DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Jonathan M. Wainwright Memorial VA Medical Center

Walla Walla, Washington

CHIP REPORT | REPORT #19-00053-57 | JANUARY 8, 2020

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Figure 1. *Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA* (*Source: https://vaww.va.gov/directory/guide/, accessed on September 25, 2019*)

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the outpatient settings of the Jonathan M. Wainwright Memorial VA Medical Center (the facility). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

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

This unannounced visit was conducted during the week of July 22, 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

[1] The OIG's review of the emergency department and urgent care center (UCC) operations and management focused on the clinical risks of the emergency department/UCC areas. This review was not performed at the Jonathan M. Wainwright Memorial VA Medical Center because the facility did not have an emergency department or UCC.

other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, chief of staff, associate director for Patient Care Services (ADPCS), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure with the Executive Leadership Council having oversight for several working groups. The director and acting chief of Quality Management were co-chairs of the Quality, Safety, and Value Board which was responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.

The facility did not have a stable leadership team. Although three of the four leadership positions had been filled, the leaders had only worked together for one month. The director was permanently assigned in January 2019. The ADPCS and associate director were assigned in January 2017 and August 2017, respectively. The associate chief of staff for Primary Care had only been recently appointed as acting chief of staff in June 2019.

The OIG noted that selected employee satisfaction survey results indicated that employees seem generally satisfied with facility leaders; however, the director and associate director appear to have an opportunity to improve employee satisfaction and trust. For the two patient experience survey scores applicable to the facility, one survey question was higher than the VHA average while other was lower than the VHA average. The facility leaders seemed to be actively engaged with employees and patients and were working to improve employee and patient engagement and satisfaction. The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to maintain positive perceptions of the facility through active stakeholder engagement).

The OIG's review of the facility's accreditation findings, sentinel events,[2] and disclosures did not identify any substantial organizational risk factors. However, the OIG is concerned with leadership turnover. Over the past two years, the facility had two interim facility directors before the current director was permanently assigned and four chiefs of staff—two permanent and two interim.

[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."

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, the leaders should continue to take actions to improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "2-star" quality rating.[4]

The OIG noted deficiencies in five of the seven clinical areas reviewed and issued 17 recommendations that are attributable to the director, chief of staff, and associate director. These are briefly described below.

Medical Staff Privileging

The OIG team found general compliance with requirements for privileging. However, the OIG identified noncompliance with focused and ongoing professional practice evaluation processes.[5]

Environment of Care

The facility generally complied with requirements for safety, environmental cleanliness, and the women veterans program at the parent facility. The OIG team did not find any issues with the availability of medical equipment and supplies. However, the OIG identified noncompliance with patient privacy and emergency power supply system requirements at the parent facility. In addition, the OIG identified safety and environmental cleanliness concerns at the Lewiston VA Clinic.

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

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

[5] The 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."

Medication Management

The OIG team found general compliance with requirements for most of the performance indicators evaluated, including the controlled substances coordinator reports, pharmacy operations, requirements for controlled substances inspectors, and facility review of override reports. However, the OIG team noted concerns with reconciliation of one day's dispensing from pharmacy to the dispensing unit and verification of hard copy prescriptions during monthly controlled substances area and pharmacy inspections.

Mental Health

The OIG team found many of the performance indicators were achieved, including the designation of a military sexual trauma (MST) coordinator, establishing informational outreach, and tracking MST-related data. However, the OIG team noted concerns with requirements for establishing and monitoring MST-related staff training, communicating MST-related issues with facility leaders, completing initial evaluations, and providers completing MST mandatory training.

Women's Health

Generally, the OIG team found compliance with many of the performance indicators, including requirements for a designated women veterans program manager and clinical champion, clinical oversight of the women's health program, tracking of required data related to cervical cancer screening, and provision of follow-up care. The OIG team noted concerns with the Women Veterans Health Committee core members' meeting attendance and timely notification of abnormal test results.

Summary

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

Comments

The Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 62–63, and the responses within the body of the report for the full

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

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Assistant Inspector General
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Contents

Purpose and Scope

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

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

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility:[8]

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (specifically the controlled substances inspection program)
6. Mental health (focusing on military sexual trauma follow-up and staff training)
7. Geriatric care (spotlighting antidepressant use for elderly veterans)
8. Women's health (particularly abnormal cervical pathology results notification and follow-up)

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

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

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

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

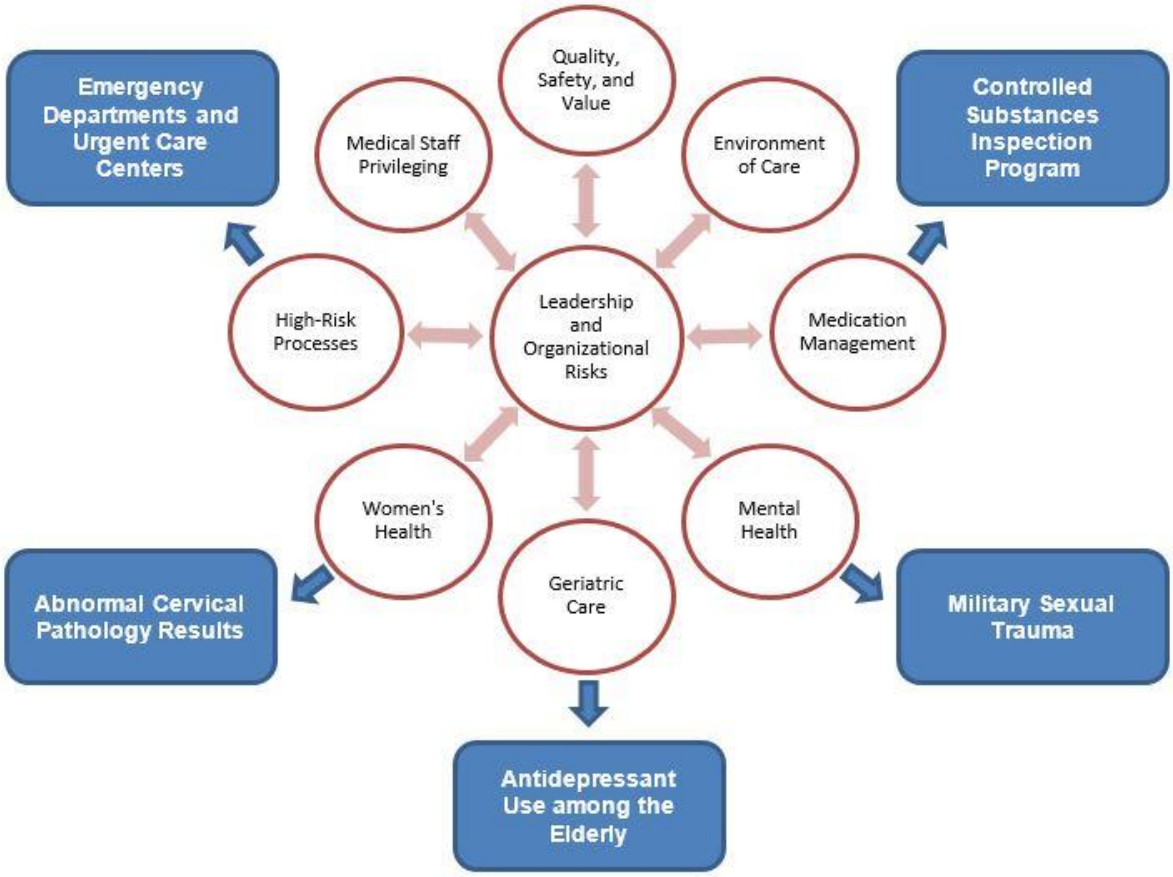

Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

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;[9] physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from September 23, 2017, through July 25, 2019, the last day of the unannounced multi-day site visit.[10] While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

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

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

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

[10] The range represents the time period from the last unannounced CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

