



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of Veterans
Integrated Service Network
4: VA Healthcare
Pittsburgh, Pennsylvania



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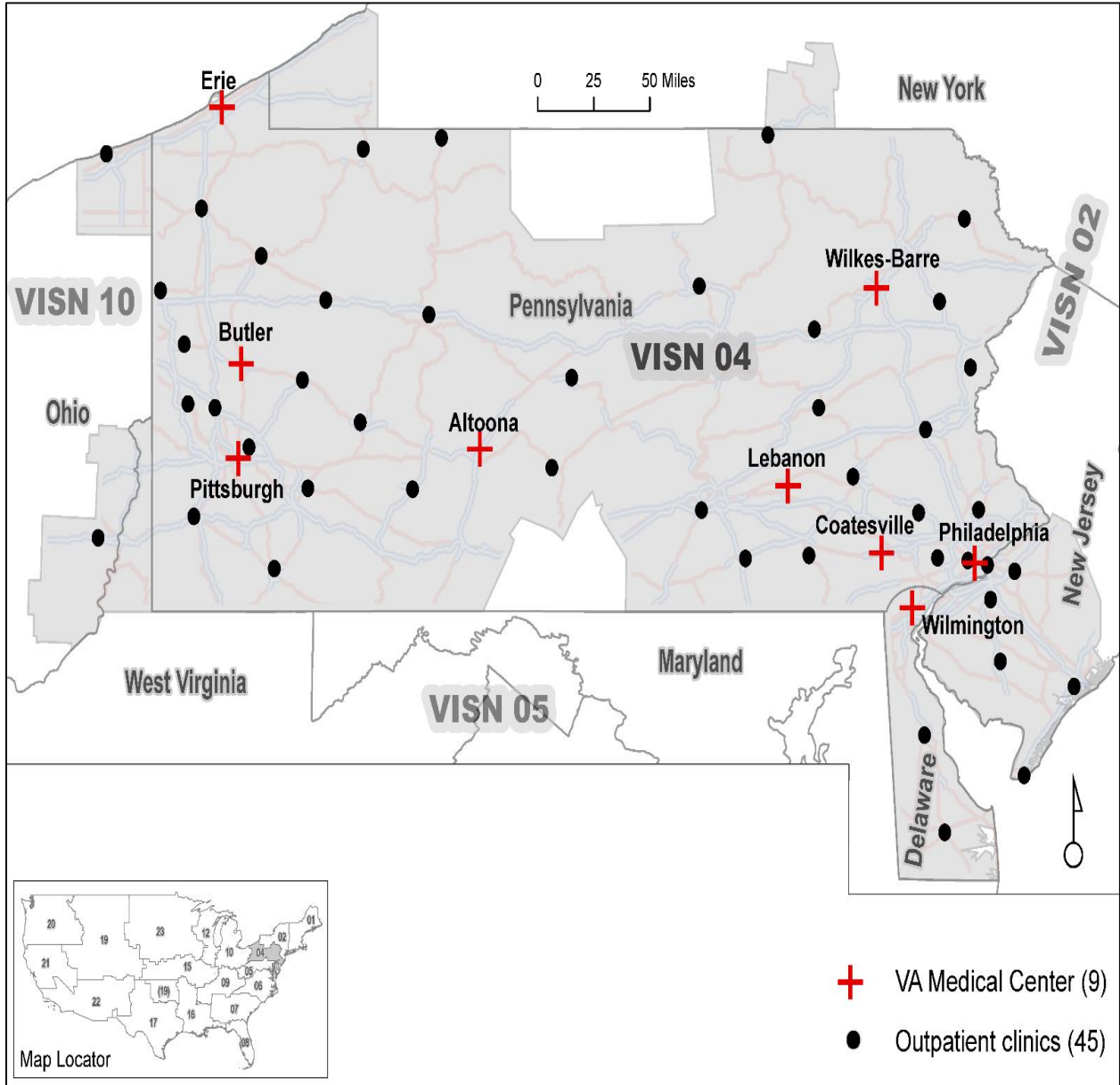


Figure 1. VA Healthcare—Veterans Integrated Service Network 4, Pittsburgh, Pennsylvania

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	chief medical officer
FPPE	focused professional practice evaluation
FY	fiscal year
HCS	health care system
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QMO	quality management officer
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
VAMC	VA medical center
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 leadership performance and oversight by the VA Healthcare–Veterans Integrated Service Network (VISN). This inspection covers key clinical and administrative processes 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 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 (QSV);
2. Medical staff privileging;
3. Environment of care; and
4. Medication management (specifically the controlled substances inspection program).

The OIG conducted this unannounced visit during the week of June 24, 2019, while concurrent inspections of the following VISN 4 facilities were also performed:

- Coatesville VA Medical Center (VAMC)
- VA Butler Health Care Center

The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. The findings presented in this report are a snapshot of VISN 4 and facility performance within the identified focus areas at the time of the OIG visit. The findings in this report may help the VISN 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

The VISN leadership team consists of the acting network director, deputy network director, chief medical officer (CMO), and quality management officer (QMO). Organizational communication and accountability are managed through a committee reporting structure, with the VISN’s Executive Committee of the Executive Leadership Council having oversight for groups including the Healthcare Delivery, Healthcare Operations, QSV, and Organizational Health Committees.

At the time of the OIG’s visit, the VISN’s deputy director, CMO, and QMO had been working together for 16 months. The acting network director had been assigned for a 120-day detail and was beginning a second 120-day detail.

The OIG noted that selected employee satisfaction survey results indicated that VISN leaders were engaged and promoted a culture of safety where employees feel safe bringing forward issues and concerns. The selected patient experience survey scores for the VISN were similar to or better than the VHA averages. VISN leaders also appeared to support efforts to provide accessible and inclusive care for women veterans.

The OIG’s evaluation of VISN access metrics and clinician vacancies did not identify any significant organizational risks. Interviewed leaders were knowledgeable about efforts taken to reduce veteran suicide in VISN 4 and shared information that highlighted efforts to develop and the implement strategies for high-risk veterans.

The leadership team was also knowledgeable within their scope of responsibility about selected Strategic Analytics for Improvement and Learning (SAIL) and community living center (CLC) metrics and should continue to take actions to sustain and improve performance of measures contributing to the SAIL “5-star” quality ratings and care provided throughout VISN 4.^{1,2}

The OIG noted deficiencies in two of the four clinical areas reviewed and issued two recommendations that are attributable to the network director and chief medical officer. These are briefly described below.

Medical Staff Privileging

During CHIP reviews of the Coatesville VAMC and VA Butler Health Care Center, the OIG identified a noncompliance trend with the Executive Committee of the Medical Staff not documenting its decision to recommend privileges for licensed independent practitioners based on focused and ongoing professional practice evaluation results.

Environment of Care

The OIG noted a written policy for the comprehensive environment of care program and inventory management programs assessed through a quality control review and did not identify

¹ 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.)

² Based on fiscal year 2018, quarter 3 ratings at the time of the site visit.

any patterns or trends during CHIP reviews within the VISN. However, the OIG found that the VISN had not established an emergency management committee as required.

