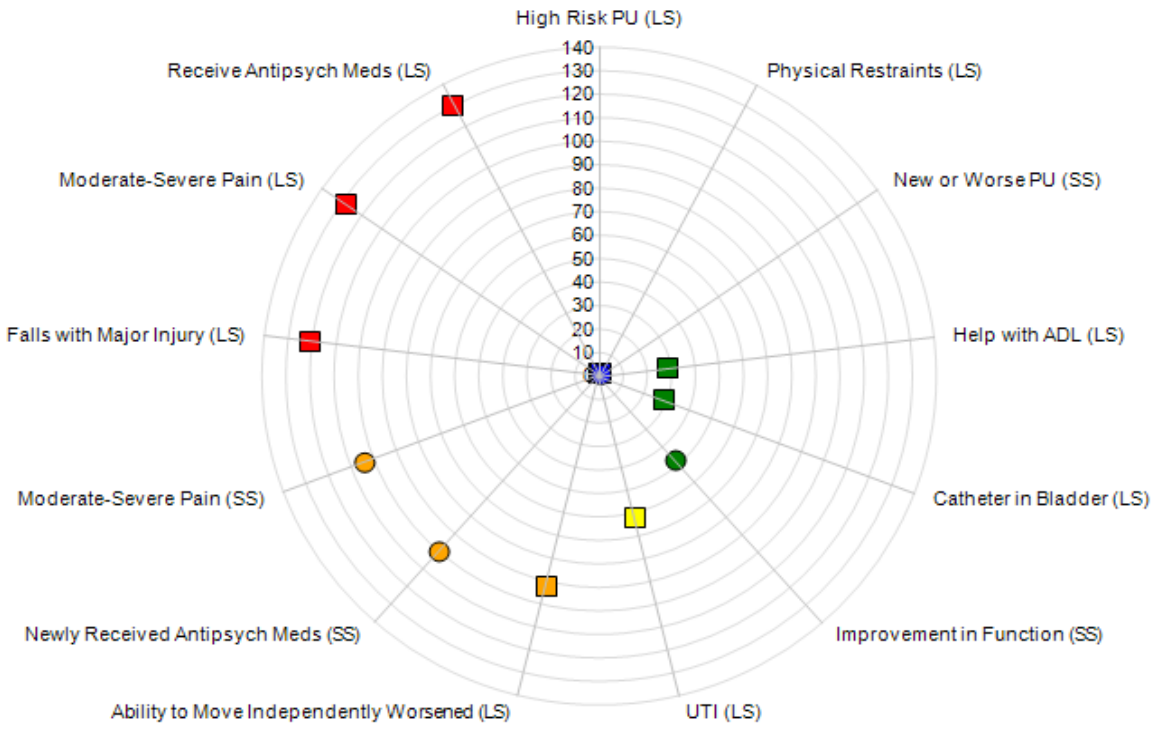

Figure 7. *Facility CLC Quality Measure Rankings (as of December 31, 2018)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team appeared relatively stable, with all four positions permanently filled. The leaders are engaged in monitoring patient safety and care through the Performance Improvement Committee, the committee responsible for QSV functions at the facility; however, the OIG noted that the director was not the chair of this committee. Selected survey scores related to employees' satisfaction with the facility executive leaders were generally better than VHA averages, with the exception of the director who had similar to or worse than VHA and facility averages. Based upon the two patient experience survey questions applicable to the facility, patients were generally satisfied with the leadership and care provided. The facility leaders appeared actively engaged with employees and patients during leadership rounds and the veteran-centered VA television show are working to sustain and further improve employee and patient engagement and satisfaction. The OIG's review of the facility's TJC accreditation findings noted the receipt of a preliminary denial of accreditation for the hospital survey and that two recommendations from that survey remained open. However, the facility had an action plan for closure and received full accreditation in August 2018. In addition, the OIG's review of the facility's sentinel events and disclosures identified opportunities for the facility leaders to review

the process for evaluating cases for possible institutional disclosure and to ensure accurate data collection and reporting, including, but not limited to, documenting, tracking, and completing disclosures for all events that meet criteria. Finally, the leadership team was knowledgeable within their scope of responsibility about selected SAIL and CLC metrics but should continue to take actions to sustain and improve performance of measures contributing to the SAIL "5-star" and CLC "3-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.[41] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[42] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[43]

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,[44] utilization management (UM) reviews,[45] patient safety incident reporting with related root cause analyses,[46] and cardiopulmonary resuscitation (CPR) episode reviews.[47]

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[48]

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[41] 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.)

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

[43] VHA Directive 1026.

[44] 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.

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

[46] 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."

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

[48] VHA Directive 1190.

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[49]

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.[50]

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.[51]

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:[52]

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

[49] VHA Directive 1117(2).

[50] VHA Handbook 1050.01.

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

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

  - 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[53]
- UM[54]
  - 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[55]
  - 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

Quality, Safety, Value Conclusion

The OIG found general compliance with the requirement for resuscitative episode review. However, the OIG identified concerns with peer review activities, completion of utilization

[53] VHA Directive 1190.

[54] The facility does not provide inpatient medical or surgical care.

[55] 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]."

management reviews and analysis of data, root causes analyses, and submission of an annual patient safety report which warranted recommendations for improvement.

Specifically, VHA requires that peer reviewers use at least one of the nine aspects of care (such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation) to evaluate level 2 or level 3 peer review findings.[56] Of the 20 cases reviewed, 15 cases were categorized as level 2 or 3, and all 15 lacked evidence of the required aspects of care. When the reviewer does not identify an aspect of care, this may impact the ability of the committee to determine if appropriate care was provided. The risk manager was unaware of the need to have an aspect of care documented by the peer reviewer, despite being familiar with VHA requirements.

Recommendation 1

1. The chief of staff ensures that peer reviewers consistently use at least one of the aspects of care when conducting peer reviews and monitors reviewers' compliance.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: Effective June 15, 2019, the Peer Review forms were updated and revised to capture the nine aspects of care. The aspect(s) of care, for each individual case reviewed, is reflexive of the discussion of the Peer Review Committee during the evaluation of care under review.

The Initial Reviewer will assign a one or more aspect(s) of care when assigning a Level 2 or a Level 3 to the care.

To ensure compliance of utilizing the nine aspects of care, the Chief of Staff, or designee, will review 100% of peer review cases each month, for six consecutive months, until a threshold of 90% compliance is achieved.

Effective July 2019, compliance of the utilization of one of the nine aspects of care will be reported monthly to Peer Review Committee, which reports to Executive Committee of the Medical Staff (ECMS), that reports to the Executive Committee of Governing Board.

VHA requires that improvement activities resulting from QSV reviews are completed, evaluated, and monitored for effectiveness. Further, when the Peer Review Committee recommends individual improvement actions, clinical managers are required to implement those actions.[57] For 6 of 14 peer reviews, where improvement actions were recommended, there was no evidence of implementation. The failure to implement the peer review recommendations likely prevented

[56] VHA Directive 1190.

[57] VHA Directive 1190.

immediate and long-term improvements in patient care in the practice of one or more healthcare providers. The risk manager stated there was no process in place to ensure completion of the recommended actions.

Recommendation 2

2. The chief of staff ensures that managers consistently implement, and document completion of improvement actions recommended by the Peer Review Committee and monitors the managers' compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Chief of Staff will ensure timely completion of improvement actions recommended by the Peer Review Committee by reporting out the number of days that has lapsed since the recommendation was issued. Improvement opportunities will be considered "overdue" once they reach 60 days old.

The Chief of Staff, or designee, will keep a running track of number of days that has lapsed since the recommendation was issued during the monthly Peer Review Committee. Any improvement action that exceeds 60 days will be considered "overdue". The target will be that 90%, or better, of improvement actions are completed "on time" (within 60 days of being issued). The percentage of compliance will be monitored at each Peer Review Committee meeting and reflected in the meeting minutes. Monitoring of compliance will continue until 90% compliance, or better, is achieved for six consecutive months.

Effective January 2020, improvement actions will be monitored for completion within 60 days of being issued and reported monthly at the Peer Review Committee, which reports to Executive Committee of the Medical Staff (ECMS), that reports to the Executive Committee of Governing Board.

VHA requires quarterly reporting of peer review data to the "Medical Executive Committee (or equivalent)" (Executive Committee of the Medical Staff).[58] Peer review data were not reported to the Executive Committee of the Medical Staff from July 2018 through March 2019. When data are not presented regularly, facility leaders may not be aware of trends that could indicate potential or actual patient care issues. The risk manager reported being unaware of the need to present peer review data quarterly to the Executive Committee of the Medical Staff.

[58] VHA Directive 1190.

Recommendation 3

3. The chief of staff ensures that peer review data is reported quarterly to the Executive Committee of the Medical Staff and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Risk Manager has been reporting Peer Review data to the Executive Committee of the Medical Staff (ECMS) monthly. In addition, the Risk Manager will begin reporting Peer Review data to ECMS, as required by VHA Directive 1190, Peer Review for Quality Management, November 21, 2018. The Peer Review data will contain 100% of the required elements in compliance by the VHA Directive.