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

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

Executive Leadership Position Stability and Engagement

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

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

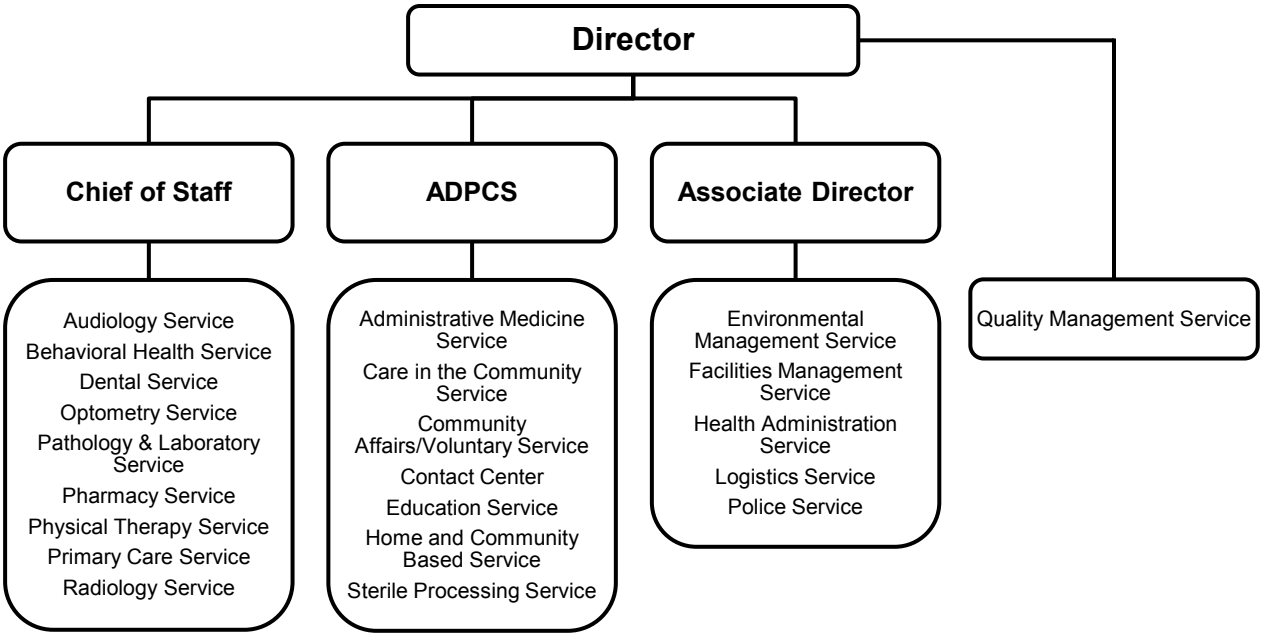

Figure 3. *Facility Organizational Chart*[12]
Source: Jonathan M. Wainwright Memorial VA Medical Center (*received July 22, 2019*)

At the time of the OIG site visit, the facility did not have a stable leadership team—the executive team had been working together for one month, although two leaders have been in their position for over two years (see Table 1). The current acting chief of staff, previously the facility's associate chief of staff for Primary Care, was newly assigned a month prior.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	January 14, 2019
Chief of staff	June 22, 2019 (acting)
Associate director for Patient Care Services	January 8, 2017
Associate director (also known as Associate director for Operations)	August 6, 2017

Source: Jonathan M. Wainwright Memorial VA Medical Center human resources officer (*received July 22, 2019)*

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

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

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

The director serves as the chairperson of the Executive Leadership Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Council oversees various working groups, such as the Clinical Executive Board, Environment of Care Board, Integrated Ethics Board, and Nurse Professional Council. See Figure 4.

These leaders are also engaged in monitoring patient safety and care through the Quality, Safety, and Value Board, for which the director and acting quality manager are co-chairs. The Quality, Safety, and Value Board is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes, and it reports to the Executive Leadership Council.

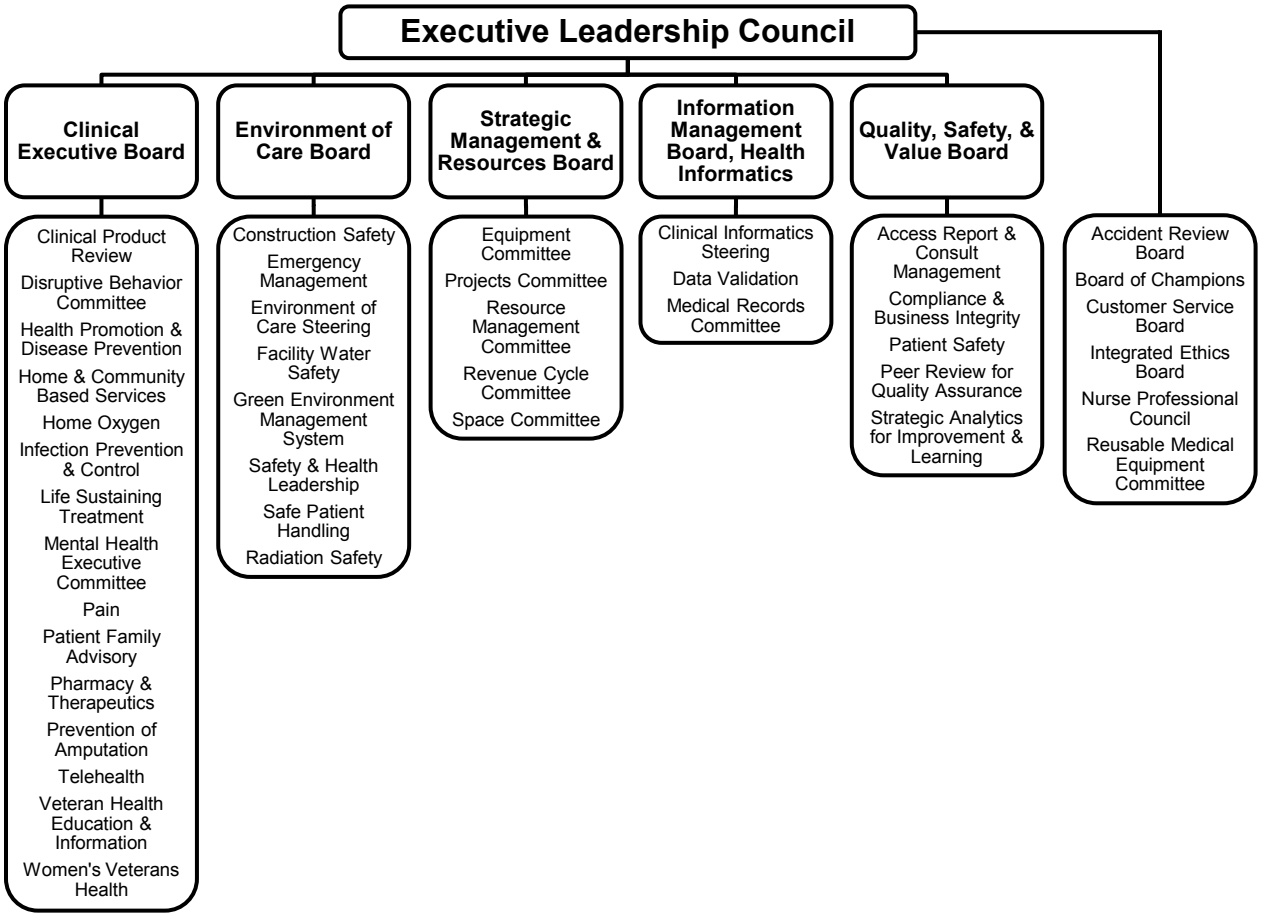

Figure 4. *Facility Committee Reporting Structure*[13]
Source: Jonathan M. Wainwright Memorial VA Medical Center (*received July 23, 2019*)

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,

[13] The Executive Leadership Council directly oversees the Accident Review Board, Board of Champions, Customer Service Board, Integrated Ethics Board, Nurse Professional Council, and the Reusable Medical Equipment Committee.

through September 30, 2018.[14] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey.