Summary

In reviewing key healthcare processes, the OIG issued two recommendations for improvement directed to the network director and chief medical officer. The number of recommendations should not be used, however, as a gauge for the overall quality provided within this VISN. The intent is for VISN leaders to use these recommendations as a road map to help improve operations and clinical care throughout the network of assigned facilities. 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 agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendix G, page 52, and the responses within the body of the report for the full text of the Network directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Contents

Abbreviations	ii
Report Overview	iii
Results and Inspection Impact	iii
Purpose and Scope	1
Methodology	2
Results and Recommendations	3
Leadership and Organizational Risks.....	3
Quality, Safety, and Value	25
Medical Staff Privileging	27
Recommendation 1	27
Environment of Care	29
Recommendation 2	30
Medication Management: Controlled Substances Inspections	31
Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings.....	32
Appendix B: VISN 4 Profile.....	35
Appendix C: Survey Results.....	36
Appendix D: Office of Inspector General Inspections	44
Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions	47

Appendix F: Strategic Analytics for Improvement and Learning (SAIL) Community Living
Center (CLC) Measure Definitions.....51

Appendix G: VISN Director Comments.....52

OIG Contact and Staff Acknowledgments53

Report Distribution54



Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) review is to evaluate leadership performance and oversight by VA Healthcare–Veterans Integrated Service Network (VISN) 4. This focused evaluation 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) leaders so that informed decisions can be made to improve 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.³ Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.⁴

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

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)

³ 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.)

⁴ 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.)

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 documents and administrative and performance measure data and discussed processes and validated findings with VISN leadership and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from December 12, 2015, through June 28, 2019, the last day of the unannounced week-long site visit.⁵

The review was performed during concurrent inspections of VISN 4's Coatesville VA Medical Center (VAMC) and VA Butler Health Care Center. 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 VISN completes corrective actions. The network 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.

⁵ The range represents the time from the last Combined Assessment Program review of two VISN 4 facilities inspected simultaneously within this VISN—and in this case, the Coatesville VAMC—to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the ability to provide care in all of the selected clinical and administrative areas of focus.⁶ To assess the VISN's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Access to care
5. Clinician vacancies
6. Oversight inspections
7. VHA performance data

Additionally, the OIG assessed VISN 4 efforts to reduce the rates of suicides, a leading cause of death in the United States.⁷

Executive Leadership Position Stability and Engagement

A VISN consists of a geographic area which encompasses a population of veteran beneficiaries. The VISN is defined based on VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VAMCs, clinics, and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is designed to be the basic budgetary and planning unit of the veterans health care system.⁸

VISN 4 is responsible for oversight of nine medical centers and 46 outpatient clinics. According to data from the VA National Center for Veterans Analysis and Statistics, VISN 4 had a veteran population of 1,089,176 within its borders at the end of FY 2016.

⁶ 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.)

⁷ The Centers for Disease Control and Prevention. *CDC VitalSigns*™, June 2018. <https://www.cdc.gov/violenceprevention/suicide/datasources.html>. (The website was accessed on April 12, 2019.)

⁸ Detailed explanation of VISNs provided by Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration, Department of Veterans Affairs, before the House Committee on Veterans' Affairs, May 22, 2018.

VISN 4 has a leadership team consisting of the acting network director, deputy network director, chief medical officer (CMO), and quality management officer (QMO). The CMO is responsible for overseeing facility-level patient care programs. Figure 2 illustrates the VISN’s reported organizational structure.

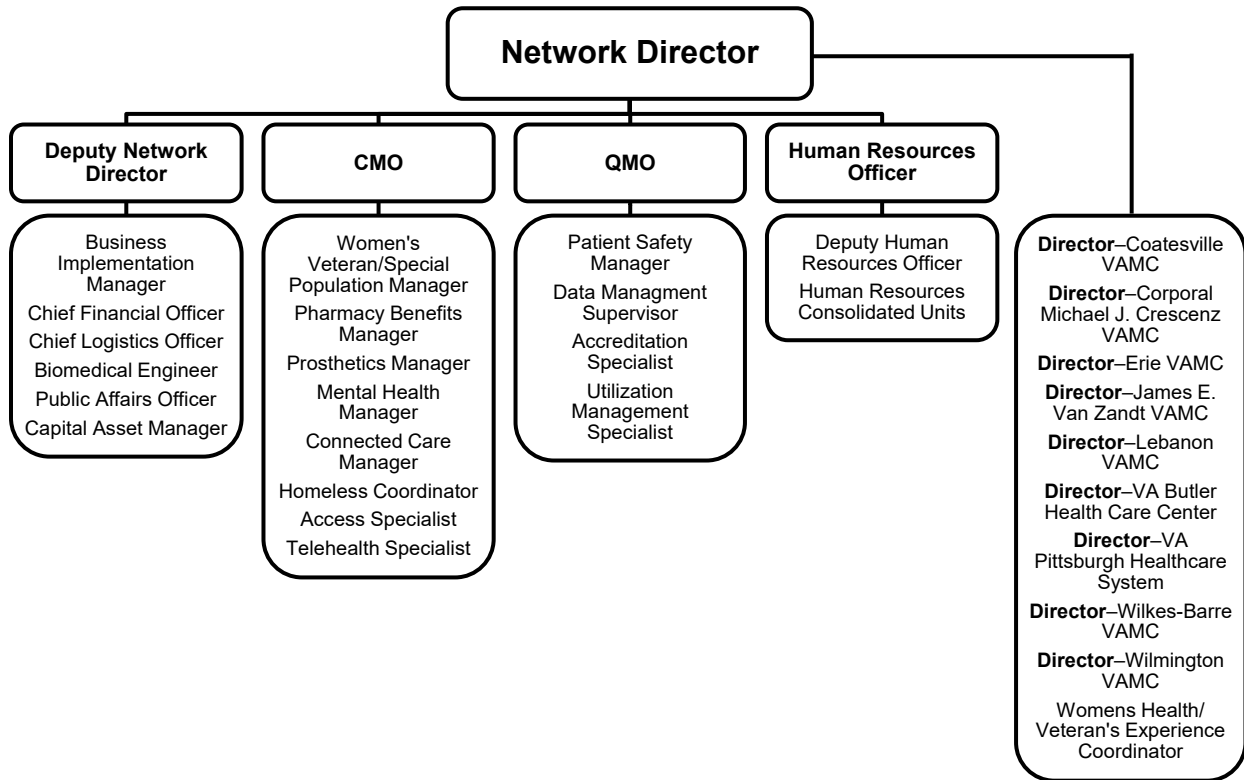


Figure 2. VISN 4 Organizational Chart⁹
Source: VA Healthcare–VISN 4 (received June 24, 2019)

At the time of the OIG site visit, the executive team was led by an acting network director, who had been assigned for one 120-day detail and was beginning a second 120-day detail. The rest of the executive team had been working together in a permanent capacity for 16 months (see Table 1).