The Chief of Staff, or designee, will audit the ECMS meeting minutes, for 2 consecutive quarters, to ensure 100% compliance of the required Peer Review elements are reported in ECMS, that reports to Executive Committee of Governing Board.

For managing the quality and efficient use of resources, VHA requires reviews be conducted for at least 75 percent of acute inpatient and observation stays. In addition, VHA requires that physician UM advisors complete a secondary review and document decisions into the National Utilization Management Integration application.[59] From April 2018 through March 2019, the OIG found that only 44 percent of the required acute inpatient and observations stay reviews were completed by the utilization review staff. In addition, from October 2018 through March 2019, no physician UM advisor reviews were completed. When reviews are not completed, this negatively impacts the facility's ability to ensure the provision of clinically appropriate and fiscally efficient patient care. The chief of Quality Management cited the lack of UM personnel, the need to prioritize completing the TJC requirements to maintain full accreditation, the exit of the previous physician UM advisor, and the inability to procure training for the physician advisor's replacement as the reasons for noncompliance.

Recommendation 4

4. The facility director ensures utilization management staff complete and document acute inpatient and observations stay reviews as required and monitors staff compliance.

[59] VHA Directive 1117(2).

Facility concurred.

Target date for completion: February 28, 2020

Facility response: The Department of Quality Management continues to seek to replace the Utilization Management Registered Nurse (RN) position that has been vacated since August 2019.

As of September 2019, the Department of Quality Management has trained another Quality Management RN Specialist as a back-up to the Utilization Management role. This has facilitated the increase in the inpatient utilization management review with 68% for September 2019, 100% for October 2019, and 91% for November 2019.

Quality Management will monitor monthly compliance of 100% of inpatient utilization management review, for additional six months, with the expectation of compliance level being greater than 75%.

Effective November 2019, compliance of the monthly inpatient reviews will be reported in the Utilization Management Committee which reports to Executive Committee of the Medical Staff, that reports to the Executive Committee of Governing Board.

Recommendation 5

5. The facility director ensures that Physician Utilization Management Advisor(s) consistently complete reviews and document their decisions in the National Utilization Management Integration database and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: As of November 2019, the Department of Mental Health has identified providers that will be trained as Physician Utilization Management Advisors.

Education and training of Physician Utilization Management Advisors will have a target completion date of December 31, 2019.

Effective January 1, 2020, Quality Management will monitor monthly compliance of 100% of Physician Utilization Management Advisors' reviews, for additional six months, with the expectation of compliance level being greater than 75%, with a target completion date of June 30, 2020. Monitoring and compliance will be reported in the Utilization Management Committee Executive Council which reports to the Executive Committee of Governing Board.

Furthermore, the VHA requires interdisciplinary review of UM data. This process must include, but not be "limited to, representatives from UM, medicine, nursing, social work, case management, mental health, and chief Business Office revenue-utilization review."[60] There was no evidence that an interdisciplinary group met to review UM data from June 2018 through May 2019. As a result, no analyses were conducted to identify trends or deficiencies, attainment of appropriate benchmarks, or the need for improvement actions by an interdisciplinary team. The chief of Quality Management believed the committee had met but was unable to provide evidence and stated the lack of minutes may be due to competing priorities for the acting UM manager, who was also the acting patient safety manager.

Recommendation 6

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

Facility concurred.

Target date for completion: July 30, 2020

Facility response: As of July 2019, the Quality Management Department has facilitated monthly Utilization Management (UM) Committee meetings that review UM data. The committee is interdisciplinary, as directed by VHA Directive.

The UM Committee meets monthly, and committee core members are expected to attend, at a minimum, 11 monthly meetings (92%) out of the 12 scheduled meetings, annually. If core members miss 2 meetings in a 6-month period, the Medical Facility Director (MFD), or designee, will send an email to the member and their supervisor, asking them to re-commit to the meeting or to have an alternate representative.

Effective January 2020, the percentage of attendance at each Utilization Management Committee meeting will be reported to Executive Council which reports to the Executive Committee of Governing Board.

VHA requires the completion of a minimum of eight patient safety analyses annually, including root cause analyses and aggregated reviews. These reviews must include all required content.[61] The facility did not complete any root cause analyses for FY 2018. The lack of completed root cause analyses diminishes the facility's ability to identify and mitigate system vulnerabilities instrumental in reducing patient harm. The chief of Quality Management attributed the lack of compliance to uncompleted work, a contributing factor leading to termination of the previous patient safety manager within the past year.

[60] VHA Directive 1117(2).

[61] VHA Handbook 1050.01.

Recommendation 7

7. The facility director ensures that the patient safety manager or designee completes the required number of root cause analyses that include the required content annually and monitors the patient safety manager's compliance.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The Patient Safety Manager will ensure just in time training for Root Cause Analysis (RCA) team members prior to the initiation of the RCA. RCA just in time training will encompass VHA Handbook 1050.01 requirements for RCA process and documentation to include, but not limited to, elements such as determination of human and other factors and the processes and systems related to the occurrence; analysis of the underlying systems; identification of system vulnerabilities or risks and their potential contributions to the adverse event or close call; consideration of relevant literature; exclusion of individuals directly involved in the event; and identify at least one root cause with corresponding action and outcome measure. A minimum of eight RCAs will be completed annually, where the required elements for each individual or aggregate RCA, and its status, will be reported monthly, effective November 2019, to the Quality, Safety, and Value Committee (formerly Performance Improvement Committee) that reports to the Executive Committee of Governing Board.

Additionally, VHA requires the annual submission of a patient safety report to facility leaders which provides an overview of the status of the patient safety program.[62] The patient safety annual report was not completed for FY 2018. The absence of an annual patient safety report prevents facility leaders from gaining an overview of patient safety issues, successes, and opportunities for improvement. The chief of Quality Management did not realize the annual patient safety report had not been completed, as the focus had been on completing backlogged root cause analyses.

Recommendation 8

8. The facility director ensures that the patient safety manager or designee provides an annual patient safety report to facility leaders and monitors the patient safety manager's compliance.

[62] VHA Handbook 1050.01.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: The Patient Safety Manager will submit an annual Patient Safety report within three months of the end of each fiscal year to Quality, Safety, and Value Committee (formerly Performance Improvement Committee), that reports to the Executive Committee of Governing Board.

The 2019 Annual Patient Safety report will be submitted to Quality, Safety, and Value Committee (formerly Performance Improvement Committee) during the December 23, 2019 committee meeting.

Quality Management will monitor annual compliance (met/not met) of the Annual Patient Safety report to be submitted to Quality, Safety, and Value Committee (formerly Performance Improvement Committee).

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).[63]

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.[64]

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."[65]

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.[66] 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.[67]

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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[63] 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.)

[64] VHA Handbook 1100.19.

[65] VHA Handbook 1100.19.

[66] 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).

[67] 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.)

- One solo or/few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months[68]
- Seven LIPs hired within 18 months before the site visit
- Twenty LIPs re-privileged within 12 months before the visit
- Ten providers who underwent a FPPE for cause within 12 months prior to the visit

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[69]
  - 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

[68] The 18-month period was from December 3, 2017, through June 3, 2019; The 12-month review period covered June 3, 2018, through June 3, 2019; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being fewer than three providers in the facility that are privileged in a particular specialty.

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

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

Medical Staff Privileging Conclusion

The OIG found general compliance with requirements for privileging. However, the OIG identified concerns with FPPE, OPPE, and FPPE for cause processes.

VHA requires that "the criteria for the FPPE process are to be defined in advance, using objective criteria accepted by the practitioner," and include a documented time frame; and the criteria should be shared with the provider before the evaluation.[70]

The OIG reviewed 17 practitioner profiles (7 FPPE and 10 FPPE for cause) and found that 13 lacked evidence that the criteria were defined in advance, and 14 did not have a clearly documented time frame or for those FPPE for cause were time-limited. In 8 of the 10 FPPE for cause profiles, there were no clear expectations and outcomes identified. This could potentially result in unclear and ill-defined expectations for the medical staff leaders performing the evaluation as well for the providers who are being evaluated. Failure to clearly set expectations, defined in advance, and set time frames can hinder the evaluation of the provider. The chiefs of primary care and mental health reported that FPPE information was communicated verbally to providers upon initial orientation, however, the communication was not documented. Additionally, the chief of staff reported that the service chiefs did not have training on the correct FPPE procedures or required documentation. The OIG noted that many providers had been placed on FPPE for cause without being notified. The facility had received a recommendation from TJC survey in June 2018 for not having a process for evaluating providers performance.

[70] VHA Handbook 1100.19. 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).

This resulted in the facility conducting a 100 percent retrospective review using newly developed triggers related to medical record documentation.

Recommendation 9

9. The chief of staff ensures that clinical managers clearly define the criteria, time frames, and expectations with providers in advance for focused professional practice evaluations and monitors the clinical managers' compliance.

Facility concurred.

Target date for completion: January 31, 2020

Facility response:

Current Providers: Each Service Line will complete a one-time procedure of notifying all of their Licensed Independent Practitioner (LIP) providers with the blank Focused Professional Practice Evaluation (FPPE) coversheets that list the criteria and triggers and the corresponding blank peer chart review forms before July 31, 2020. Each Service Line will track and receive verification from all LIP providers that they have received and accepted the criteria and triggers. The Chief of Staff, or designee, will complete a one-time 100% audit to ensure compliance.