The OIG found the facility average for the selected survey leadership questions was generally similar to the VHA average.[15] The members of the executive leadership team were similar to or better than the VHA and facility averages, except for the associate director who had lower averages for all survey questions. Opportunities exist for the associate director to improve employee satisfaction. During leadership interviews, the director spoke frankly of ongoing challenges with changes implemented by the new leadership team, and the associate director attributed the low survey results to implementing meaningful changes and holding staff accountable. In all, employees appear generally satisfied with facility leaders.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[16]	0–100 where HIGHER scores are more favorable	71.7	72.0	71.7	73.1	71.8	36.4
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	3.2	3.5	3.4	3.8	2.1

[14] Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, and associate director. It is important to note that the 2018 All Employee Survey results are not reflective of employee satisfaction with the current facility director and acting chief of staff.

[15] The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.4	3.7	4.0	3.9	2.3
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	3.9	3.9	3.9	1.8

Source: VA All Employee Survey (*accessed June 20, 2019*)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. With the exception of the director and associate director, the facility, ADPCS, and chief of staff averages were generally similar to the VHA averages. For the survey question related to moral distress, the director average was worse than both the VHA and facility averages.[17] Opportunities exist for the director and associate director to provide a workplace environment where employees feel safe bringing forth issues and concerns.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.7	3.6	3.9	4.1	3.0

[17] It is important to note that the 2018 All Employee Survey results are not reflective of employee satisfaction with the current facility director.

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
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	3.3	3.8	3.9	3.0
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	2.3	1.2	0.9	1.4

Source: VA All Employee Survey (*accessed June 20, 2019*)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through September 30, 2018. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.[18]

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to relevant survey questions that reflect patients' attitudes toward facility leaders (see Table 4). For the two applicable patient experience survey

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

questions, the patient-centered medical home average was lower than VHA average, and the specialty care rating was similar to VHA average. Opportunities appear to exist for leaders to improve patient satisfaction.

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?* [19]	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	74.4
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	76.2

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

[19] The facility does not provide inpatient care; therefore, the facility average for two inpatient survey questions is not applicable (n/a).

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.[20] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[21] Indicative of effective leadership, the facility has closed all recommendations for improvement.[22]

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[23]

[20] 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.

[21] 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."

[22] 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.

[23] 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.

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 (*Comprehensive Healthcare Inspection Program Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington,* Report No. 17-01746-116, March 1, 2018)	September 2017	10	0
TJC Ambulatory Accreditation	December 2018	7	0
TJC Behavioral Health Care Accreditation		5	0
TJC Home Care Accreditation		2	0

Source: OIG and TJC (*inspection/survey results verified with the accreditation manager on July 23, 2019*)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from September 23, 2017 (the prior comprehensive OIG inspection), through July 25, 2019.[24]

[24] 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 Jonathan M. Wainwright Memorial VA Medical Center is a low complexity (3) facility as described in Appendix B.)

Table 6. Summary of Selected Organizational Risk Factors (September 23, 2017, through July 25, 2019)

Factor	Number of Occurrences
Sentinel Events[25]	0
Institutional Disclosures[26]	2
Large-Scale Disclosures[27]	0

Source: Jonathan M. Wainwright Memorial VA Medical Center's acting chief of Quality Management/risk manager (*received July 24, 2019*)

The OIG also reviewed patient safety indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[28] However, the data are not applicable since inpatient care is not provided at the facility.

During the inspection, the OIG was concerned with leadership turnover. Over the past two years, the facility had two interim facility directors prior to the appointment of the current director and four chiefs of staff (two interim appointments and two permanent assignments). Additionally, managers cited leadership turnover, specifically in the chief of staff position, as a contributing factor to noncompliant review areas, such as medical staff privileging and women's health (particularly abnormal cervical pathology result notification and follow-up).

[25] 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."

[26] 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."

[27] 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."

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

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[29]

VA also uses a star-rating system where facilities with a "5-star" rating are performing within the top 10 percent of facilities and "1-star" facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.[30] As of June 30, 2018, the facility was rated as "2-star" for overall quality.

[29] VHA Support Service Center (VSSC), *The Strategic Analytics for Improvement and Learning (SAIL) Value Model*. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

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

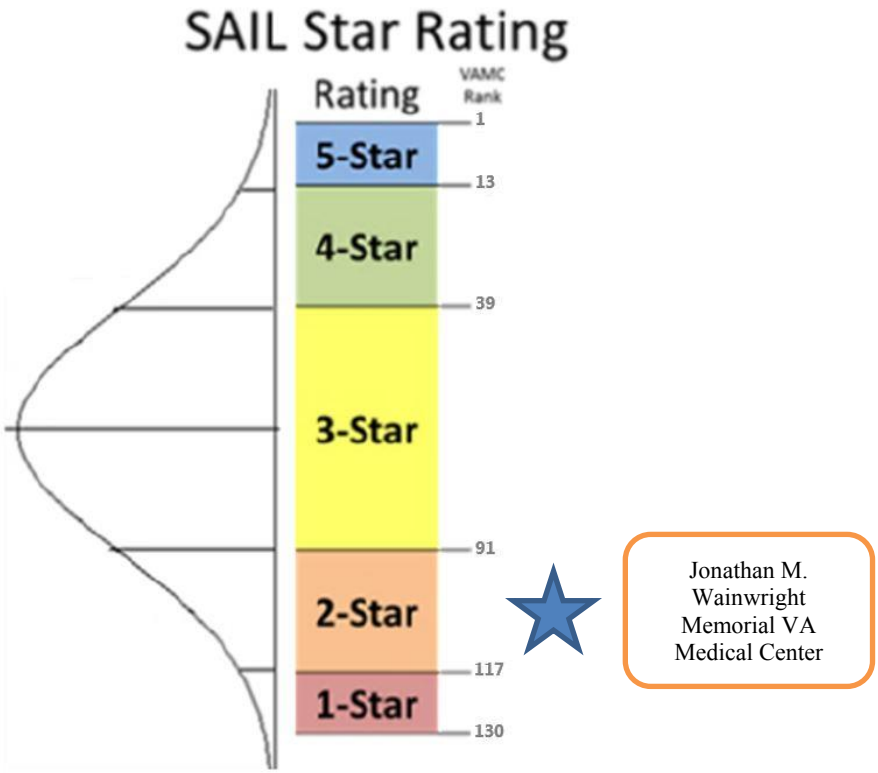

Figure 5. *Strategic Analytics for Improvement and Learning Star Rating Distribution* (*as of June 30, 2018*)
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed June 20, 2019)

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 green data points to indicate high performance in the areas of patient-centered medical home (PCMH) same day appointment and ambulatory care sensitive condition (ACSC) hospitalization. Metrics that need improvement are denoted in orange and red (for example, mental health (MH) population (Popu) coverage, call responsiveness, and best place to work).[31]