⁹ For this VISN, the Network Director is responsible for the directors of the Coatesville VAMC, Corporal Michael J. Crescenzo VAMC, Erie VAMC, James E. Van Zandt VAMC, Lebanon VAMC, VA Butler Health Care Center, VA Pittsburgh Healthcare System, Wilkes-Barre VAMC, and Wilmington VAMC; and the Women’s Health/Veteran’s Experience Coordinator.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network Director	February 11, 2019 (acting) ¹⁰
Deputy Network Director	February 4, 2018
Chief Medical Officer	January 4, 2016
Quality Management Officer	June 7, 2015

Source: VA Healthcare–VISN 4 (received June 24, 2019)

To help assess VISN executive leaders’ engagement, the OIG interviewed the network director, deputy network director, CMO, and QMO regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

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

The leaders are members of the VISN’s Executive Committee of the Executive Leadership Council, which is responsible for processes that enhance network performance through:

- Conducting strategic planning
- Allocating financial resource
- Developing policies
- Managing performance
- Communicating with stakeholders
- Developing new leaders

The Executive Committee of the Executive Leadership Council, for which the network director serves as the chairperson, has oversight of various committees, including the Healthcare Delivery, Healthcare Operations, QSV, and Organizational Health Committees. See Figure 3.

¹⁰ The acting director was appointed VISN 4 Network Director effective September 1, 2019.

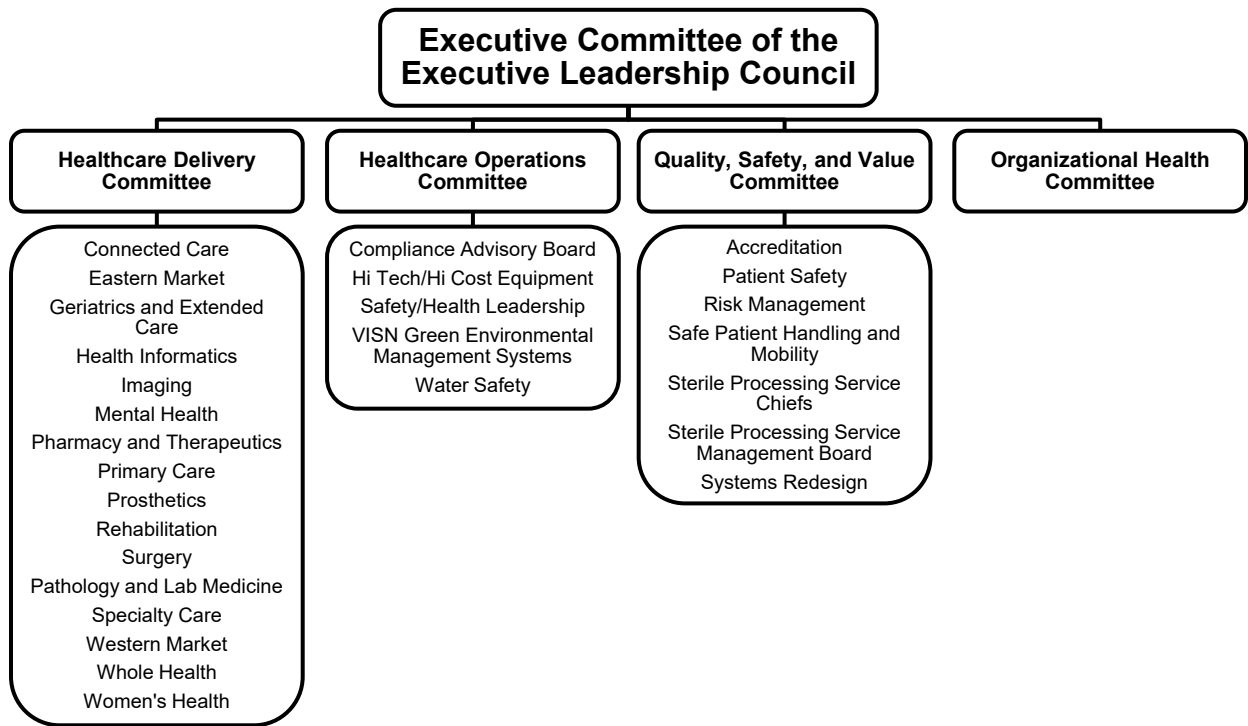


Figure 3. VISN 4 Committee Reporting Structure
Source: VA Healthcare—VISN 4 (received June 28, 2019)

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 VISN leadership.

To assess employee attitudes toward VISN and facility leaders, the OIG reviewed employee satisfaction survey results from VHA’s All Employee Survey that relate to the period of October 1, 2017, through September 30, 2018.¹¹ Table 2 summarizes employee attitudes as expressed in VHA’s All Employee Survey for VHA, the VISN office, and VISN leaders. The OIG found the

¹¹ Ratings are based on responses by employees who report to or are aligned under the network director, deputy network director, CMO, and QMO.

VISN office and leaders’ averages for the selected survey leadership questions were consistently higher than the VHA averages.¹²

**Table 2. Survey Results on Employee Attitudes toward VISN 4 Leadership
(October 1, 2017, through September 30, 2018)**

Questions/ Survey Items	Scoring	VHA Average	VISN 4 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average
All Employee Survey: <i>Servant Leader Index Composite</i> ¹³	0–100 where HIGHER scores are more favorable	71.7	86.0	92.1	80.0	80.4	98.1
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	4.1	4.4	3.6	4.1	4.6
All Employee Survey: <i>My organization’s senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	4.3	4.4	4.1	4.2	4.8

¹² 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. The VISN Director retired on January 31, 2019. It is important to note that the network director’s scores are not reflective of the director, who assumed the role after the survey was administered.

¹³ 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	VISN 4 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	4.0	4.1	3.7	4.1	4.5

Source: VA All Employee Survey (accessed November 14, 2018)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA’s All Employee Survey. Note that the VISN office and executive leadership team averages for the selected survey questions were also consistently better than the VHA averages. VISN leaders appear to be maintaining an environment where employees feel safe bringing forth issues and concerns.

Table 3. Survey Results on Employee Attitudes toward the VISN 4 Workplace (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	VISN 4 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	4.4	5.0	3.9	4.4	4.4
All Employee Survey: <i>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).</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	4.3	4.6	4.2	3.9	4.8

Questions/ Survey Items	Scoring	VHA Average	VISN 4 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average
All Employee Survey: <i>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)?</i>	0 (Never) – 6 (Every Day)	1.5	1.0	1.0	1.3	0.5	1.1

Source: VA All Employee Survey (accessed May 24, 2019)

Patient Experience

To assess patient attitudes toward VISN and 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 VISN 4 and compares the results to the overall VHA averages.¹⁴

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients’ attitudes toward VISN and facility leaders (see Table 4). The VISN averages for each of the selected survey questions are similar to or higher than the VHA averages, indicating that VISN 4 patients are generally more satisfied compared to VHA patients in general. VISN 4 facility scores for the selected questions are presented in Appendix B.

¹⁴ Ratings are based on responses by patients who received care within the VISN.