New Providers: When new providers are brought on during their orientation/onboarding each Service Line will supply the provider with the Service and Occupation/position specific criteria and triggers for OPPE/FPPE. This will be done by supplying the provider a blank PPE coversheet which includes the criteria and triggers. A signature line will be added to the provider's orientation checklist to indicate that they have received the PPE coversheet, and understand and accept the criteria and triggers. Another line will be added explaining the timelines and timeframes for FPPEs. Service Lines are to keep this new provider checklist in the provider's profile. The Chief of Staff, or designee, will complete the 20% audit of new provider profiles for each Service Line, biannually.

For Cause FPPE: On all FPPEs the reviewed provider is required to sign or acknowledge receipt and acceptance of the FPPE results on the FPPE coversheet. The FPPE coversheet states the criteria, triggers, and has a box for supervisors to enter the FPPE timeframe. The Credentialing Office will complete a 20% audit quarterly of completed FPPE reviews. FPPE audits of 90% or better will be reported quarterly to the Executive Committee of the Medical Staff, which reports up to the Executive Committee of the Governing Board.

VHA requires the Executive Committee of the Medical Staff to review and evaluate LIPs' initial and re-privileging requests, and that "the minutes must reflect the documents reviewed and the rationale for the stated conclusion."[71] The OIG found all 28 practitioner profiles reviewed

[71] VHA Handbook 1100.19.

(including 7 FPPEs and 21 OPPEs) did not have evidence that the Executive Committee of the Medical Staff's decisions to recommend privileges were based on the results of an FPPE or OPPE. This resulted in providers delivering care without thorough evaluation of their professional practice. The credentialing coordinator reported a lack of awareness that a statement reflecting the decision to recommend privileges based on FPPE and OPPE results needed to be included in the minutes.

Recommendation 10

10. The chief of staff makes certain that the Executive Committee of the Medical Staff reviews and evaluates the focused and ongoing professional practice evaluation results and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Credentialing and Privileging Committee collects data on ensuring that Professional Practice Evaluation (PPE) results are reviewed and utilized to determine the continuation of current privileges. These data are reported and reviewed at the Executive Committee of the Medical Staff (ECMS) monthly meeting, with a goal of 90% compliance, or better, of PPE results reviewed.

To monitor compliance for PPE evaluation and utilization in the deciding privileging actions, the Chief of Staff, or designee, will audit the Executive Committee of the Medical Staff (ECMS) monthly meeting minutes for six consecutive months to ensure evaluation activity results are documented in the practitioner's profile, with a goal of 90% compliance (all meeting minutes reviewed and audited). Results of the analysis will be reported to ECMS for two consecutive quarters, which is reported to the Executive Committee of Governing Board.

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.[72]

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.[73]

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.[74]

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.[75] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[76]

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

[73] 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).

[74] 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.)

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

[76] 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,[77] and National Fire Protection Association standards.[78] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[79]

In all, the OIG team inspected 14 areas—physical therapy, prosthetics, audiology/speech, mental health outpatient, dental clinic, nephrology, podiatry, rheumatology, primary care, women's clinic, community living center, eye clinic, pain clinic, and mental health inpatient. The team also inspected the Fitchburg 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
  - 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

[77] 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.)

[78] 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.)

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

  - 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 parent facility met safety requirements associated with the above performance indicators. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG found damaged furniture in two locations at the facility. The OIG also identified concerns at the Fitchburg VA Clinic related to cleanliness and a tripping hazard that warranted a recommendation for improvement.

Specifically, TJC requires that areas used by patients are clean and that the facility takes action to minimize or eliminate identified safety risks in the environment.[80] OIG found damaged furniture in two locations at the facility.[81] In addition, at the Fitchburg VA Clinic, the lobby carpet was heavily stained and dirty, and an improperly installed computer wire was exposed and posed a tripping hazard. When patient care areas have carpet that is heavily soiled, it may contain bacteria and other organisms that can increase the risk for infections. The chief of Facilities Management reported that they have been attempting to work with the lessor to rectify the carpet issue but have not come to an agreeable solution. In addition, the lessor is responsible for appropriately installing the computer wire.

Recommendation 11

11. The associate director ensures that patients areas are clean and that action is taken to minimize or eliminate identified safety risks in the environment and monitors compliance.

[80] TJC Environment of Care standard EC.02.01.01; TJC Environment of Care standard EC.02.06.01.

[81] Prosthetics waiting room building 1 and community living center.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: Main Campus: The damaged furniture identified at the main campus has been removed as of June 5, 2019. By December 30, 2019, the Chief of Environmental Management Services, will develop a process and procedure for identifying, removing, and replacing damaged furniture throughout VA Medical Center Central Western Massachusetts Healthcare System (VAMC CWMHCS).

The Chief of Environmental Management Service will ensure that Environmental Management Service workers clean areas of the main campus. Environment of Care rounds inspect clinical areas within the facility bi-annually, all other areas are inspected annually. In addition to the facility Environment of Care rounds conducted, weekly inspection check sheets are being developed to ensure Environmental Management Service supervisors monitor for compliance and initiate corrective actions for deficiencies. Weekly checklists will be submitted to the Chief of Environmental Management Services for review. Compliance will be monitored by the Chief of Environmental Management Services for six consecutive months to ensure identified deficiencies are corrected at 90%.

The deficiencies identified are tracked until closed within fourteen days, or an action plan is initiated and tracked until closure if unable to correct deficiency within the time frame.

For six consecutive months, the Chief of Environmental Management Services will report compliance of cleanliness and safety risks at the monthly Environment of Care Committee, that reports to Administrative Executive Board, that reports to the Executive Committee of Governing Board.

Community Based Outpatient Clinic (CBOC): As of June 12, 2019, the Fitchburg CBOC lobby has been cleaned, and tripping hazard has been fixed.

The Fitchburg Community Based Outpatient Clinic (CBOC) is a lease space and is under contract for environmental care services for cleaning. Effective September 15, 2019, VAMC CWMHCS has assigned Clinic Administrators that are responsible for the day-to-day activities of the Central and Western CBOCs of VAMC CWMHCS.

By December 30, 2019, the Clinic Administrators, together with the CBOCs' lessors, will develop a process and procedure to ensure the CBOCs are cleaned regularly and safety risks are identified and corrected timely.

The Clinic Administrators will check the CBOCs monthly for cleanliness and safety risks, for an additional six consecutive months. Monthly monitoring and compliance will be reported to the Environment of Care Committee, that reports to Administrative Executive Board, that reports to the Executive Committee of Governing Board.

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.[82] 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.[83]

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.[84]

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;[85] 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[86]
- Requirements for controlled substances inspectors

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

[83] 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.

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

[85] The two quarters were from October 1, 2018 through March 30, 2019.

[86] 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[87]
  - Accountability for all prescription pads in pharmacy
  - Verification of hard copy controlled substances prescriptions
  - Verification of twice a week (three days apart) inventories of the main vault[88]
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[89]

[87] 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."

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

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

Medication Management Conclusion

The OIG found general compliance with requirements for some of the performance indicators evaluated, including the controlled substances coordinator reports, the controlled substances inspectors completing annual competency assessments, and pharmacy inspections. It was noted by the OIG that the staff responsible for conducting the monthly review of balance adjustments were also able to conduct balance adjustments. This was corrected while the OIG was onsite. However, the OIG identified deficiencies with controlled substances inspectors' terms of appointment, controlled substances non-pharmacy area inspections, and override reports reviewed by the facility warranting recommendations for improvement.

VHA requires that the director appoint an adequate number of controlled substances inspectors to a term not to exceed three years.[90] The OIG found that for 7 of 10 controlled substances inspectors reviewed, the inspectors' appointment letters included general timeframes (for example, "FY 2017–FY 2020"). This resulted in ambiguity due to the lack of specific appointment and end dates. Although the controlled substances coordinator also maintained a list of inspectors with appointment and end dates, the seven inspectors' appointment periods exceeded three years. The controlled substances coordinator was aware of the appointment term but had not been documenting the appointment on the letter.

Recommendation 12

12. The facility director ensures that controlled substances inspectors are appointed in writing with a term not to exceed three years and monitors compliance.

Facility concurred.

Target date for completion: June 1, 2020

Facility response: All Controlled Substance Inspectors appointment terms letters were revised to be date-specific (not month-specific as was prior practice), not to exceed three years and signed by the Medical Center Director.

Compliance rate from June 30, 2019 through December 1, 2019, has been 100% (11/11 compliant times two quarterly checks), with a sustainment goal of 100%. The Controlled Substance Coordinator will report quarterly to Quality, Safety, and Value Committee (formerly Performance Improvement Committee), that reports to the Executive Committee of Governing Board.