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

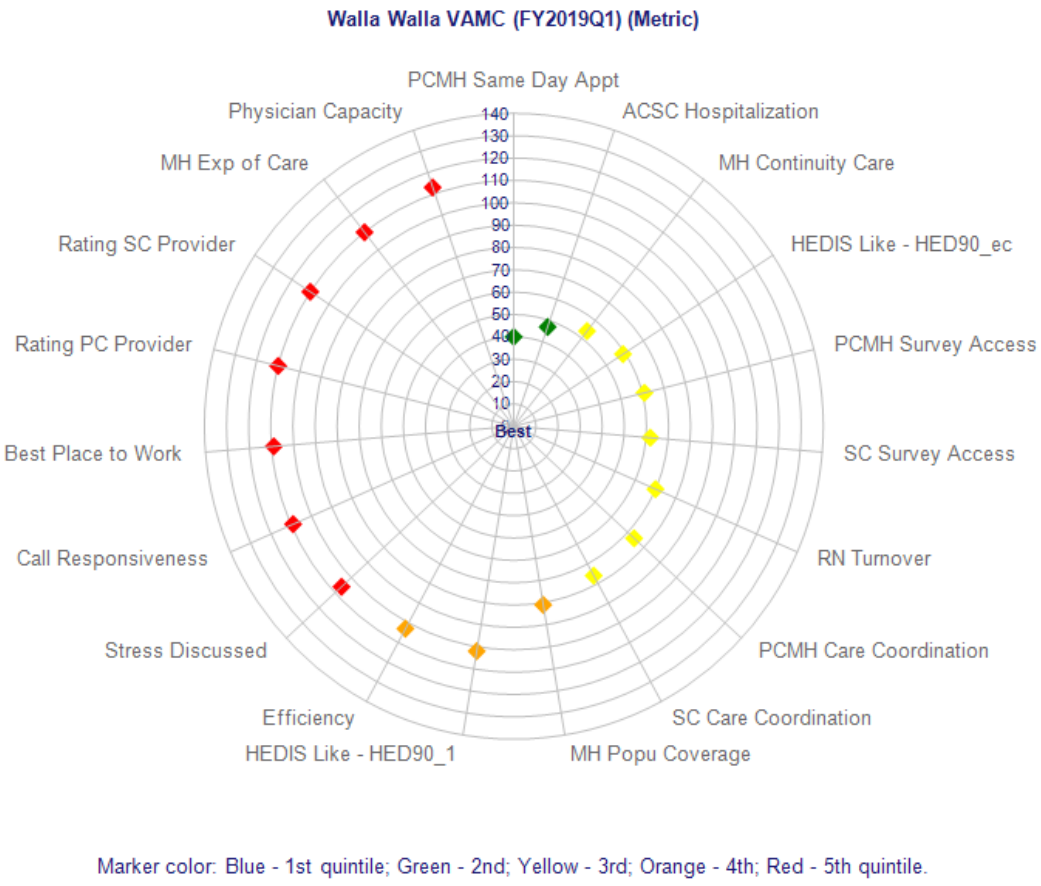

Figure 6. *Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as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

Leadership and Organizational Risks Conclusion

At the time of the OIG site visit, the facility did not have a stable leadership team. Although three of the four leadership positions had been filled, the leaders had only worked together for one month. Selected survey scores related to employee satisfaction and trust in the facility executive leaders were generally similar to VHA averages, with the exception of the director who scored lower than VHA average on some questions and the associate director who generally had lower averages for most survey questions. Opportunities exist for the director and associate director to improve employee satisfaction and trust. The two applicable patient experience survey questions for this facility showed one survey score above and one survey score below VHA averages. The facility leaders seemed actively engaged with employees and patients and were working to improve employee and patient engagement and satisfaction. The OIG's review of the facility's accreditation findings, sentinel events, and disclosures did not identify any

substantial organizational risk factors. The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to maintain positive perceptions of the facility through active stakeholder engagement); however, the OIG is concerned with leadership turnover. Over the past two years, the facility had two interim facility directors, before the current director was permanently assigned, and four chiefs of staff—two permanent and two interim chiefs of staff. The leadership team seemed knowledgeable within their scope of responsibility about selected SAIL metrics but should continue to take actions to improve performance of measures contributing to the SAIL "2-star" quality rating.

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.[32] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[33] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[34]

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,[35] utilization management (UM) reviews,[36] patient safety incident reporting with related root cause analyses,[37] and cardiopulmonary resuscitation (CPR) episode reviews.[38]

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.[39]

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[32] 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.)

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

[34] VHA Directive 1026.

[35] 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.

[36] 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 on July 31, 2019.

[37] 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."

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

[39] 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.[40]

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.[41]

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.[42]

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 evaluated the following performance indicators:[43]

- 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

[40] VHA Directive 1117(2).

[41] VHA Handbook 1050.01.

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

[43] For CHIP reviews, 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[44]
- UM[45]
  - 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[46]
  - 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

Generally, the facility met requirements as reflected by the performance indicators above. The OIG made no recommendations.

[44] VHA Directive 1190.

[45] The facility does not provide inpatient care.

[46] 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]."

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).[47]

Clinical privileges need to be specific, based on the individual's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[48]

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."[49]

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.[50] 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.[51]

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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[47] 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.)

[48] VHA Handbook 1100.19.

[49] VHA Handbook 1100.19.

[50] 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).

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

- Five solo or few (less than three in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months[52]
- Two LIPs hired within 18 months before the site visit
- Four LIPs re-privileged within 12 months before the visit
- No providers underwent a FPPE for cause within 12 months prior to the visit

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[53]
  - 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

[52] The 18-month period was from January 23, 2018, through July 22, 2019. The 12-month period covered July 23, 2018, through July 22, 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.

[53] 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 team found general compliance with the requirements for privileging. However, the OIG team identified noncompliance with selected requirements for the FPPE and OPPE processes that warranted recommendations for improvement.

VHA requires that all LIPs with new privileges or who are new to the facility have focused professional practice evaluations (FPPEs) completed and documented in the practitioner's provider profile and reported to an appropriate committee of the medical staff. This process involves the evaluation of privilege-specific competence of the practitioner who has not had documented evidence of competently performing the requested privileges. Evaluation methods may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.[54] In the review of three providers granted initial privileges, the OIG found incomplete FPPE data collection for one solo/few provider. As a result, providers delivered care without a thorough evaluation of the provider's practice. The acting chief of staff and the credentialing coordinator stated that staff shortages and frequent turnover in the chief of staff position contributed to the noncompliance.

Recommendation 1

1. The chief of staff ensures that service chiefs initiate and complete focused professional practice evaluations and monitors service chiefs' compliance.

[54] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: August 2020

Facility response: A new process was developed and in the process of being finalized and put into practice. Education is to be provided in December 2019. The process is to be moved to Medical Staff Coordinator (MSC) and has established deadlines and internal quality checks. The MSC is to ensure FPPEs are initiated, completed and presented to Clinical Executive Board (CEB) on providers in required timeframe from initial hire.

Quality Management, or their designee, will audit 100% of new provider hires monthly to attain 100% compliance with initiation and completion within timeframe for six consecutive months. The results will be reported to the Quality, Safety, & Value Board (QSVB) for oversight. Facility will provide six months of QSVB minutes to demonstrate closure. 100% of all new hires will be audited every 6 months by Quality Management or designee and results will be reported to QSVB.

For OPPEs, VHA requires that clinical managers consider relevant service- and practitioner-specific data utilizing defined criteria when recommending the continuation of LIP's privileges to the Executive Committee of the Medical Staff. Such data are maintained as part of the practitioner's provider profile and may include direct observations, clinical discussions, and clinical record reviews. This OPPE process is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that may impact quality of care and patient safety.[55] For one of four solo/few and one of four general providers' profiles where an OPPE was used to support the renewal of privileges, the OIG did not find evidence that the recommendation to continue privileges was based in part on the results of completed OPPE activities. This allowed the providers to continue to deliver care without a thorough evaluation of their practice. The acting chief of staff and the credentialing coordinator attributed the noncompliance to shortage of credentialing staff and a lack of consistent leadership due to frequent turnover in the chief of staff and provider positions. Additionally, the acting chief of Quality Management attributed the noncompliance to previously established timelines that allowed delays in receiving completed reports from clinical managers.

Recommendation 2

2. The chief of staff makes certain that service chiefs' determination to recommend continuation of privileges be based in part on results of ongoing professional practice activities and monitors service chiefs' compliance.

[55] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: August 2020

Facility response: Information has been added to the summaries presented to CEB and documented in minutes when renewing privileges. The Chief of Staff will ensure service chiefs' compliance through signing all CEB minutes.

Quality Management, or their designee, will audit 100% compliance with appropriate documentation for six consecutive months. The results will be reported to the Quality, Safety, & Value Board (QSVB) for oversight. Facility will provide six months of CEB minutes with corresponding privilege renewal summaries to demonstrate closure. CEB minutes and privilege renewal summaries will be audited every 6 months and results reported to QSVB.