**Table 4. Survey Results on Patient Attitudes within VISN 4
(October 1, 2017, through September 30, 2018)**

Questions	Scoring	VHA Average	VISN 4 Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	66.9	66.1
Survey of Healthcare Experiences of Patients (inpatient): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	84.2	85.0
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.3	83.0
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.5	80.2

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

VHA also collects Inpatient, Patient-Centered Medical Home, and Specialty Care Survey SHEP data by gender. Over the last decade, the number of women using VA health care has nearly doubled; and, it is expected that by 2020, women veterans will comprise nearly 11 percent of the total veteran population. For this reason, it is important for VHA to provide accessible and inclusive care for women veterans.¹⁵

The OIG reviewed responses to several relevant survey questions that reflect patients’ attitudes toward care received in the VISN (see Tables 5–7). The VISN averages for women respondents for the selected Inpatient, Patient-Centered Medical Home, and Specialty Care Survey questions were higher than the corresponding VHA averages for women. VISN 4 facility scores for the

¹⁵ Altarum Institute. *Study of Barriers for Women Veterans to VA Health Care Final Report*, April 2015. The Deborah Sampson Act, Senate Bill 514 was introduced by Senator Jon Testor (D-Mont.) on February 14, 2019 with the goal of eliminating barriers to women veteran’s care and to require specific data to be tracked and reported so that VHA will be able to direct and focus resources where they are needed most. <https://www.congress.gov/bill/116th-congress/senate-bill/514/text>. (The website was accessed on June 12, 2019.)

selected questions are presented in Appendix B and note various opportunities for facility improvement.

**Table 5. Inpatient Survey Results on Patient Attitudes within VISN 4 by Gender
(October 1, 2017, through September 30, 2018)**

Questions	Scoring	VHA		VISN 4	
		Male Average	Female Average	Male Average	Female Average
<i>During this hospital stay, how often did doctors treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	83.6	81.4	83.0	90.9
<i>During this hospital stay, how often did nurses treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	82.7	81.9	83.5	89.1
<i>Would you recommend this hospital to your friends and family?</i>	The measure is calculated as the percentage of responses in the top category (Definitely yes).	67.4	59.5	66.0	67.3

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 24, 2019)

Table 6. Patient-Centered Medical Home Survey Results on Patient Attitudes within VISN 4 by Gender (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA		VISN 4	
		Male Average	Female Average	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.2	40.3	59.8	49.7
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	58.8	49.8	68.2	53.2
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	70.1	65.7	78.6	69.6

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 24, 2019)

Table 7. Specialty Care Survey Results on Patient Attitudes within VISN 4 by Gender (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA		VISN 4	
		Male Average	Female Average	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	47.6	43.2	53.1	63.5
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	55.2	50.7	59.1	54.5
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	68.7	65.5	72.7	76.9

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 24, 2019)

During OIG interviews, VISN leaders described their quarterly review of women veteran data for patient satisfaction and reportedly identified concerns with the Choice program, availability of specialty providers, and facility hours. The VISN leaders also monitored response times for the Women Veterans Call Center and ensured that VISN facilities arranged appointments or answered their non-urgent questions within three days. Lastly, the VISN also tracked and compared male and female scores for clinical diabetic control and statin use.

Access to Care

A VA priority is achieving and maintaining an optimal workforce to ensure timely access to the best care and benefits for our nation's veterans. VHA has a goal of providing patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred

date if a clinically indicated date is not provided.¹⁶ VHA has utilized various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates.¹⁷ Wait time measures based on “create date” have the advantage of not relying upon the accuracy of the “preferred date” entered into the scheduling system and are particularly applicable for new primary care patients where the care is not initiated by referral, or consultation, that includes a “clinically indicated date.” The disadvantage to “create date” metrics is that wait times do not account for specific patient requests/availability. Wait time measures based on patient preferred dates consider patient preferences but rely upon appointment schedulers accurately recording the patients’ wishes into the scheduling software.¹⁸

When patients could not be offered appointments within 30 days of clinically indicated or preferred dates, patients became eligible to receive non-VA (community) care through the VA Choice program—eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.¹⁹ However, with the passage of the VA MISSION Act of 2018 on June 6, 2018, and subsequent enactment on June 6, 2019, eligibility criteria for obtaining care in the community now include average drive times and appointment wait times:²⁰

- Average drive time
 - 30-minute average drive time for primary care, mental health, and non-institutional extended care services
 - 60-minute average drive time for specialty care
- Appointment wait time
 - 20 days for primary care, mental health care, and non-institutional extended care services, unless the veteran agrees to a later date in consultation with a VA health care provider

¹⁶ According to VHA Directive 1230(1), *Outpatient Scheduling Processes and Procedures*, July 15, 2016 (amended July 12, 2019), the “Clinically Indicated Date (CID) is the date an appointment is deemed clinically appropriate by a VA health care provider. The CID is contained in a provider entered Computerized Patient Record System (CPRS) order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request... The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity.”

¹⁷ Completed appointments cube data definitions, <https://biooffice.pa.cdw.va.gov/>. (The website was accessed on March 28, 2019.)

¹⁸ Office of Veterans Access to Care, *Specialty Care Roadmap*, November 27, 2017.

¹⁹ VHA Directive 1700, *Veterans Choice Program*, October 25, 2016.

²⁰ VA Office of Public Affairs Media Relations, *Fact Sheet: Veteran Community Care – Eligibility, VA MISSION Act of 2018*, April 2019. <https://www.missionact.va.gov/library/files/MISSION-Act-Veteran-Community-Care-Eligibility-Fact-Sheet.pdf>. (This website was accessed on June 27, 2019.)

- 28 days for specialty care from the date of request, unless the veteran agrees to a later date in consultation with a VA health care provider

To assess access to primary and mental health care within VISN 4, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics for the most recently completed quarter. Tables 8 and 9 provide wait time statistics for completed primary care and mental health appointments from January 1, 2019, through March 31, 2019.

**Table 8. Primary Care Appointment Wait Times
(January 1, 2019, through March 31, 2019)**

Facility	New Patient Appointments	Average New Patient Wait from Create Date
VA Healthcare–VISN 4	5,899	18.1
Coatesville VAMC (Coatesville, PA)	340	14.1
Corporal Michael J. Crescenz VAMC (Philadelphia, PA)	1,194	30.5
Erie VAMC (Erie, PA)	336	16.6
James E. Van Zandt VAMC (Altoona, PA)	267	19.5
Lebanon VAMC (Lebanon, PA)	983	13.8
VA Butler Health Care Center (Butler, PA)	396	10.6
VA Pittsburgh HCS (Pittsburgh, PA)	926	16.1
Wilkes-Barre VAMC (Wilkes-Barre, PA)	747	12.5
Wilmington VAMC (Wilmington, DE)	710	18.0

Source: VHA Support Service Center (accessed May 24, 2019)