VHA requires that the controlled substances inspection program staff reconcile one random day's stocking/refilling from the pharmacy to every automated dispensing cabinet and one

[90] VHA Directive 1108.02(1).

random day's return of stock to pharmacy from every automated dispensing unit during controlled substances area inspections.[91] The OIG found that from October 1, 2018, to March 30, 2019, all six areas reviewed did not have evidence of reconciliation of one day's stocking/refilling from pharmacy or return of stock to pharmacy from each dispensing area. When the reconciliation process is not completed, it will impact the facility's ability to identify discrepancies and potential drug diversion activities. The controlled substances coordinator disclosed this deficiency in the previous quarterly trend report dated April 10, 2019, and recommended corrective plans of action; however, these action plans had yet to be implemented at the time of the OIG team's visit.

Recommendation 13

13. The facility director ensures that monthly reconciliation of one day's dispensing from pharmacy to every automated dispensing cabinet and one day's return of stock to pharmacy from every automated dispensing cabinet is performed during controlled substances inspections and monitors compliance.

Facility concurred.

Target date for completion: June 1, 2020

Facility response: The Controlled Substance Coordinator (CSC) has added the following checks to the Control Substance Inspector's (CSI) monthly inspection worksheet; all CSIs were provided education on this new process on June 6, 2019:

-Monthly reconciliation of one randomly selected day's worth of dispensing from pharmacy to every automated dispensing cabinet (Omnicell).

-Monthly reconciliation of one randomly selected day's worth of return stock from every Omnicell to pharmacy.

The Controlled Substance Coordinator (CSC) will monitor CSI activity monthly for 90% compliance and report to the Quality, Safety, and Value Committee (formerly Performance Improvement Committee), that reports to Executive Committee of Governing Board. The goal is to maintain compliance for 6 consecutive months (December 2019 through May 2020) to ensure sustainment.

VHA requires that during non-pharmacy area inspections, controlled substances inspectors verify evidence of a written or electronic controlled substances order for a prescribed number of randomly selected patients.[92] The OIG found that in six areas reviewed, the facility was not able to provide evidence of verification of controlled substances orders (electronic or written) for five

[91] VHA Directive 1108.02(1).

[92] VHA Directive 1108.02(1).

randomly selected dispensing activities. When controlled substances orders are not verified, this may result in the inability to confirm that medications were administered to the patient as ordered. In addition, there may be missed opportunities to identify potential drug diversion activities. The controlled substances coordinator stated that the controlled substances inspectors were instructed by a prior controlled substances coordinator that a total of five verifications of controlled substance orders were required for the entire facility. The current controlled substances coordinator stated that the inspectors were subsequently given clarification about the required five randomly selected dispensing activities for each area. Additionally, the controlled substances coordinator stated that this deficiency was self-identified and new forms were developed to include verification in all non-pharmacy areas; full implementation of this corrected process was pending at the time of the OIG visit.

Recommendation 14

14. The facility director ensures that controlled substances inspectors verify there is evidence of a written or electronic controlled substances order for five randomly selected dispensing activities during monthly inspections and monitors compliance.

Facility concurred.

Target date for completion: January 31, 2020

Facility response: The Controlled Substance Coordinator (CSC) provided education to the Controlled Substance Inspectors (CSI) on June 6, 2019, ensuring that, going forward, the CSIs verify controlled substance orders after picking from the Omnicell Transaction by date dispensing activity - five (5) random patients from each Omnicell location.

The Controlled Substance Coordinator (CSC) will monitor CSI activity monthly for 100% compliance and report to the Quality, Safety, and Value Committee (formerly Performance Improvement Committee), that reports to Executive Committee of Governing Board. The goal is to maintain compliance for 6 consecutive months (July 2019 through December 2019) to ensure sustainment.

TJC requires that "the hospital evaluates the effectiveness of its medication management system." TJC also requires that when automatic dispensing cabinets are used, the hospital has a policy describing the types of medication overrides that will be reviewed for appropriateness and the frequency of reviews.[93] The OIG team found that the pharmacy staff lacked a process for reviewing medication overrides. This resulted in missed opportunities to identify potential drug diversion activities and any discrepancies related to controlled substances. The chief of Pharmacy stated that reviews of overrides are only completed when triggered by a discrepancy

[93] TJC. Medication Management standard MM.08.01.01.

and reported that no routine override report reviews were conducted. The controlled substances coordinator and the chief of Pharmacy stated that they felt the periodic review met the intent of the requirement.

Recommendation 15

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

Facility concurred.

Target date for completion: June 1, 2020

Facility response: The Chief of Pharmacy will develop and implement a local policy governing override authorizations and procedures for automated dispensing equipment (Omnicell) by December 31, 2019 and will ensure all appropriate staff are trained on this new policy by January 31, 2020.

The Chief of Pharmacy will report completion of training, and implementation of the policy, to the next scheduled Quality, Safety, and Value (QSV) Committee (formerly Performance Improvement Committee) meeting following January 31, 2020. Thereafter, the Chief of Pharmacy, or representative designated by the Chief of Staff, will brief Omnicell override report reviews to QSV on a quarterly basis. The goal is 100% monthly review of Omnicell override reports.

Going forward, the policy will be updated in accordance with VHA guidance governing local policies.

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."[94] 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.[95]

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.[96] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[97]

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.[98] Those who screen positive must have access to appropriate MST-related care.[99] 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.[100]

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

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

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

[96] VHA Directive 1115.

[97] 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.)

[98] 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."

[99] VHA Directive 1115.

[100] VHA Handbook 1160.01.

[101] 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.[102]

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 45 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

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

Mental Health Conclusion

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

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 within 90 days.[103] The OIG determined that 2 of 7 providers hired before July 1, 2012, did not complete the

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

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

required MST mandatory MST training. The OIG also found that 9 of 13 providers hired after July 1, 2012, did not complete the mandatory MST training within 90 days, and three providers had no evidence of completing any MST-related training. Untimely or lack of training could potentially prevent clinicians from providing a consistent level of counseling, care, and services to veterans who experienced MST. The chief of mental health reported that due to a human error with assignment of training, the providers at Fitchburg and Worcester VA clinics did not complete the required MST training.

Recommendation 16

16. The chief of staff confirms 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: April 30, 2020

Facility response: The VA Central Western Massachusetts Healthcare System provides and monitors Military Sexual Trauma (MST). Upon hire, employees are assigned a job code by Human Resources. The assignment of MST training auto-populates based on the employee's job code; which appears on the employee's "To-Do" list in TMS. Training is assigned to employees upon hire. It was identified that employees did not complete MST training prior to the 90 days post hire. Required MST training reminders are sent by Talent Management Systems (TMS) with notification to the employee and supervisor, until completion.

Pursuant to VHA Directive 1115.01, Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers, April 14, 2017, the VA Central Western Massachusetts Healthcare System conducted an audit of employees who required MST training within 90 days upon hire, from May 2017 to November 2019, with 93% compliance rate.

The Education Department's TMS Domain Manager will generate a monthly TMS MST training report that will be submitted to the MST Coordinator for compliance review. Monitoring will be reevaluated monthly, for six consecutive months, to ensure compliance of 90% or greater; and will be reported to Quality, Safety, and Value Committee (formerly Performance Improvement Committee), that reports to the Executive Committee of Governing Board.

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."[104] 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.[105]

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."[106]

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.[107] 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."[108] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[109] 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.[110] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[104] 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.)

[105] *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.)

[106] 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.)

[107] 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.)

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

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

[110] 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.[111]

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 37 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.[112] The OIG evaluated the following performance indicators:

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

Geriatric Care Conclusion

The OIG team found that clinicians generally documented reasons for prescribing antidepressant medications. However, the OIG team identified deficiencies with patient and/or caregiver education specific to the newly prescribed medications, evaluation of patient and/or caregiver understanding when education was provided, and reconciliation of patients' medications that warranted recommendations for improvement.

TJC requires that clinicians educate patients and families about safe and effective use of medications and evaluate patient/caregiver understanding of the education provided.[113] Based on electronic health records reviewed, the OIG estimated that clinicians provided this education to 62 percent of the patients at the facility.[114] In addition, the OIG estimated that clinicians assessed understanding of the education provided in 61 percent of the records reviewed.[115] Providing medication education and ensuring it is understood is important for patients to be able to manage their own health at home.[116] The director of the CLC reported that these are general elements of

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

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

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

[114] The OIG estimated that 95 percent of the time, the true compliance rate was somewhere between 46.0 and 77.5 percent, which is statistically significantly below the 90 percent benchmark.

[115] The OIG estimated that 95 percent of the time, the true compliance rate was between 40.1 and 80.9 percent, which is statistically significantly below the 90 percent benchmark.

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

patient care which are implied. The chief of Primary Care stated that excessive time constraints and cumbersome report templates were additional reasons for noncompliance.

Recommendation 17

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

Facility concurred.

Target date for completion: June 30, 2020

Facility response: Education will be provided to clinicians at VA Medical Center Central Western Massachusetts (VAMC CWM) by the Chief of Staff (COS), or designee, regarding the importance of risks inherent in antidepressant use among the elderly; patient and/or caregiver education regarding safe and effective use; and documenting the education provided about the potential interactions and side effects of newly prescribed medications, and patient and/or caregiver understanding of the education provided, at the Medical Staff Meeting scheduled on January 15, 2020. Any provider/prescriber absent from the meeting will be re-educated by their supervisor within two weeks of the staff meeting or of their return to work, whichever comes first.