VHA also requires that the Executive Committee of the Medical Staff (referred to as the Clinical Executive Board at this facility) review and evaluate providers' initial and reprivileging requests and that committee minutes reflect the documents reviewed (for example, FPPE and OPPE results). The committee's recommendation is then submitted to the facility director for approval.[56] For five LIPs—two solo/few and three general providers—the OIG found that the Clinical Executive Board did not document its decision to recommend continuation of privileges based on FPPE and OPPE data. This resulted in incomplete reviews and inadequate data to support granting or continuing clinical privileges to these providers. The acting chief of staff and credentialing coordinator attributed the noncompliance to shortage of credentialing staff and frequent turnover in the chief of staff position.

Recommendation 3

3. The chief of staff ensures that the Clinical Executive Board document its decision to recommend privileges based on focused and ongoing professional practice evaluation results and monitors the board's compliance.

Facility concurred.

Target date for completion: August 2020

Facility response: The minutes were modified to include the decision to recommend privileges based on FPPE and OPPE results. The Chief of Staff will ensure compliance through signing all CEB minutes.

The facility to provide six months of CEB minutes to demonstrate closure. Quality Management, or designee, will audit CEB minutes every six months and results will be reported to QSVB.

[56] VHA Handbook 1100.19.

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.[57]

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.[58]

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.[59]

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.[60] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[61]

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

[58] 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).

[59] 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.)

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

[61] 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,[62] and National Fire Protection Association standards.[63] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[64]

In all, the OIG team inspected seven areas—behavioral health, ambulatory care, pulmonary, optometry, dental, surgical, and the residential rehabilitation treatment program. The team also inspected the Lewiston 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[65]
  - Mental health environment of care rounds
  - Nursing station security
  - Public area and general unit safety

[62] 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.)

[63] 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.)

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

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

  - 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, environmental cleanliness, and women veterans program requirements associated with the above performance indicators. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG team noted concerns with patient privacy and emergency power testing at the parent facility. Additionally, the OIG found noncompliance with general safety and environmental cleanliness at the Lewiston VA Clinic.

Specifically, TJC requires the protection of patient information against "unauthorized access, use, and disclosure."[66] The OIG team noted eight computer monitors, in public view in the ambulatory care clinic, with visible protected patient identification and health information. This may result in unauthorized access to protected patient information. The unit manager reported inattention to detail regarding the missing computer privacy screens.

Recommendation 4

4. The associate director makes certain staff protect patient identification and health information on all computer monitors and monitors staff compliance.

[66] TJC. Information Management standard IM.02.01.03, EP 5.

Facility concurred.

Target date for completion: February 2020

Facility response: Bulk order for privacy screens placed and 18 screens were received October 17, 2019. A risk assessment completed, and available screens were placed in high risk areas. 22 additional screens remain on back order. Shipment will be tracked until received, and then distributed.

Facility will conduct an audit of all noted computers and ensure 100% compliance by January 15, 2020. To ensure staff will continue to comply, checking for privacy screens on computers will be added to Environment of Care (EOC) rounds. Privacy deficiencies will be reported to the EOC steering committee (meets every other month) thru EOC rounds report and documented in these minutes.

VHA requires facilities to regularly test appropriate physical security precautions, including panic alarms in high-risk outpatient areas.[67] The OIG team found no evidence of panic alarm testing at the Lewiston VA Clinic. This resulted in a lack of assurance of a safe environment for patients, visitors, and staff. The clinic manager and VA Police chief believed the clinic met the requirement by conducting the tests each month and were unaware that testing documentation was required.

Recommendation 5

5. The facility director makes certain monthly panic alarm testing is performed and evidence is maintained at the Lewiston VA Clinic and monitors compliance.

Facility concurred.

Target date for completion: March 2020

Facility response: Facility has updated the master testing log and had included Lewiston VA Clinic. Testing were conducted for six consecutive months. Compliance Deficiencies will be reported monthly to the Safety & Health Leadership Committee (SHLC) for sustainability.

The Chief of Police will maintain testing logs. The facility to provide six months of logs to demonstrate closure.

Furthermore, VHA and TJC require hospitals to identify environmental deficiencies, hazards, and unsafe practices, and to keep furnishings and equipment safe, clean, functional, and in good repair.[68] At the Lewiston VA Clinic, the OIG found three exam rooms with torn linoleum floors,

[67] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012

[68] TJC Environment of Care standard EC.02.06.01; VHA Directive 1608.

and walls in four exam rooms had multiple holes. These conditions resulted in a lack of assurance of a clean and safe patient care environment. The clinic manager was aware of the flooring condition and cited property owners' unresponsiveness to repeated flooring repair requests as the reason for noncompliance. A Facilities Management Service engineer acknowledged lack of follow up on the wall repairs and attributed the noncompliance to competing priorities.

Recommendation 6

6. The associate director makes certain that the floors and walls are safe and in good condition at the Lewiston VA Clinic and monitors compliance.

Facility concurred.

Target date for completion: June 2020

Facility response: The Lewiston Clinic is a leased building. The Walla Walla VAMC (WWVAMC) lease contracting officer is working with the owner of the building to complete necessary repairs. Progress will be reported to Safety & Health Leadership committee (SHLC) monthly until repairs are completed.

Facility to provide monthly SHLC minutes until completed.

VHA and TJC require facilities to perform weekly inspections of the emergency power supply system.[69] Further, TJC requires facilities to document the inspection results and completion dates.[70] From January 2018 through June 2019, the OIG was unable to find evidence of documented weekly inspections for all five emergency generators. Inspecting the emergency generators increases the likelihood of detecting problems and reduces the risk of losing this critical resource during a power disruption. The current Facilities Management Service chief reported completing weekly inspections, but the results were not documented due to competing priorities. The chief also stated that the previous service chief did not maintain inspection logs, which contributed to the noncompliance.

Recommendation 7

7. The associate director ensures that the chief of Facilities Management Service completes and documents weekly emergency generator inspections and monitors compliance.

[69] VHA Directive 1028, *Electrical Power Distribution Systems*, July 25, 2014; TJC Environment of Care standard EC.02.05.07, EP4.

[70] TJC. Environment of Care standard EC.02.05.07, EP4.

Facility concurred.

Target date for completion: August 2020

Facility response: Facility Management Services created logs, weekly checks initiated mid-August, and logged into VISTA for tracking. This data is monitored by the Facility Management Services Maintenance and Operations Foreman or designee and deficiencies are reported to the SHLC monthly, which is chaired by the Associate Director. Quality Management or designee to audit logs for compliance of weekly checks. Results to be reported to QSVB until 90% or greater compliance is achieved.

Facility to provide Logs and QSVB minutes for six consecutive months.

TJC requires facilities to test emergency generators once every 12 months using supplemental loads if the generators do not meet either the 30 percent of nameplate rating or the recommended exhaust gas temperature during monthly testing.[71] TJC also requires testing of emergency generators at least once every 36 months for a minimum of four continuous hours.[72]

Of the five emergency generators, one failed to meet the minimum monthly testing criteria, and the OIG team found no evidence of annual supplemental load testing. Additionally, two generators lacked evidence of triennial testing for a minimum of four continuous hours. Testing increases the likelihood of detecting problems and reduces the risk of losing critical emergency power when needed. The Facilities Management Service chief attributed the noncompliance to the previous chief's failure to complete the required emergency generator testing.

Recommendation 8

8. The associate director ensures that the Facilities Management Service chief annually tests all generators requiring an annual supplemental load and monitors compliance.

[71] TJC. Environment of Care standard EC.02.05.07, EP6.

[72] TJC. Environment of Care standard EC.02.05.07, EP9.