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

**Table 9. Mental Health Appointment Wait Times²¹
(January 1, 2019, through March 31, 2019)**

Facility	New Patient Appointments	Average New Patient Wait from Create Date
VA Healthcare–VISN 4	2,004	9.6
Coatesville VAMC, (Coatesville, PA)	112	4.7
Corporal Michael J. Crescenz VAMC (Philadelphia, PA)	263	10.9
Erie VAMC (Erie, PA)	133	6.1
James E. Van Zandt VAMC (Altoona, PA)	142	21.9
Lebanon VAMC (Lebanon, PA)	261	8.6
VA Butler Health Care Center (Butler, PA)	76	3.6
VA Pittsburgh HCS (Pittsburgh, PA)	402	3.6
Wilkes-Barre VAMC (Wilkes-Barre, PA)	286	11.0
Wilmington VAMC (Wilmington, DE)	329	17.4

Source: VHA Support Service Center (accessed May 24, 2019)

Based upon wait times alone, the MISSION Act may improve access to primary care for patients in the Corporal Michael J. Crescenz VAMC, where the average wait time for new primary care appointments is 30.5 days, and the James E. Van Zandt VAMC, where the average wait time for new mental health appointments is 21.9 days. The wait times also highlight opportunities for these facilities to improve the timeliness of primary care provided “in house” and, thus decrease the potential for fragmented care among those who are referred to community providers.

To improve wait times, VISN 4 facilities offer “Video on Demand” appointments through the VA Video Connect program for routine appointments and for patients who cancel their traditional scheduled appointment at the healthcare facility within 48 hours of that scheduled appointment.²² VISN 4 also utilizes mental health providers at the VA Pittsburgh HCS and the

²¹ Reported mental health wait times are for appointments designated as clinic stop 502, Mental Health Clinic Individual, and records visits for the evaluation, consultation, and/or treatment by staff trained in mental diseases and disorders.

²² VA Video Connect connects veterans with their health care team from anywhere, using encryption to ensure a secure and private session. This technology makes VA health care more convenient and reduces travel times for veterans, especially those in very rural areas with limited access to VA health care facilities, and allows quick and easy health care access from any mobile or web-based device.

VA New York Harbor HCS (Manhattan, NY)²³ to see VISN 4 patients through existing telehealth services.

Clinician Vacancies

Within the healthcare field, there is general acceptance that staff turnover, or instability, and high clinical vacancy rates negatively impact access to care, quality of health care provided, patient safety, and patient and staff satisfaction. Turnover can directly affect staffing levels and further reduce staff and organizational performance through the loss of experienced staff.²⁴

To assess the extent of clinical vacancies across VISN 4 facilities, the OIG requested and reviewed the number of vacancies by facility, position, service/section, and full-time employee equivalents (FTE). Table 10 provides the vacancy rates across the VISN for physicians, physician assistants, nurses, and physical therapists as of June 27, 2019.

**Table 10. Reported Vacancy Rates for VISN 4 Facilities
(as of June 27, 2019)**

Facility	Clinical Vacancies	Clinical Vacancy Rate	Total Vacancy Rate
Coatesville VAMC (Coatesville, PA)	23	5%	1.25%
Corporal Michael J. Crescenz VAMC (Philadelphia, PA)	90	21%	4.88%
Erie VAMC (Erie, PA)	14	3%	0.76%
James E. Van Zandt VAMC (Altoona, PA)	11	3%	0.60%
Lebanon VAMC (Lebanon, PA)	84	19%	4.56%
VA Butler Health Care Center (Butler, PA)	18	4%	0.98%
VA Pittsburgh HCS (Pittsburgh, PA)	109	25%	5.91%
Wilkes-Barre VAMC (Wilkes-Barre, PA)	47	11%	2.55%
Wilmington VAMC (Wilmington, DE)	36	8%	1.95%

Source: VISN 4 human resources officer (received June 27, 2019)

Upon closer inspection, the OIG found clinical vacancies across VISN 4 for physicians (~130 FTE), nurses (~270 FTE), physician assistants (~20 FTE), and physical therapists (~7 FTE). Given the potential opportunities to improve primary care wait times at Corporal Michael J. Crescenz VAMC and mental health wait times at James E. Van Zandt VAMC, the OIG also reviewed the number of clinical vacancies related to these specialties. Clinical staffing may be a

²³ VA New York Harbor HCS (Manhattan, NY) is part of VISN 2: New York/New Jersey VA Health Care Network.

²⁴ J. Buchanan, “Reviewing the Benefits of Health Workforce Stability,” *Human Resources for Health* 8, no. 29 (2010).

contributing factor for primary care wait time challenges at Corporal Michael J. Crescenz VAMC, where 6.5 primary care, family practice, and general internal medicine FTE were vacant.

The VISN also reportedly plans to sustain current staffing and increase positions at both the Mental Health (Pittsburgh) and Primary Care (Wilmington) VISN Clinical Resource Telehealth Hubs through the acceptance of VA Office of Rural Health funds²⁵ for fiscal years 2020 and 2021. The Pittsburgh and Wilmington Telehealth Hubs bring specialty staff and services closer to the veteran's home. Veterans connect with VA health specialists in medical centers from the veteran's community clinic. Providers perform exams, make diagnoses, and manage care virtually.

VISN Efforts to Reduce Veteran Suicide

Suicide is a leading cause of death in the United States, and suicide rates in almost all states increased from 1999 through 2016.²⁶ Although the unadjusted rate of suicide among veterans decreased from 30.5 to 30.1 per 100,000 veterans from 2015 to 2016, the suicide rate for veterans age 18–34 has risen substantially since 2005. With approximately 20 million veterans in United States, the number of veterans who die by suicide annually is significant.²⁷ Further, the issue of suicide has garnered recent Congressional and media interest given the suicides of three veterans at VA facilities in Georgia and Texas within five days of each other in April 2019.

VA has made suicide prevention its top priority with the Office of Mental Health and Suicide Prevention implementing significant suicide prevention initiatives: expanding the Veterans Crisis Line to three call centers; launching a suicide prevention training video;²⁸ implementing the Mayor's Challenge;²⁹ and partnering with the departments of Defense and Homeland Security to support veterans during their transition from military to civilian life.³⁰

²⁵ In 2006, the VA Office of Rural Health was established under 38 USC § 2006 to coordinate care for the millions of veterans who reside in rural communities.

²⁶ The Centers for Disease Control and Prevention, *CDC Vital signs*TM, June 2018.

²⁷ Office of Mental Health and Suicide Prevention, U.S. Department of Veterans Affairs, February 5, 2019. https://www.mentalhealth.va.gov/suicide_prevention/. (The website was accessed on April 12, 2019.)

²⁸ VA Operation S.A.V.E. outlines steps for staff to help veterans—Signs of suicidal thinking, Ask questions, Validate the veteran's experience, Encourage treatment, and Expedite getting help. <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4071>. (The website was accessed on June 21, 2019.)

²⁹ "The Mayor's Challenge was launched in March 2018, bringing together representatives of eight cities to develop local action plans to prevent Veteran suicide. Since then, the Mayor's Challenge program has expanded to a total of 24 cities. An inaugural Governor's Challenge that involved seven state teams took place in February, replicating the effort on the state level. Participants in both programs form interagency teams to bolster Veteran suicide-prevention efforts in their communities." <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5230>. (The website was accessed on December 10, 2019.)