Effective February 1, 2020, to confirm documentation of patient and/or caregiver education regarding potential interactions and side effects of newly prescribed high-risk medications, and documentation of patient and/or caregiver understanding of this education, the Chief of Staff, or designee, will randomly review 30 charts of patients over 65 years of age, who were newly prescribed any of these high-risk medications (or 100% if less than 30 of these medications were started), until a threshold of 90% compliance, or better, with both education documentation and documentation of understanding of the education by the patient and/or caregiver (# of charts reviewed with patient and/or caregiver education and documentation of understanding of the education / # of charts reviewed, monthly), is reached for six consecutive months. Monitoring of this recommendation will be reported monthly to the Executive Committee of the Medical Staff (ECMS), which reports to the Executive Committee of Governing Board.

According to TJC, medication reconciliation "is a process of comparing the medications a patient is taking (and should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications."[117] The OIG team estimated that providers performed medication reconciliation for 43 percent of the

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

patients at the facility, based on electronic health records reviewed.[118] Failure to reconcile and document accurate patient medication information increases the risk of "duplications, omissions, and interactions" in the patient's actual drug regimen.[119] The chiefs of primary care, mental health, and pharmacy reported the absence of a clear process for proper documentation within the progress note and cumbersome report templates that prevent easy modification of medications as reasons for noncompliance.

Recommendation 18

18. The chief of staff ensures clinicians complete and document medication reconciliation as required and monitors the clinicians' compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Chief of Staff (COS), or designee, will afford re-education of prescribers, across VA Medical Center Central Western Massachusetts Health Care System, on the importance of complying with Medical Center Memorandum 119-44, Medication Reconciliation and Essential Medication Information Standards, with a target training completion date of December 30, 2019.

Effective January 15, 2020, to assess the degree to which medication reconciliation is being performed, the Chief of Staff, or designee, will perform a random, monthly, medication reconciliation review of 30 charts of patients over 65 years of age who were newly prescribed any of these high-risk medication (or 100% if less than 30 of these medications were started), until a threshold of 90% compliance, or better, is achieved for six consecutive months. Monitoring will be reported monthly, until demonstrated as fully compliant, to the Executive Committee of the Medical Staff (ECMS), which reports to the Executive Committee of Governing Board.

[118] The OIG estimated that 95 percent of the time, the true compliance rate was somewhere between 27.7 and 59.6 percent, which is statistically significantly below the 90 percent benchmark.

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

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

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.[120] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[121] In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus infection, use of oral contraceptives for five or more years, and having given birth to three or more children.[122] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[123]

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.[124]

VHA requires that each facility have a "full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health care." VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women's health program. Each facility must also have a "Women Veterans Health Committee (WVHC) comprised of appropriate facility leadership and program directors, which develops and implements a Women's Health Program strategic plan." The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.[125]

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

[120] 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.)

[121] 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.)

[122] 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.)

[123] 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.)

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

[125] 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.[126]

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

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

Women's Health Conclusion

Generally, the OIG found compliance with some of the performance indicators, including requirements for a designated women veterans program manager, clinical champion, and follow-up care when indicated. The OIG noted concerns with the Women Veterans Health Committee membership, tracking of cervical cancer data, and communicating abnormal results to patients that warranted recommendations for improvement.

Specifically, VHA requires that the core membership of the Women Veterans Health Committee include a women veterans program manager; a women's health medical director; "representatives from primary care, mental health, medical and/or surgical subspecialties,

[126] VHA Directive 1330.01(2).

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."[127] The Women Veterans Health Committee must also meet at least quarterly to discuss issues associated with the women's health program and provide a "report to leadership with signed minutes at the Clinical Executive Board level."[128]

From October 2018 through April 2019, the Women Veterans Health Committee did not meet. The OIG's review of the Executive Committee of the Medical Staff for the past 12 months also showed no reporting from the Women Veterans Health Committee. This limited the facility's ability to identify issues affecting women's health care. The women's health medical director stated the previous women veterans program manager was detailed to another position in September 2018 and was unable to coordinate and facilitate the Women Veterans Health Committee meetings.

Recommendation 19

19. The facility director confirms that the Women Veterans Health Committee meets at least quarterly, includes required core members, and reports to the appropriate executive committee and monitors the committee's compliance.

Facility concurred.

Target date for completion: September 30, 2020

Facility response: The Women Veterans' Health Committee, at a minimum, meets quarterly, every fiscal year. Committee core members are expected to attend, at a minimum, 3 meetings out of 4 scheduled meetings, annually (75% annual attendance). If core members miss two meetings in a 6-month period, the Women Veterans Program Manager (WVPM) will send an email to the member and their supervisor, asking them to re-commit to the meeting or to have an alternate representative.

The Women Veterans' Health Committee quarterly meeting minutes, including attendance lists, will serve as record of monitoring and compliance. Deficiencies in attendance will be addressed at the Executive Committee of the Medical Staff (ECMS), which reports to the Executive Committee of Governing Board.

VHA requires each facility to implement a process to ensure tracking of cervical cancer data, including notification of patients who are due for screening, tracking of completion of screening, results reporting, and follow-up care.[129] The OIG found that cervical cancer data was not being tracked by the facility staff. When data are not tracked and monitored, patients may not receive

[127] VHA Directive 1330.01(2).
[128] VHA Directive 1330.01(2).
[129] VHA Directive 1330.01(2).

timely health screenings, results notification, and/or follow-up care. The women's health medical director stated that, although a process was implemented in April 2019 to delegate the tracking of cervical cancer data to the patient-aligned care teams, the data was not tracked and there was no monitoring or oversight to ensure compliance.

Recommendation 20

20. The chief of staff ensures tracking and monitoring of cervical cancer data and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: As of September 2019, a spreadsheet tracking system that captures required data, such as patients due for screening, screening completion date, pathology results and reporting, and follow-up care, was developed for use by all Primary Care Aligned Teams (PACT). Training of all PACTs, on the utilization of this tracking system, will have a target completion date of December 30, 2019.

Effective January 1, 2020, the Nurse Managers will monitor each PACT's compliance on capturing the required data into the tracking system, with a minimum of 10 Women Veterans' healthcare data per week. The PACTs are expected to capture 100% of all Women Veterans enrolled in Primary Care and served at VA Medical Center Central Western Massachusetts, until 100% completion.

The Women Veterans Program Manager (WVPM) will ensure PACT's compliance on the utilization of the tracking system and the required data capture, by randomly reviewing 30 charts, on a monthly basis, from the PACT's data capture. Monitoring and compliance will be reevaluated for six consecutive months, from January 2020 to June 2020, until compliance of 90% or greater is achieved; which will be reported to the Women Veterans Health Committee (WVHC), which reports to Executive Committee of the Medical Staff (ECMS), which reports to the Executive Committee of Governing Board.

In addition, VHA requires that ordering providers, or a designee, notify patients of abnormal results within seven calendar days of results becoming available.[130] The OIG determined that providers communicated abnormal results in a timely manner to patients in 70 percent of the electronic health records reviewed.[131] When test results are not communicated in a timely manner, there are potential adverse outcomes related to delays in receiving appropriate follow-up

[130] VHA Directive 1330.01(2).

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

care. The women's health medical director and the primary care nurse manager were unable to identify a reason for noncompliance.

Recommendation 21

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

Facility concurred.

Target date for completion: June 30, 2020

Facility response: Women's Health providers will be re-educated regarding abnormal cervical pathology notification requirements during the Primary Care Providers' Meeting scheduled on December 11, 2019. To capture 100% of the women's health providers, those who are not in attendance during the meeting will be sent the meeting minutes. The Women's Health Medical Director (WHMD) will follow-up with these providers with an email that will have a voting button of "Yes" or "No", to capture re-education. The re-education of 100% of women's health providers will have a target completion date of December 30, 2019.

An abnormal cervical pathology tracking system (Excel spreadsheet), was created by the Women's Health Medical Director (WHMD). Effective January 1, 2020, upon completion of the re-education of women's health providers, the abnormal cervical pathology tracking system will be implemented. Each Primary Care Aligned Team (PACT), along with their Nurse Managers, will monitor their own tracking system, which includes notification of abnormal cervical pathology 7 business days from receipt of test results (as per VHA Directive 1330.01(2), Health Care Services for Women Veterans). On a monthly basis, the Women's Health Medical Director (WHMD) will monitor for compliance of the tracking system which will be reported to the Women Veterans Health Committee (WVHC), which reports to Executive Committee of the Medical Staff (ECMS), which reports to the Executive Committee of Governing Board.

Monitoring will be reevaluated monthly (# of abnormal test results notified within required timeframe / # of abnormal test results), for six consecutive months, to ensure compliance of 90% or greater, with a target completion date of June 30, 2020.

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

The facility complied with few of the performance indicators used by the OIG team to assess the operations and management of the UCC. The OIG found concerns with operating the UCC 24 hours per day, seven days a week, without a waiver and a lack of a minimum of two registered nurses on duty during all hours of operation, a provider backup call schedule, support services during all hours of operation, availability of social work services, development and implementation of patient flow measures, proper UCC signage, availability of a mental health

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

intervention room, and availability of pediatric resuscitation and obstetric equipment that warranted recommendations for improvement.