Facility concurred

Target date for completion: April 2020

Facility response: The Chief of Facility Management Services (FMS) identified all generators requiring testing, and when testing was completed for tracking. The Chief of FMS will ensure all testing is tracked and completed. Chief of FMS will report progress to SHLC monthly, until 100% completion. To sustain change, Chief of FMS will report status of annual checks quarterly to SHLC. Quality Management to audit tracking log. Results will be reported to QSVB until 100% completed.

Facility will provide documentation that 100% of generators that require annual supplemental load testing were completed.

Recommendation 9

9. The associate director ensures that the Facilities Management Service chief tests the emergency generators at least once every 36 months for a minimum of continuous four hours and monitors compliance.

Facility concurred.

Target date for completion: April 2020

Facility response: The Chief of Facility Management Services (FMS) identified all generators requiring triennial emergency testing, and when testing was completed for tracking. The Chief of FMS will ensure all testing is tracked and completed. Chief of FMS will report progress to SHLC monthly, until 100% completion.

To sustain change, Chief of FMS will report status to SHLC. Quality Management to audit tracking log. Results will be reported to QSVB until 100% completed.

Facility will provide documentation that 100% of generators that require triennial emergency testing were completed.

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.[73] 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.[74]

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.[75]

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;[76] 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[77]
- Requirements for controlled substances inspectors

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

[74] 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.

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

[76] The two quarters were from January 1, 2019 through June 30, 2019.

[77] 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[78]
  - 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[79]
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[80]

[78] 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."

[79] 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*.)

[80] 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 team found general compliance with requirements for most of the performance indicators evaluated, including the controlled substances coordinator reports, pharmacy operations, requirements for controlled substances inspectors, and facility review of override reports. However, the OIG team noted concerns with controlled substances area and pharmacy inspections that warranted recommendations for improvement.

Specifically, VHA requires controlled substances inspection program staff to reconcile one random day's refilling from the pharmacy to every automated dispensing unit during controlled substances area inspections.[81] From January 2019 to June 2019, the OIG found that the one non-pharmacy storage area with an automated dispensing unit lacked reconciliation of one-day dispensing from the pharmacy. Failure to reconcile dispensing of controlled substances may cause delays in identifying potential drug diversion activities. The controlled substances coordinator was unaware of the requirement.

Recommendation 10

10. The facility director ensures that controlled substances inspection staff reconcile one day's dispensing from the pharmacy to the automated dispensing unit and monitors coordinator's compliance.

Facility concurred.

Target date for completion: August 2020

Facility response: Controlled substance inspectors (CSI) run reports for one day's dispensing and reconcile during monthly controlled substance inspection. Results of reconciliation are documented on the CSI form. The controlled substance coordinator will audit reconciliations and include data in quarterly report to the Quality, Safety, & Value Board (QSVB), which is chaired by the facility director.

Facility to provide copies of CSI report to QSVB for six consecutive months. The quarterly report for FY 20 QTR 2 will be presented to QSVB in April 2020.

VHA requires that controlled substances inspectors verify hard copy prescriptions during monthly pharmacy inspections.[82] From January 2019 to June 2019, the OIG was unable to find evidence that, for the one pharmacy at the facility, the controlled substances inspectors verified hard copy prescriptions. Inspectors' failure to thoroughly complete monthly inspections of the pharmacy can result in missed opportunities to identify potential drug diversion activities and

[81] VHA Directive 1108.02(1).
[82] VHA Directive 1108.02(1).

discrepancies related to controlled substances. The controlled substances coordinator was unaware of the requirement.

Recommendation 11

11. The facility director makes certain that controlled substances inspectors verify hard copy controlled substances prescriptions during monthly pharmacy inspections and monitors inspectors' compliance.

Facility concurred.

Target date for completion: August 2020

Facility response: The Chief of Pharmacy and controlled substance coordinator developed a report for the controlled substance inspector (CSI) to randomly select 50 prescriptions (or 100% if less than 50) to verify the hard copy. The controlled substance coordinator will audit for compliance and include data in quarterly report to the Quality, Safety, & Value Board (QSVB), which is chaired by the facility director.

Facility to provide copies of CSI report to QSVB for six months. The quarterly report for FY 20 QTR 2 will be presented to QSVB in April 2020.

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."[83] 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.[84]

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

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

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

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

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

[85] VHA Directive 1115.

[86] 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.)

[87] 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."

[88] VHA Directive 1115.

[89] VHA Handbook 1160.01.

[90] 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.[91]

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 32 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

The OIG team found many of the performance indicators were achieved, including the designation of an MST coordinator, establishing informational outreach, and tracking MST-related data. However, the OIG team noted concerns with requirements for establishing and monitoring MST-related staff training, communicating MST-related issues with local leaders, completing initial evaluations, and providers completing MST mandatory training that warranted recommendations for improvement.

Specifically, VHA requires MST coordinators to establish and monitor MST-related staff training and communicate the status of MST services and initiatives with local leaders.[92] The

[91] 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.

[92] VHA Directive 1115.

OIG team determined that the facility had no process in place for establishing and monitoring MST-related staff training or communicating MST-related services and initiatives with leaders. This may hinder the MST coordinator's efforts to enhance staff training and leadership's ability to identify and address improvement opportunities. The MST coordinator believed mandatory MST training was assigned to new hires by the Talent Management System administrator and that employees completed this during the new employee orientation process and was unaware of the requirement to communicate MST services status with leaders.

Recommendation 12

12. The facility director ensures the military sexual trauma coordinator establishes and monitors military sexual trauma-related staff training and monitors coordinator's compliance.

Facility concurred.

Target date for completion: February 2020

Facility response: The military sexual trauma (MST) coordinator assigned MST training in Talent Management System (TMS) to 100% of applicable staff. Training to be completed by assigned staff by February 2020. Additionally, applicable new employees will be assigned TMS training by MST coordinator during new employee orientation (NEO).

Quality Management, or designee, will audit training completion log. The results will be reported to QSVB monthly until 100% compliance. To sustain compliance, MST coordinator will report training compliance deficiencies in Mental Health Executive committee (MHEC) monthly meeting. Facility will provide documentation of completed training by applicable staff by February 2020.

Recommendation 13

13. The facility director ensures the military sexual trauma coordinator communicates the status of military sexual trauma-related services and initiatives with leaders and monitors coordinator's compliance.

Facility concurred.

Target date for completion: August 2020

Facility response: The MST coordinator includes the status of military sexual trauma-related services and initiatives in monthly report to the MHEC. The MHEC chair reports any compliance issues to the CEB. First report was October 24, 2019.

The facility will provide six consecutive months of MHEC minutes documenting compliance.

VHA requires that providers complete an initial evaluation for all new patients referred for mental health services within 24 hours of the referral.[93] The OIG determined that providers completed an initial evaluation within one business day for 86 percent of patients referred for mental health services.[94] Failure to provide consistent and timely evaluation can result in missed opportunities to identify potential patient risks and to offer appropriate follow-up. The chief of Behavioral Health and MST coordinator cited a lack of oversight as the reason for noncompliance.

Recommendation 14

14. The chief of staff ensures providers complete initial evaluations within the required time frame for all new patients referred for mental health services for military sexual trauma and monitors providers' compliance.

Facility concurred.

Target date for completion: August 2020

Facility response: The MST coordinator developed a standard operating procedure. At the Medical Staff Meeting on September 20, 2019 and Behavioral Health Staff Meeting on November 13, 2019, all providers were educated on the requirement and timeframes for referrals. Additionally, an email was sent to all providers to reinforce the education presented at the meeting, this was sent out on December 5, 2019.

Quality Management, or their designee, will audit 100% compliance with appropriate documentation and appropriate timeframe of initial evaluations for six consecutive months. The results will be reported to the Quality, Safety, & Value Board (QSVB) for oversight. Facility will provide six months of QSVB minutes. The MST coordinator monitors compliance via VHA Support Service Center (VSSC) chart audits and data will be reported to the MHEC at least quarterly. The MHEC reports to the CEB quarterly for oversight and continued monitoring.