³⁰ Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016*, September 2018.

Interviewed leaders were knowledgeable about efforts taken to reduce veteran suicide in VISN 4 and shared information that highlighted efforts to develop and implement strategies for high-risk veterans. VISN 4 outreach efforts include assignment of the VISN mental health chief as the co-chair of the state level suicide prevention subcommittee of the Governor’s Advisory Council’s Veteran’s Health Promotion Committee; coordination with the Allegheny County court system to transfer veterans involuntarily committed under Pennsylvania law to the VA Pittsburgh HCS for care and judicial review;³¹ and implementation of a program developed at the Lebanon VAMC, which records a “save” in the veteran’s electronic health record. A “save” is any veteran encounter in which staff have a concern of suicidal or homicidal ideation resulting in emergency interventions or care such as a warm handoff to the emergency department, a call to 911, or initiation of a health and welfare check. Electronic health record notes annotated with “save” can be analyzed to determine if staff actions resulted in a “save” and where the veteran was receiving care (for example, mental health, primary care, or Housing and Urban Development–VA Supportive Housing (HUD–VASH³²)) when actions were initiated.

VISN leadership cited that resources and funding for VHA suicide prevention efforts were generally satisfactory; however, VISN leaders suggested that increased resources for coordination with local outreach programs could help identify and assist at-risk veterans who are not enrolled in the VHA system.

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders respond to identified problems. Except for those made in recently published reports, VISN and facility leaders have closed all recommendations for improvement listed in Appendix C.³³

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

³¹ The Pennsylvania law pertaining to mental health voluntary and involuntary commitments may be found at 55 Pa. Code § 5100.71 *et seq.*

³² U.S. Department of Housing and Urban Development–VA Supportive Housing, HUD–VASH, is a collaborative program between HUD and VA combines HUD housing vouchers with VA supportive services to help Veterans who are homeless and their families find and sustain permanent housing. <https://www.va.gov/homeless/hud-vash.asp>. (The website was accessed on August 1, 2019.)

³³ A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations.

“understand the similarities and differences between the top and bottom performers” within VHA.³⁴

VA also uses a star-rating system where VISNs and facilities with a “5-star” rating are performing within the top 10 percent and “1-star” VISNs and facilities are performing within the bottom 10 percent. As of June 30, 2018, VISN 4 was rated at “5-star” for overall quality. Table 11 summarizes the SAIL star-ratings for facilities within the VISN.

**Table 11. VISN 4 Facility SAIL Star-Ratings for Overall Quality
(as of June 30, 2018)**

Facility	Star Rating
Coatesville VAMC (Coatesville, PA)	5
Corporal Michael J. Crescenz VAMC (Philadelphia, PA)	3
Erie VAMC (Erie, PA)	5
James E. Van Zandt VAMC (Altoona, PA)	4
Lebanon VAMC, (Lebanon, PA)	5
VA Butler Health Care Center (Butler, PA)	5
VA Pittsburgh HCS (Pittsburgh, PA)	4
Wilkes-Barre VAMC (Wilkes-Barre, PA)	3
Wilmington VAMC (Wilmington, DE)	3

Source: VHA Support Service Center (accessed April 5, 2019)

Figure 4 illustrates the VISN’s quality of care and efficiency metric rankings and performance as of December 31, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of rating (of) primary care (PC) and mental health (MH) providers, MH experience (Exp) of care, and rating (of) hospital). Metrics that need improvement are denoted in orange (for example, admit reviews met, and complications).³⁵

³⁴ VHA Support Service Center (VSSC), *The Strategic Analytics for Improvement and Learning (SAIL) Value Model*, <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

³⁵ For information on the acronyms in the SAIL metrics, please see Appendix D.

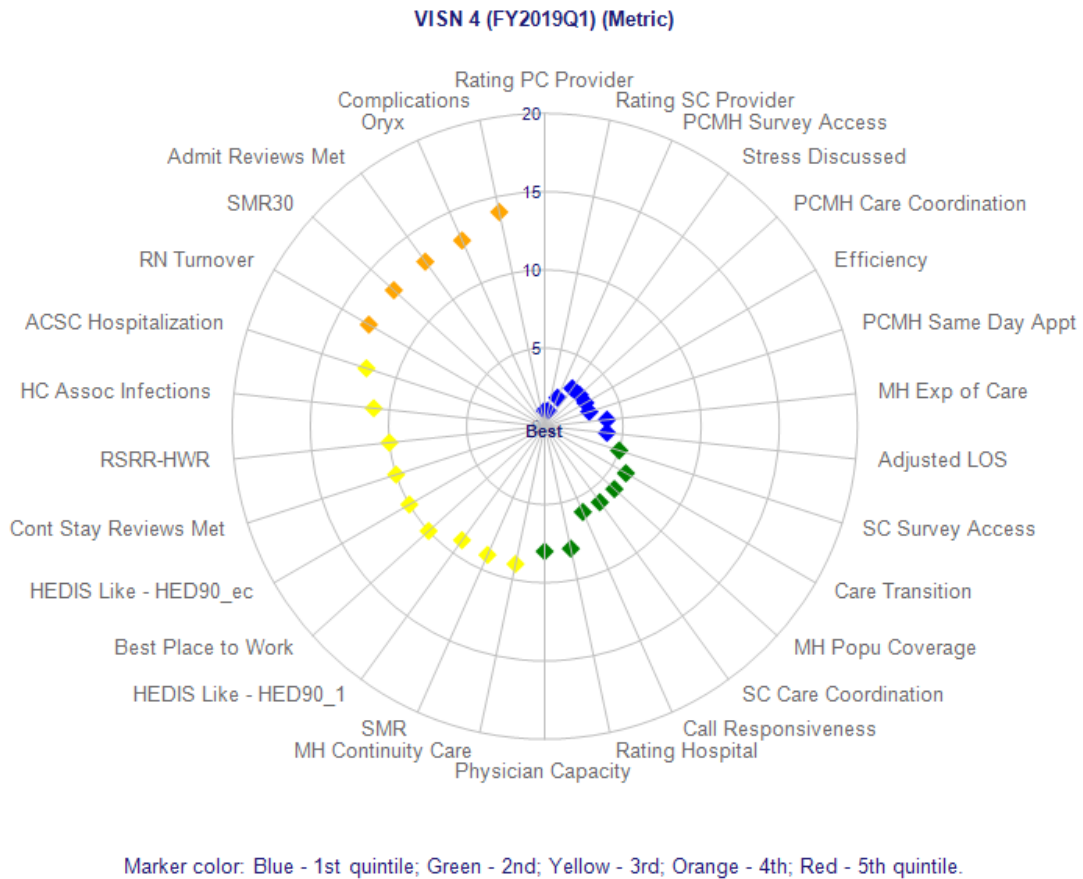


Figure 4. Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)

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.