Specifically, VHA requires that VA medical facilities operating a UCC 24 hours a day, seven days a week, must request and receive approval for a waiver from the national director of Emergency Medicine "to ensure safe patient care with proper staffing and support."[142] The OIG found that the UCC operated 24 hours a day, seven days a week, but had not obtained the necessary approved waiver. This resulted in a lack of assurance that the facility provides urgent care with proper staffing and support services.

The OIG was provided a copy of an Executive Summary from a consultative visit by VA Central Office staff on May 8–10, 2018, for evaluation of a waiver request. The request was a waiver from the requirement to have a provider continuously present in the UCC during weekends, holidays, evenings, and nights and to close medical care and only offer mental health services during those hours. The waiver request was not approved by the VHA National Emergency Medicine Program Director and the Assistant Deputy for Clinical Operations Management. The consultative team did provide recommendations.

The chief of staff (also the director of the UCC) provided the OIG with an unsigned document titled "Restructuring Proposal for UCC," dated September 12, 2018, which detailed a plan to close the UCC by March 2019 through a phased reduction in the hours of operation while having patients treated in primary care.

Recommendation 22

22. The facility director makes certain that the facility has an approved waiver from the national director of Emergency Medicine if the urgent care center continues to operate 24 hours a day, seven days a week.

Facility concurred.

Target date for completion: February 10, 2020

Facility response: VA Central Western MA Healthcare System (VA CWM HCS) is no longer seeking a waiver for Urgent Care Center operations. VA CWM HCS has approval from VACO to close Urgent Care.

VHA requires that VA UCCs have appropriately educated and qualified emergency care professionals physically present in the UCC during all hours of operation. This includes a licensed physician and a minimum of two registered nurses.[143] The OIG found that the UCC was staffed by at least one licensed physician, who was also assigned as the Medical Officer of the

[142] VHA Directive 1101.05(2).

[143] VHA Directive 1101.05(2).

Day; however, there was only one registered nurse assigned seven days a week between 11 p.m. to 7 a.m. This violates VHA policy and could cause potential delay in emergent care and lead to negative patient outcomes. The chief of staff reported difficulty recruiting night shift nursing staff and challenges with maintaining fiscal stewardship as the reasons for noncompliance.

Recommendation 23

23. The facility director ensures that the urgent care center is staffed with at least two registered nurses physically present during all hours of operation and monitors compliance.

Facility concurred.

Target date for completion: February 10, 2020

Facility response: VA Central Western Massachusetts Healthcare System (VA CWM HCS) has approval from VACO to close Urgent Care. This issue will be resolved by February 10, 2020, when Urgent Care operations stop. In the interim, additional nursing staff will be sought out to provide the minimum of two nurses.

Monitoring of compliance will begin in March 2020 and will be reported by a compliance rate (percentage of shifts staffed with two nurses) to the Executive Committee of the Medical Staff (ECMS), which reports up to the Executive Committee of the Governing Board. Compliance will be monitored and reported until final closure of the Urgent Care Clinic, or six consecutive months of full compliance (90% or better), whichever comes first.

Adequate staffing during all hours of operation requires an effective backup call process. VHA requires that UCCs have a written staffing contingency plan, including a backup call schedule to address situations when additional providers are needed.[144] The OIG found that from 7:00 a.m. to 4:30 p.m., Monday through Friday, there was no backup call schedule, which could potentially impact the facility's ability to provide uninterrupted and timely patient care. The chief of staff stated an informal process is used during regular business hours and thought that met the intent of the directive.

Recommendation 24

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

[144] VHA Directive 1101.05(2).

Facility concurred.

Target date for completion: February 10, 2020

Facility response: The Chief of Staff implemented a backup schedule for urgent care providers on 11/27/2019. Providers on the backup schedule were educated about the backup schedule and their responsibilities on that date. The UCC Nurse Manager and Administrative Officer will monitor weekly whether any of the primary Urgent Care providers were on leave, and if a backup provider filled in as required. Weekly compliance will continue for six months of consecutive compliance greater than 90% or the closure of the UCC. VA CWM HCS has been granted permission to close the UCC and will do so in February 2020. Data will be reported monthly to the Executive Committee of the Medical Staff by the Urgent Care Administrative Officer, which then reports up to the Executive Committee of the Governing Board.

In addition, VHA requires that necessary resources, including "sufficient support services," are available within the UCC to ensure timely access to care for patients.[145] VHA also requires that the UCC maintain a list of on-call consultative services for social work, mental health, and specialty physician staff, who are required to respond to assist with patient care.[146]

The OIG found that the UCC does not have laboratory or radiology services available or on call during all hours of operation. The lack of coverage in the UCC may impact the facility's ability to provide uninterrupted and timely patient care. The chief of staff stated that a memorandum of understanding is in place with the local hospital for completion of labs or diagnostic services and patient admission, if required.

The OIG team found that the facility also lacked social work service or on-call availability after hours, weekends, or holidays during hours of UCC operations. The lack of available social work staff could potentially delay the determination of urgent and non-urgent patient care and/or disposition. The chief of staff stated that there was a memorandum of understanding in place to assist with social work and placement needs during weekend, holiday, evening, and night shifts and believed that met the intent of the requirement.

Recommendation 25

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

[145] VHA Directive 1101.05(2).

[146] VHA Directive 1101.05(2).

Facility concurred.

Target date for completion: February 10, 2020

Facility response: VA Central Western MA HCS has approval from VACO to close Urgent Care. The requirement to have support services will not apply when Urgent Care stops operations. In the interim, hospital policy is to send any Veteran to the local community hospital if his/her diagnosis and treatment may be changed by laboratory results or radiology studies that are not currently available at VA CWM at that time. VA CWM uses a voucher program to fill prescriptions at a non-VA pharmacy in the instance that a Veteran needs a prescription after Pharmacy hours of operation.

10% of all UCC visits will be audited to ensure that support services are obtained when needed (at VA CWM or through a local community hospital). Monthly compliance will continue for six months of consecutive compliance greater than 90% or the closure of the UCC. VA CWM HCS has been granted permission to close the UCC and will do so in February 2020. Data will be reported monthly to the Executive Committee of the Medical Staff by the Urgent Care Administrative Officer, which then reports up to the Executive Committee of the Governing Board.

Recommendation 26

26. The facility director makes certain that social work services are available to the urgent care center during all hours of operation, and monitors compliance.

Facility concurred.

Target date for completion: February 10, 2020

Facility response: VA Central Western MA HCS has approval from VACO to close Urgent Care. The closure will take place on February 10, 2020. Due to the need for hiring additional staff and/or union notification and bargaining before a call schedule can be implemented, this action will meet compliance starting February 1, 2020. The requirement for social work service will not apply when the Urgent Care Center stops operations.

Monitoring of compliance will begin in March 2020 and will be reported by a compliance rate (percentage of shifts staffed with Social Work Services) to the Executive Committee of the Medical Staff (ECMS), which reports up to the Executive Committee of the Governing Board. Compliance will be monitored and reported until final closure of the Urgent Care Clinic, or six consecutive months of full compliance (90% or better), whichever comes first.

VHA requires that facilities monitor organizational performance improvement, including evaluation of patient flow throughout the organization.[147] Furthermore, TJC specifies hospital measures and sets goals for the components of the patient flow process.[148] The OIG found that the facility had two UCC patient flow metrics that were underperforming (door to diagnostic evaluation by a qualified medical provider and patients who leave without being seen by a provider). The facility, however, did not have established plans for improvement. When a facility fails to have an action plan for poorly performing UCC metrics, the opportunity to address delays in timely and appropriate disposition is missed. Although facilities must adhere to requirements for UCCs until a transitional plan is approved, the chief of staff stated the facility had not developed action plans for improvement and cited awaiting approval of a transitional plan to close the UCC from the VHA Emergency Medicine National Office.

Recommendation 27

27. The facility director ensures that action plans are developed and implemented for underperforming patient flow metrics in the urgent care center and monitors compliance.

Facility concurred.

Target date for completion: February 10, 2020

Facility response: The Chief of Urgent Care will educate providers on the required use of EDIS to improve metrics the week of December 1, 2019. The EDIS measures will be followed weekly by the nurse manager of Urgent Care. Providers who need to improve will receive continued education. This weekly monitoring will continue until VA Central Western Massachusetts HCS reaches the 50th % for patient flow metrics. Results will be reported monthly to the Executive Committee of the Medical Staff, which reports up to the Executive Committee of the Governing Board.

Furthermore, VHA requires that facilities have appropriate signage at all entrances directing patients to the UCC.[149] The OIG inspection team found that the UCC lacked directional signage at the road frontage, on campus outside of the UCC, at the main facility entrance, and inside the building. Patients may encounter delays when seeking urgent or emergent care if directional signage is inadequate. The chief of staff attributed noncompliance to ongoing construction projects because the previous signs were removed the month prior to accommodate the work.

[147] VHA Directive 1101.05 (2).
[148] TJC. Leadership standard LD.04.03.11.
[149] VHA Directive 1101.05(2).

The chief of staff also reported that the facility had a project to evaluate signage throughout the facility.