VHA also requires that all primary care and mental health providers complete MST mandatory training; for those hired after July 1, 2012, training must be completed no later than 90 days after assuming their position.[95] Of the 20 clinicians hired after July 1, 2012, the OIG was unable to find evidence of training completion for five clinicians and five others did not complete the mandatory training within 90 days after entering their position. This could potentially result in clinicians providing counseling, care, and service without the required MST training. The MST

[93] VHA Handbook 1160.01.

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

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

coordinator was aware of the 90-day requirement but believed that the mandatory MST training was assigned to new hires by the Talent Management System administrator and that all new providers completed training during the new employee orientation process.

Recommendation 15

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

Facility concurred.

Target date for completion: August 2020

Facility response: The MST coordinator assigned MST training in TMS to 100% of applicable staff, including Primary Care and Mental Health clinical staff involved with MST. Training to be completed by assigned staff by February 2020. Additionally, applicable new employees will be assigned TMS training by MST coordinator during new employee orientation (NEO).

Quality Management, or designee, will audit training completion log via in collaboration with the TMS Domain Manager via monthly TMS reports generated electronically. The results will be reported to QSVB monthly until 100% compliance is achieved. To sustain compliance, MST coordinator will report training compliance deficiencies in MHEC monthly meeting.

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."[96] 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.[97]

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."[98]

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.[99] 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."[100] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[101] 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.[102] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[96] 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.)

[97] *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.)

[98] 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.)

[99] 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.)

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

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

[102] 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.[103]

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 38 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.[104] The OIG evaluated the following performance indicators:

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

Geriatric Care Conclusion

Generally, the facility met requirements as reflected by the performance indicators above. The OIG team made no recommendations.

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

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

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

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.[105] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[106] In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.[107] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[108]

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.[109]

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.[110]

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

[105] 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.)
[106] 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.)
[107] 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.)
[108] 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.)
[109] VHA Directive 1330.01(2), *Health Care Services for Women Veterans,* February 15, 2017 (amended July 24, 2018).
[110] 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.[111]

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 five 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 veteran's 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 team found compliance with many of the performance indicators, including requirements for a designated women veterans program manager and clinical champion, clinical oversight of the women's health program, tracking of required data related to cervical cancer screening, and provision of follow-up care. However, the OIG found noncompliance with the Women Veterans Health Committee core members' meeting attendance and timely notification of abnormal test results to patients that warranted recommendations for improvement.

Specifically, VHA requires that the core membership of the Women Veterans Health Committee includes a women veterans program manager; a women's health medical director;

[111] VHA Directive 1330.01(2).

"representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care; and a member from executive leadership."[112] The OIG found that the Women Veterans Health Committee consisted of all required core members. However, for the meetings held between October 2017 through March 2019, meeting minutes showed that the mental health and social work services representative did not attend any of the meetings. Additionally, the OIG team noted inconsistent meeting attendance by other committee members. This resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans. The acting chief of staff and the interim women veterans program manager reported that frequent turnover in the chief of staff and women's health medical director positions caused lack of accountability for staff attendance at required meetings.

Recommendation 16

16. The facility director confirms that the Women Veterans Health Committee members attend meetings consistently and monitors the committee's compliance.

Facility concurred.

Target date for completion: August 2020

Facility response: The Women's Health Program Manager (WHPM) will ensure that the Women Veterans Health Committee (WVHC) members attend meetings consistently and monitors the committee's compliance. Deficiencies in attendance will be reported to CEB.

The facility to provide meeting minutes for WVHC demonstrating greater than 90% of members' attendance for six consecutive months.

VHA also requires that providers notify patients with abnormal cervical pathology results within seven calendar days of the report becoming available to the ordering provider.[113] The OIG team determined that providers communicated abnormal results in a timely manner to patients in 60 percent of the electronic health records reviewed.[114] This resulted in delayed patient notification and initiation of follow-up care. The acting chief of staff and the interim women veterans program manager reported that frequent staff turnover resulted in a lack of staff accountability and that inconsistencies with the abnormal test results communication process delayed notification.

[112] VHA Directive 1330.01(2).

[113] VHA Directive 1330.01(2).

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

Recommendation 17

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

Facility concurred.

Target date for completion: August 2020

Facility response: The WHPM developed a standard operating procedure and training of staff is scheduled to take place in January 2020. The process now includes the nurse care managers in tracking results. The WHPM will track compliance of providers communicating abnormal cervical pathology results.

Quality Management or designee will conduct audit verifying notification within required time frame was met through randomized chart audits of 30 (or 100% if less than 30) monthly. Facility to maintain 90% or greater compliance for six months. The results will be reported to the Quality, Safety, & Value Board (QSVB) for oversight. Facility will provide six months of QSVB minutes.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• None	• None
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• Service chiefs initiate and complete FPPEs. • Service chiefs determination to recommend continuation of privileges be based in part on results of OPPE activities.	• The Clinical Executive Board documents its decision to recommend privileges based on FPPE and OPPE results.

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
		• Staff protect patient identification and health information on all computer monitors.	• Monthly panic alarm testing is performed and evidence is maintained at the Lewiston VA Clinic.
			• Floors and walls are safe and in good condition at the Lewiston VA Clinic.
			• The chief of Facilities Management Service completes and documents weekly emergency generator inspections.
			• The Facilities Management Service chief annually tests all generators requiring an annual supplemental load.
			• The Facilities Management Service chief tests the emergency generators at least once every 36 months for a minimum of continuous four hours.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• None	• Controlled substances program staff reconcile one day's dispensing from the pharmacy to each dispensing unit. • Controlled substances inspectors verify hard copy controlled substances prescriptions during monthly pharmacy inspections.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers	• Providers complete initial evaluations within the required time frame for all new patients referred for mental health services for MST. • Providers complete MST mandatory training within the required time frame.	• MST coordinator establishes and monitors MST-related staff training. • MST coordinator communicates the status of MST-related services and initiatives with leaders.
Geriatric Care: Antidepressant Use among the Elderly	• Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data • Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated	• Ordering providers communicate abnormal cervical pathology results to patients within the required time frame.	• The Women Veterans Health Committee members attend meetings consistently.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) facility reporting to VISN 20.[115]

Table B.1. Facility Profile for Jonathan M. Wainwright Memorial VA Medical Center (687/00) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[116]	Facility Data FY 2017[117]	Facility Data FY 2018[118]
Total medical care budget in millions	$100,780,814	$94,742,776	$106,998,112
Number of:			
• Unique patients	19,424	19,545	20,227
• Outpatient visits	184,873	176,897	174,362
• Unique employees[119]	470	487	490
Type and number of operating beds:			
• Domiciliary	36	36	36
Average daily census:			
• Domiciliary	27	27	27

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

[115] 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."
[116] October 1, 2015, through September 30, 2016.
[117] October 1, 2016, through September 30, 2017.
[118] October 1, 2017, through September 30, 2018.
[119] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[120]

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)[121]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[122] Provided	Diagnostic Services[123] Provided	Ancillary Services[124] Provided
Richland, WA	687GA	7,258	4,016	Dermatology Pulmonary/ Respiratory disease	n/a	Nutrition Pharmacy Social work Weight management
Lewiston, ID	687GB	5,780	2,281	Dermatology	n/a	Pharmacy
La Grande, OR	687GC	2,900	511	Dermatology Pulmonary/ Respiratory disease Eye	n/a	Nutrition Pharmacy Weight management

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

[121] 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."