To address complications and admission review rates, the VISN QMO, in conjunction with the Corporal Michael J. Crescenz VAMC (Philadelphia, PA) director and QMO, developed an action plan to conduct daily reviews of in-hospital complication rates and accomplish prompt physician utilization management review of patients not meeting criteria upon admission. Preliminary results showed improvement for complication rates and increased staff to completion of admission reviews.

The SAIL Value Model also includes “SAIL CLC,” which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in

the Centers for Medicare & Medicaid Services’ (CMS) *Nursing Home Compare*.³⁶ The SAIL CLC provides a single resource to review quality measures and health inspection results. It includes star ratings for an unannounced survey, staffing, quality, and overall results.³⁷ Table 12 summarizes the rating results for the facility CLCs within the VISN as of June 30, 2018.

**Table 12. VISN 4 CLC SAIL Star-Ratings
(as of March 31, 2019)**

CLC Location	Unannounced Survey Star Rating	Staffing Star Rating	Quality Star Rating	Overall Star Rating
Altoona, PA	4	5	2	5
Butler, PA	3	5	2	4
Coatesville, PA	5	5	2	5
Erie, PA	5	5	3	5
Lebanon, PA	5	5	2	5
Philadelphia, PA	2	5	5	4
Pittsburgh, PA	3	5	2	4
Wilkes-Barre, PA	4	5	5	5
Wilmington, DE	4	5	4	5

Source: VHA Support Service Center (accessed April 5, 2019)

The SAIL CLC also includes a radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 5 illustrates the VISN’s CLC quality rankings and performance compared with other VA CLCs as of March 31, 2019. The figure uses blue and green data points to indicate high performance (for example, in the areas of moderate-severe pain—long stay and short stay (LS and SS) and high-risk pressure ulcer (LS)). Measures that need improvement are denoted in orange and red (for example, new or worse pressure ulcer

³⁶ According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, August 22, 2019, “In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several “star” ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes.”

³⁷ *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>. (The website was accessed on September 3, 2019, but is not accessible by the public.)

(PU)—SS, newly received antipsych meds—SS, and help with activities of daily living (ADL)—SS)).³⁸

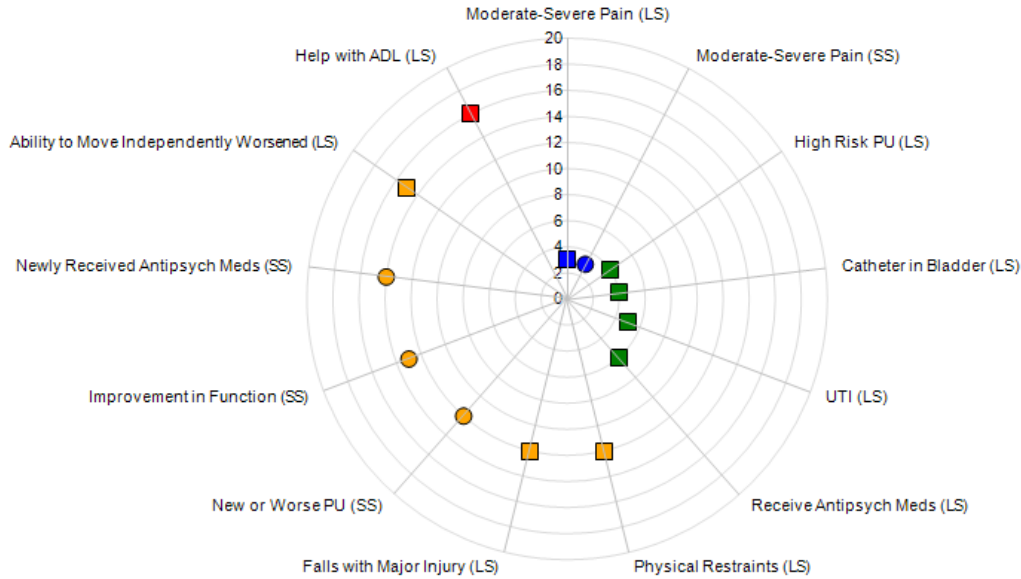


Figure 5. CLC Quality Measure Rankings (as of March 31, 2019)

LS = Long-Stay Measure SS = Short-Stay Measure

Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness. For data definitions, see Appendix E.

The VISN leaders acknowledged issues with the quality ratings and Long Term Care Institute unannounced survey findings, which prompted the development of an action plan to improve scores in dignity, grievance resolution, and accommodation of resident needs. The VISN has also disseminated a best practice for pressure ulcer care developed by a system redesign team at Coatesville VAMC. The team standardized processes on all units, which eliminated variation, improved documentation accuracy, reduced facility-acquired pressure injuries, and shortened rounding time. A system of interdisciplinary collaboration for prevention, assessment, diagnosis, and treatment of tissue trauma was created, which showed an 87 percent reduction in facility-acquired pressure injuries.

Leadership and Organizational Risks Conclusion

The VISN’s executive leadership team appeared stable, with the deputy director, CMO, and QMO serving together for the past 16 months prior to OIG’s on-site visit. The acting network

³⁸ For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.

director was in the role since the retirement of the previous network director in February 2019. Selected survey scores related to employees' satisfaction with the VISN executive team leaders were consistently better than VHA averages. In review of patient experience survey data, the OIG noted VISN averages for each of the selected survey questions were similar to or higher than the VHA averages. The VISN leaders appeared actively engaged with employees and patients and were working to sustain and further improve employee and patient engagement and satisfaction. The executive team leaders seemed to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as engaging with state entities and stakeholders to improve care for high-risk veterans, providing accessible and inclusive care for women veterans, implementing the “save” program across the network, and sustaining staffing for the Telehealth Hubs).

The OIG's review of access metrics and clinician vacancies did not identify any substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and CLC metrics and should continue to take actions to sustain and improve performance of measures contributing to the SAIL “5-star” quality ratings and care provided throughout VISN 4.

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.³⁹ VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.⁴⁰ VHA requires that VISNs establish a standing committee under an enterprise framework to review data, information, and risk intelligence and to ensure that key quality, safety, and value (QSV) functions are discussed and integrated on a regular basis.⁴¹

In determining whether the VISN implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV, the inspection team interviewed VISN managers and reviewed meeting minutes and other relevant documents. Specifically, the OIG evaluated the following VISN-level performance indicators:

- Standing VISN committee with responsibility for key QSV functions
 - Committee met at least quarterly
 - Committee chaired or co-chaired by the VISN Director
 - Committee reviewed aggregated QSV data and took necessary actions
- Completion of at least 75 percent of all required inpatient reviews⁴²
- Collection, analysis, and action, as appropriate, in response to VISN peer review data⁴³

The OIG also interviewed VISN managers and evaluated relevant documents when concurrent VISN facility CHIP reviews identified trends in noncompliance.

³⁹ 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.)

⁴⁰ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

⁴¹ VHA Directive 1026.

⁴² VHA Directive 1117(2) *Utilization Management Program*, July 9, 2014 (amended April 30, 2019). This directive expired July 31, 2019.

⁴³ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

Quality, Safety, and Value Conclusion

Generally, the VISN met requirements as reflected by the performance indicators above. Facility-level CHIP reviews within the VISN did not identify patterns or trends in noncompliance. The OIG made no recommendations.