Recommendation 28

28. The facility director makes certain that appropriate signage is in place to direct patients to the urgent care center and monitors compliance.[150]

Facility concurred.

Target date for completion: N/A

Facility response: The Urgent Care Center back entrance was under construction at time of the OIG CHIP survey. Temporary signs were in place at all alternate entrances to the Main Building at the Leeds Campus, as well as in the corridors of the Main Building. Effective September 27, 2019, the rear entrance to the Main Building has reopened. The temporary signs have been removed and the signs that have been in place clearly direct patients to the Urgent Care Center.

VHA also requires that UCCs have at least one psychiatric intervention room where "seriously disturbed, agitated, or intoxicated patients may be taken immediately upon arrival."[151] The OIG found that the UCC did not have a psychiatric intervention room. The lack of a psychiatric intervention room may limit appropriate environmental requirements necessary for emergency psychiatric care. The chief of staff reported the availability of one-to-one observations for patients requiring psychiatric intervention and that a team was available for an around-the-clock response. Additionally, the nurse manager and UCC director reported the age of the building was a factor in the noncompliance, however, future renovation plans include a psychiatric intervention room.

Recommendation 29

29. The facility director ensures that at least one room is identified as the psychiatric intervention room in the urgent care center and monitors compliance.

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

[151] VHA Directive 1101.05(2).

Facility concurred.

Target date for completion: February 10, 2020

Facility response: Current practice is for all Veterans who come to Urgent Care for mental health evaluation to have 1:1 observation in the Mental Health Observation Room. Veterans who are admitted to the Acute Mental Health Unit are expedited in Urgent Care to get them to the locked, acute unit quickly. This practice is to mitigate risk associated with not having a room within the Urgent Care Center that can be used as a psychiatric intervention room. VA Central Western Massachusetts HCS will not be able to make a major modification to address this change before Urgent Care stops operations. VA Central Western Massachusetts HCS has approval from VACO to close Urgent Care. The requirement for a psychiatric intervention room will not apply when the Urgent Care Center stops operations. Expected date of closure of Urgent Care Clinic is February 2020.

Lastly, VHA requires that "equipment and supplies necessary to care for patients expected to be seen in the ED [emergency department]/UCC must be readily available in the facility at all times."[152] This requirement includes pediatric/neonatal resuscitation equipment, and all medical staff must have proper training in its use.[153] The OIG found that the UCC lacked pediatric/neonatal basic life support equipment and an obstetric delivery kit. This may result in a lack of timely and appropriate treatment for patients presenting for care. The UCC director stated the facility provides only basic life support and calls 911 for higher level care.

Recommendation 30

30. The facility director ensures that equipment and supplies necessary to care for patients are readily available at all times in the urgent care center and monitors compliance.

Facility non-concurred.

Target date for completion: N/A

Facility response: VA Central Western Massachusetts HCS is a Level 3 Medical Center, that provides excellent care at this level. As a basic life support facility, the facility has the supplies necessary to care for patients at that level. VHA Directive 1101.5 (2) Emergency Medicine has a list of recommended supplies. We feel that we have the appropriate supplies on hand to maintain our high level of quality care that we provide in our Urgent Care Center. The OIG specifically cited pediatric resuscitation supplies. The facility currently has pediatric AED pads stocked with every AED, and pediatric bag valve masks in our Urgent Care Center.

[152] VHA Directive 1101.05(2).

[153] VHA Directive 1101.05(2).

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• 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	Thirty 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, chief of staff, and the associate director. 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	• Peer reviewers consistently use at least one of the aspects of care when conducting peer reviews. • Managers consistently implement and document completion of improvement actions recommended by the Peer Review Committee. • The patient safety manager or designee completes the required number of root cause analyses annually, including the required content.	• Peer review data is reported quarterly to the Executive Committee of the Medical Staff. • UM staff complete and document acute inpatient and observations stay reviews. • Physician UM advisors consistently document their decisions in the National Utilization Management Integration database. • Required representatives consistently participate in interdisciplinary reviews of utilization management data. • The patient safety manager or designee provides an annual patient safety report to facility leaders.
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• Clinical managers clearly define the criteria, time frames, and expectations with providers in advance for FPPEs. • Executive Committee of the Medical Staff reviews and evaluates FPPE and OPPE results	• 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
		• None	• Patients areas are clean and actions are taken to minimize identified safety risks in the environment.

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 are appointed in writing with a term not to exceed three years. • Monthly reconciliation of one day's dispensing from pharmacy to every automated dispensing cabinet and one day's return of stock to pharmacy from every automated dispensing cabinet is performed during controlled substances inspections. • Controlled substances inspectors verify that there is evidence of a written or electronic controlled substances order for five randomly selected dispensing activities during monthly inspections. • Development and implementation of a policy for automated dispensing cabinet medication overrides and reviews of these reports.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers	• Providers complete mandatory MST training within the required time frame.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Geriatric Care: Antidepressant Use among the Elderly	• Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation	• Clinicians provide and document patient and/or caregiver education about the safe and effective use of newly prescribed medications and evaluate understanding when education is provided. • Clinicians complete and document medication reconciliation as required.	• None
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data • Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated	• Ordering providers communicate abnormal results to patients within the required time frame.	• The Women Veterans Health Committee meets at least quarterly, includes required core members, and reports to the appropriate executive committee. • Cervical cancer screening data is tracked and monitored.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Operations and Management of Emergency Departments and UCCs	• General • Staffing for emergency department/UCC • Support services for emergency department/UCC • Patient flow • General safety • Medication security and labeling • Management of patients with mental health disorders • Emergency department participation in local/regional EMS system • Women veteran services • Life support equipment	• The UCC is staffed with at least two registered nurses physically present during all hours of operation. • A backup call schedule is maintained for UCC providers. • Support services necessary to care for patients are readily available to the UCC during all hours of operation. • Social work services are available to the UCC during all hours of operation. • Equipment and supplies necessary to care for patients are readily available at all times in the UCC.	• Facility has an approved waiver from the national director of Emergency Medicine if the UCC continues to operate 24 hours a day, seven days a week. • Action plans are developed and implemented for underperforming patient flow metrics in the UCC. • Appropriate signage is in place to direct patients to the UCC. • At least one room is identified as the psychiatric intervention room in the UCC.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) affiliated[154] facility reporting to VISN 1.[155]

Table B.1. Facility Profile for the VA Central Western Massachusetts Healthcare System (631) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[156]	Facility Data FY 2017[157]	Facility Data FY 2018[158]
Total medical care budget in dollars	$187,007,649	$203,919,352	$226,396,218
Number of:			
• Unique patients	25,887	27,187	27,997
• Outpatient visits	351,649	366,657	386,091
• Unique employees[159]	738	782	795
Type and number of operating beds:			
• Community living center	32	32	32
• Mental Health	81	81	81
• Residential psychosocial program	16	16	16
Average daily census:			
• Community living center	25	21	24
• Mental health	51	47	51
• Residential psychosocial program	15	13	12

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

[154] Associated with a medical residency program.

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

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

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

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

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

VA Outpatient Clinic Profiles[160]

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)[161]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[162] Provided	Diagnostic Services[163] Provided	Ancillary Services[164] Provided
Springfield, MA	631BY	16,086	12,203	Cardiology Dermatology Endocrinology Gastroenterology Infectious disease Neurology General surgery Podiatry	EKG Laboratory & Pathology	Nutrition

[160] Includes all outpatient clinics in the community that were in operation as of February 8, 2019. The OIG omitted *(631QA) Northampton, MA (Plantation Street),* as no workload/encounters or services were reported.

[161] 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."

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

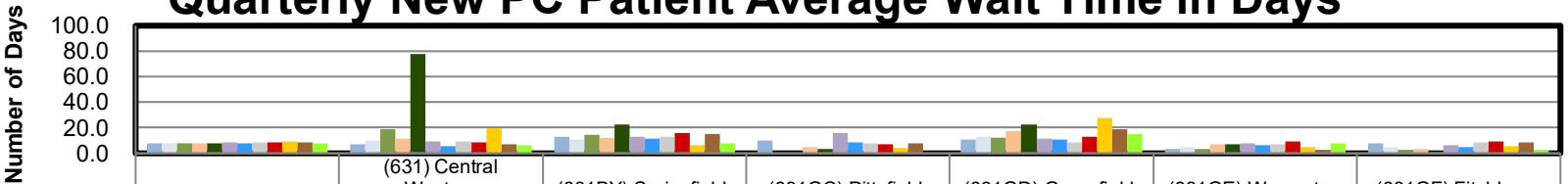
[163] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

[164] 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[162] Provided	Diagnostic Services[163] Provided	Ancillary Services[164] Provided
Pittsfield, MA	631GC	3,467	2,403	Dermatology Endocrinology Neurology	EKG	Nutrition
Greenfield, MA	631GD	4,412	3,385	Dermatology Endocrinology Neurology General surgery	EKG	Nutrition
Worcester, MA	631GE	14,668	1,040	Dermatology Endocrinology Gastroenterology Infectious disease Neurology Rheumatology Anesthesia Podiatry	EKG Laboratory & Pathology Radiology	Nutrition
Fitchburg, MA	631GF	5,335	3,233	Dermatology Endocrinology Neurology	EKG	Nutrition
Worcester, MA	631QB	50	7,829	Cardiology Dermatology Endocrinology Neurology Rheumatology	n/a	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