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

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

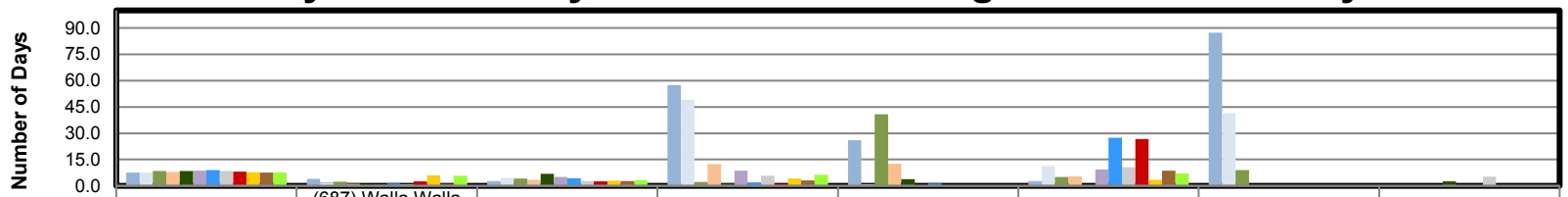
[124] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[122] Provided	Diagnostic Services[123] Provided	Ancillary Services[124] Provided
Yakima, WA	687HA	8,144	1,755	Dermatology Pulmonary/ Respiratory disease	n/a	Pharmacy Weight management Nutrition
Grangeville, ID	687QA	745	n/a	n/a	n/a	n/a
Boardman, OR	687QB	599	n/a	Dermatology	n/a	n/a
Enterprise, OR	687QC	294	20	n/a	n/a	n/a

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

Appendix C: Patient Aligned Care Team Compass Metrics[125]

Quarterly New Primary Care Patient Average Wait Time in Days

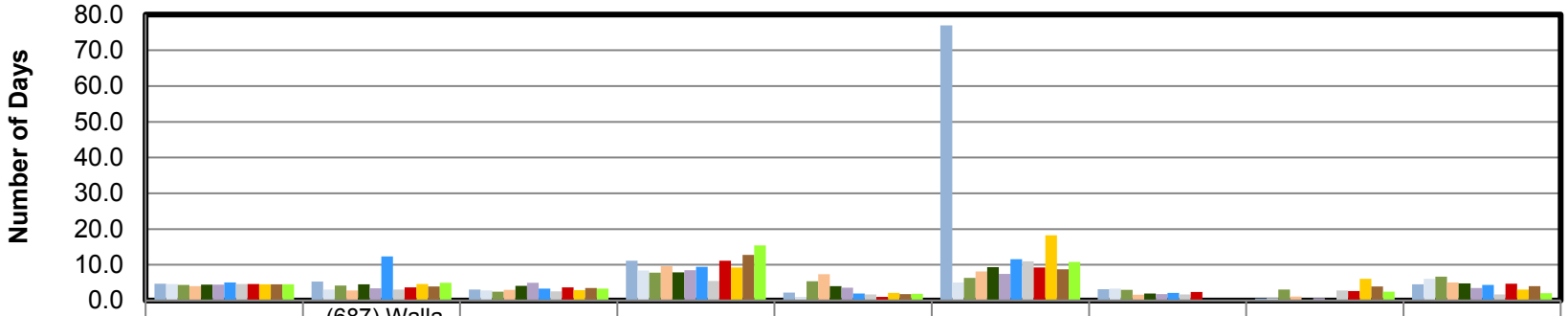


	VHA Total	(687) Walla Walla, WA (Jonathan M. Wainwright)	(687GA) Richland, WA	(687GB) Lewiston, ID	(687GC) La Grande, OR	(687HA) Yakima, WA	(687QA) Grangeville, ID	(687QB) Morrow County, OR
JUL-FY18	7.5	4.1	2.7	57.5	26.0	2.8	87.3	n/a
AUG-FY18	7.7	1.7	4.6	49.1	1.0	11.3	41.3	0.0
SEP-FY18	8.5	2.3	4.3	2.2	40.8	5.0	9.0	0.0
OCT-FY19	8.0	1.1	3.4	12.4	12.6	5.5	n/a	0.0
NOV-FY19	8.5	0.9	6.9	1.4	3.9	0.2	n/a	2.5
DEC-FY19	8.6	0.7	5.1	8.7	0.0	9.4	n/a	0.0
JAN-FY19	9.0	1.4	4.4	1.8	1.3	27.4	n/a	0.0
FEB-FY19	8.5	1.0	2.8	5.7	0.0	10.7	n/a	5.3
MAR-FY19	8.1	2.5	2.6	1.2	0.0	26.7	n/a	0.0
APR-FY19	7.8	6.0	2.9	4.2	0.0	3.5	n/a	0.0
MAY-FY19	7.6	1.2	2.8	3.1	0.0	8.7	n/a	0.0
JUN-FY19	7.6	5.7	3.2	6.3	0.0	7.0	n/a	0.0

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (687QC) Wallowa County, OR, as no workload/encounters or services were reported. The OIG has on file the facility's explanation for the increased wait times for the (687GB) Lewiston, ID; (687GC) LaGrande, OR; and (687QA) Grangeville, ID.
Data Definition: "The average number of calendar days between a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Note that prior to FY15, this metric was calculated using the earliest possible create date. The absence of reported data is indicated by "n/a."

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

Quarterly Established Primary Care Patient Average Wait Time in Days



	VHA Total	(687) Walla Walla, WA (Jonathan M. Wainwright)	(687GA) Richland, WA	(687GB) Lewiston, ID	(687GC) La Grande, OR	(687HA) Yakima, WA	(687QA) Grangeville, ID	(687QB) Morrow County, OR	(687QC) Wallowa County, OR
JUL-FY18	4.7	5.3	3.1	11.1	2.2	76.9	3.2	0.6	4.5
AUG-FY18	4.6	3.1	2.8	8.4	1.0	5.1	3.3	0.6	6.1
SEP-FY18	4.4	4.2	2.5	7.8	5.4	6.4	3.0	3.1	6.7
OCT-FY19	4.0	2.8	3.0	9.6	7.4	8.1	1.7	1.1	5.1
NOV-FY19	4.4	4.6	4.1	7.9	4.1	9.3	2.0	0.3	4.8
DEC-FY19	4.4	3.4	5.0	8.5	3.6	7.5	1.8	0.7	3.5
JAN-FY19	5.0	12.3	3.3	9.4	1.9	11.5	2.1	0.2	4.4
FEB-FY19	4.6	3.1	2.6	5.5	1.7	11.0	1.7	2.8	1.7
MAR-FY19	4.6	3.7	3.7	11.1	1.0	9.3	2.4	2.7	4.7
APR-FY19	4.5	4.7	2.9	9.2	2.2	18.3	0.0	6.1	3.1
MAY-FY19	4.5	3.9	3.5	12.8	1.8	8.8	0.0	3.9	4.0
JUN-FY19	4.5	5.0	3.4	15.4	1.9	10.8	0.0	2.5	2.1

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (687QC) Wallowa County, OR, as no workload/encounters or services were reported. The OIG has on file the facility's explanation for the increased wait times for the (687HA) Yakima, WA.
Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment(date." The absence of reported data is indicated by "n/a."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[126]

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

[126] 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: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 9, 2019

From: Director, Northwest Network (10N20)

Subj: Comprehensive Healthcare Inspection of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA

To: Director, Los Angeles Office of Healthcare Inspections (54 CH01)

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

1. Thank you for the opportunity to provide a status report on follow-up to the findings from the Comprehensive Healthcare Inspection Program Review of the Jonathan M. Wainwright Memorial VA Health Care System, Walla Walla, Washington.
2. I concur to the recommendations and responses to the findings from the review.

(Original signed by:)

John C. Mendoza, Deputy Network Director VISN 20

for

Michael J. Murphy

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 F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 2, 2019

From: Director, Jonathan M. Wainwright Memorial VA Medical Center (687/00)

Subj: Comprehensive Healthcare Inspection of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA

To: Director, Northwest Network (10N20)

1. Thank you for the opportunity to provide a status report on follow-up to the findings from the Comprehensive Healthcare Inspection Program Review of the Jonathan M. Wainwright Memorial VA Health Care System, Walla Walla, Washington.
2. VA Walla Walla concurs with the findings and recommendations and will ensure that actions to correct these finding are completed as described in the responses.

(Original signed by:)

Christopher R. Bjornberg

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

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