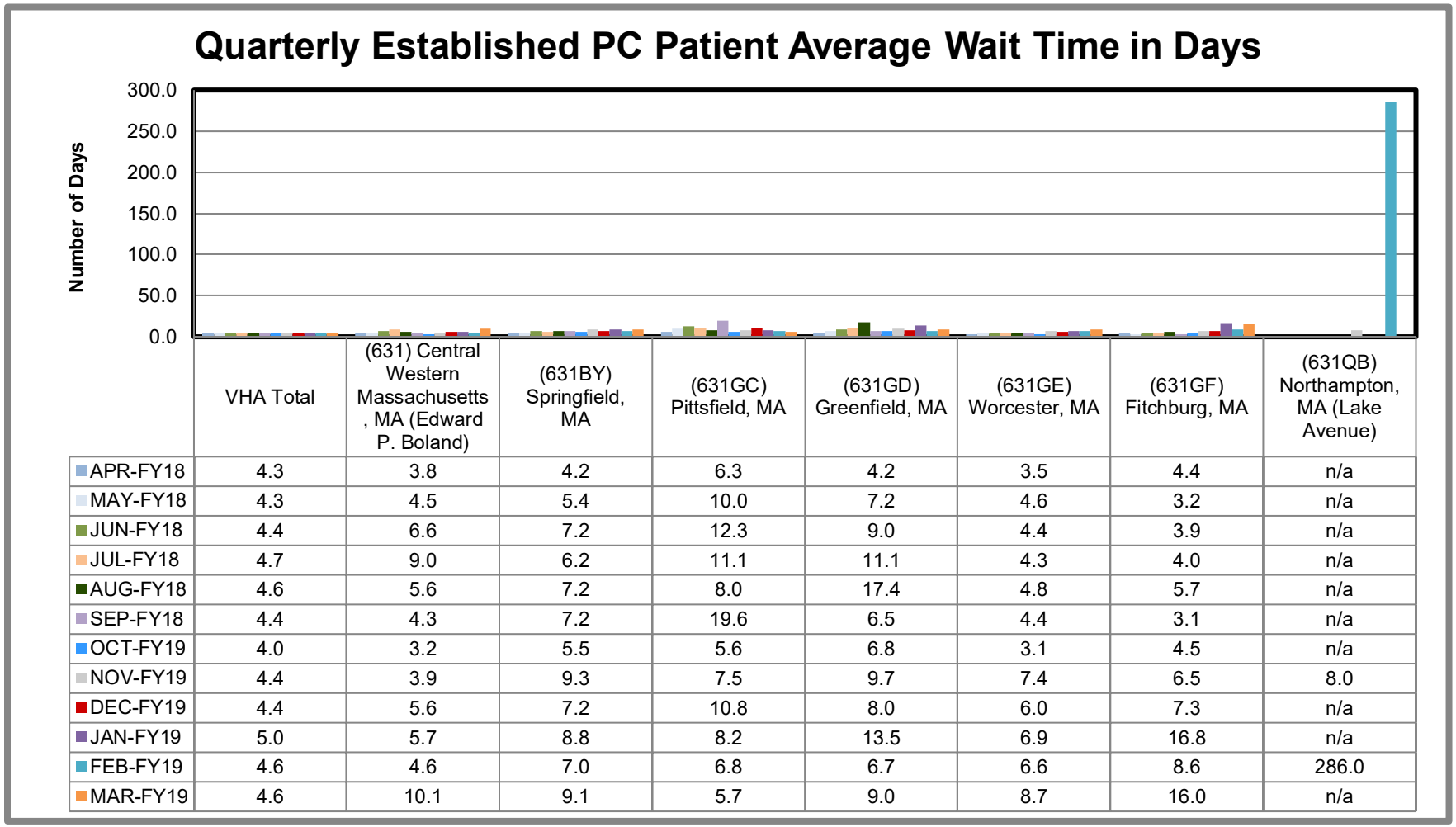
Appendix C: Patient Aligned Care Team Compass Metrics[165]



	VHA Total	(631) Central Western Massachusetts, MA (Edward P. Boland)	(631BY) Springfield, MA	(631GC) Pittsfield, MA	(631GD) Greenfield, MA	(631GE) Worcester, MA	(631GF) Fitchburg, MA
APR-FY18	7.9	7.4	12.8	10.0	10.9	3.4	7.5
MAY-FY18	7.7	10.3	10.7	0.0	12.8	5.0	5.2
JUN-FY18	7.6	18.9	14.7	0.8	12.3	3.5	3.0
JUL-FY18	7.5	11.8	12.5	4.7	17.6	7.3	3.5
AUG-FY18	7.7	77.4	22.4	3.5	22.7	7.2	0.9
SEP-FY18	8.5	9.1	13.1	16.3	11.4	8.1	6.2
OCT-FY19	8.0	5.6	11.4	8.4	11.1	6.4	5.2
NOV-FY19	8.5	9.3	13.0	7.5	8.2	7.2	8.8
DEC-FY19	8.6	8.4	15.6	7.1	13.1	9.0	9.6
JAN-FY19	9.0	20.0	6.4	4.0	27.7	5.0	5.4
FEB-FY19	8.5	7.0	15.3	8.1	18.8	2.7	8.6
MAR-FY19	8.1	6.7	7.6	0.0	15.3	7.6	2.9

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Northampton Worcester, MA (631QA) and Worcester, MA (631QB), as no workload/encounters or services were reported. The OIG has on file the facility's explanation for the increased wait times for VA Central Western Massachusetts Healthcare System (631).
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.

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



	VHA Total	(631) Central Western Massachusetts, MA (Edward P. Boland)	(631BY) Springfield, MA	(631GC) Pittsfield, MA	(631GD) Greenfield, MA	(631GE) Worcester, MA	(631GF) Fitchburg, MA	(631QB) Northampton, MA (Lake Avenue)
APR-FY18	4.3	3.8	4.2	6.3	4.2	3.5	4.4	n/a
MAY-FY18	4.3	4.5	5.4	10.0	7.2	4.6	3.2	n/a
JUN-FY18	4.4	6.6	7.2	12.3	9.0	4.4	3.9	n/a
JUL-FY18	4.7	9.0	6.2	11.1	11.1	4.3	4.0	n/a
AUG-FY18	4.6	5.6	7.2	8.0	17.4	4.8	5.7	n/a
SEP-FY18	4.4	4.3	7.2	19.6	6.5	4.4	3.1	n/a
OCT-FY19	4.0	3.2	5.5	5.6	6.8	3.1	4.5	n/a
NOV-FY19	4.4	3.9	9.3	7.5	9.7	7.4	6.5	8.0
DEC-FY19	4.4	5.6	7.2	10.8	8.0	6.0	7.3	n/a
JAN-FY19	5.0	5.7	8.8	8.2	13.5	6.9	16.8	n/a
FEB-FY19	4.6	4.6	7.0	6.8	6.7	6.6	8.6	286.0
MAR-FY19	4.6	10.1	9.1	5.7	9.0	8.7	16.0	n/a

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Northampton-Worcester, MA (631QA), as no workload/encounters or services were reported. The OIG has on file the facility's explanation for the increased wait times for Worcester, MA (631QB).
Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." The absence of reported data are indicated by "n/a."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[166]

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

[166] 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[167]

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.

[167] *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: December 9, 2019

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

Subj: Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System Leeds, MA

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

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Health System Leeds, MA. I appreciate the Office of the Inspector General's oversight and the extensive work done as part of this review. We acknowledge there are improvements to be made and we are committee to timely implementation of Office of Inspector General recommendations.
2. I have reviewed the action plans and projected completion dates. I concur with the plan and complete confidence that the plans will be effective.

(Original signed by:)

Ryan Lilly, MPA

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: December 9, 2019

From: Interim Director, VA Central Western Massachusetts Healthcare System (631/00)

Subj: Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System, Leeds, MA

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

1. Thank you for the opportunity to review the draft of VA Central Western Massachusetts Healthcare System, Leeds, MA, Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report.

2. I concur with most of the report and recommendations. Attached is the facility's corrective action plan for the recommendations.

3. VA Central Massachusetts Healthcare System continues in its ongoing efforts to provide safe, efficient, and quality services to our Veterans.

(Original signed by:)

Andrew T. McMahon

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

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Melinda Alegria, AuD, CCC-A, Team Leader Patricia Calvin, RN, MBA Andrea Der, MSN, RN Tasha Felton-Williams, DNP, ACNP Sylvester Wallace, MSW, LCSW Michelle Wilt, MBA, BSN
Other Contributors	Limin Clegg, PhD Justin Hanlon, BS LaFonda Henry, MSN, RN-BC Gayle Karamanos, MS, PA-C Yoonhee Kim, PharmD Susan Lott, MSA, RN Scott McGrath, BS Larry Ross, Jr., MS Marilyn Stones, BS Erin Stott, MSN, RN April Terenzi, BA, BS Mary Toy, MSN, RN Robert Wallace, ScD, MPH

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