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).⁴⁴

VHA also requires network directors to “maintain an appropriate credentialing and privileging process consistent with the VHA policy” and specifically charges VISN chief medical officers (CMOs) with “oversight of the credentialing and privileging process of the facilities within the VISN.”⁴⁵

The OIG interviewed VISN managers and evaluated relevant documents when concurrent VISN facility CHIP reviews identified trends in noncompliance.

Medical Staff Privileging Conclusion

The OIG identified a trend in noncompliance during CHIP reviews related to focused professional practice evaluations (FPPEs) and ongoing professional practice evaluations (OPPEs) that warranted a recommendation for improvement.

Specifically, VHA requires that the Executive Committee of the Medical Staff document its decision to grant privileges based on FPPE and OPPE results. The OIG found that the respective Executive Committees of the Medical Staff did not consistently document its decision to recommend privileges for LIPs based on FPPE and OPPE results at the Coatesville VAMC and VA Butler Health Care Center. This could impede the review of pertinent data used to recommend privileges for LIPs. The CMO was unaware of the observed trend in noncompliance as this issue was not apparent during site visits with facility chiefs of staff.

Recommendation 1

1. The chief medical officer ensures that facilities’ Executive Committees of the Medical Staff document its decision to recommend privileges for licensed independent practitioners based on focused and ongoing professional practice evaluation results and monitors facilities’ committee compliance.

⁴⁴ 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.)

⁴⁵ VHA Handbook 1100.19.

VISN concurred.

Target date for completion: July 31, 2020

VISN response: The VISN 4 Chief Medical Officer or designee will review privilege documentation for the last meeting minutes of all VISN 4 Executive Committees of the Medical Staff. Based on the results of the review standardized verbiage will be developed to include recommended requirements at time of appointment and reappointment for documenting privileges at each facility's Executive Committee of the Medical Staff. The plan regarding the minutes review and standardized verbiage actions will be communicated to all Chiefs of Staff during the next Healthcare Delivery Committee. An Audit will be developed to ensure ongoing compliance with the standardized verbiage. Compliance will be measured at 90% for six consecutive months. Results of the compliance audit will be reported to the Healthcare Delivery Committee of which the Chief Medical Officer is the chair.

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.⁴⁶ To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.⁴⁷

The OIG interviewed VISN managers and reviewed meeting minutes and other relevant documents. Specifically, the OIG evaluated the following VISN-level performance indicators:⁴⁸

- Establishment of VISN policy that maintains a comprehensive environment of care program at the VISN level
- Establishment of a VISN Emergency Management Committee (EMC) that⁴⁹
 - Met at least quarterly
 - Documented an annual review of the VISN Emergency Operation Plan (EOP) within the previous 12 months
 - Documented an annual review of the VISN Continuity of Operation Plan within the previous 12 months
 - Documented an annual review of the VISN Hazard Vulnerability Analysis within the previous 12 months
 - Conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leadership for review and approval
- Assessment of inventory management programs through a quality control review once per FY⁵⁰

⁴⁶ VHA Directive 1608, *Comprehensive Environment of Care (CEOC Program)*, February 1, 2016.

⁴⁷ VHA Directive 1608.

⁴⁸ For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

⁴⁹ VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

⁵⁰ VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016.

Environment of Care Conclusion

The OIG found evidence of a written policy that establishes and maintains a comprehensive environment of care program and inventory management programs assessed through a quality control once per fiscal year. The OIG did not identify any patterns or trends during CHIP reviews within the VISN. However, the OIG identified a deficiency with a VISN EMC requirement that warranted a recommendation for improvement.

VHA requires VISNs to establish an EMC that meets at least quarterly; documents an “annual review of the VISN [Office] EOP [Emergency Operations Plan], Continuity of Operations Plan, and Hazard Vulnerability Analysis;” and conducts, documents, and sends an annual review of the “collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement...to VISN leadership for review and approval.”⁵¹ The OIG found that the VISN had not established a VISN EMC. This resulted in a potential lack of communication to the network director about the VISN emergency management needs. The capital asset manager cited leadership fluctuations (network director and deputy director) starting in 2015 and the departure of the emergency manager approximately 2.5 years ago (the position was still vacant at the time of the on-site inspection) that delayed the establishment of a VISN EMC.

Recommendation 2

2. The network director ensures the establishment of a Veterans Integrated Service Network emergency management committee and implementation of all committee requirements.

VISN concurred.

Target date for completion: November 30, 2020

VISN response: VISN 4 will complete a charter and establish an emergency management committee. The emergency management committee will be tasked with the development and establishment of the VISN 4 emergency operations plan, the continuity of operations plan, conduct Hazard Vulnerability Analysis and create a framework to conduct, document and send an annual review of the collective VISN 4 wide strengths, weaknesses, priorities and requirements for improvement to VISN 4 Network Director or Deputy Network Director through the VISN 4 Healthcare Operations Committee. The VISN 4 Healthcare Operations Committee minutes are forwarded to the Executive Leadership Council of which the Network Director is chair.

⁵¹ VHA Directive 0320.01.

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.⁵² 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.⁵³

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. VHA also requires VISN and facility quality managers to review controlled substances inspection quarterly trend reports to ensure adherence with program requirements and that facilities take corrective actions when needed.⁵⁴

The OIG interviewed VISN managers and evaluated relevant documents to assess whether the QMO reviewed facility controlled substances inspections quarterly trend reports and when concurrent facility-level CHIP reviews within the VISN identified patterns or trends in noncompliance.

Medication Management Conclusion

Generally, the VISN met the requirement for the QMO review of facility controlled substances inspections quarterly trend reports. Facility-level CHIP reviews within the VISN did not identify patterns or trends in noncompliance. The OIG made no recommendations.

⁵² Drug Enforcement Agency Controlled Substance Schedules. <https://www.deadiversion.usdoj.gov/schedules/>. (The website was accessed on March 7, 2019.)

⁵³ 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.

⁵⁴ VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

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	<ul style="list-style-type: none"> • Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Access to care • Clinician vacancies • VISN efforts to reduce veteran suicides • Oversight inspections • VHA performance data 	Two OIG recommendations that can lead to patient and staff safety issues or adverse events are attributable to the network director and chief medical officer. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • Standing VISN committee with responsibility for key QSV functions • Completion of at least 75 percent of all required inpatient reviews • Collection, analysis, and action, as appropriate, in response to VISN peer review data • Facility-level CHIP indicators: <ul style="list-style-type: none"> ○ Protected peer reviews ○ UM reviews ○ Patient safety ○ Resuscitation episode review 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	<ul style="list-style-type: none"> • Facility-level CHIP indicators: <ul style="list-style-type: none"> ○ Privileging ○ FPPEs ○ OPPEs ○ FPPEs for cause ○ Reporting of privileging actions to National Practitioner Data Bank 	<ul style="list-style-type: none"> • Facilities' Executive Committee of the Medical Staff document its decision to recommend continuing privileges for LIPs based on FPPE and OPPE results. 	<ul style="list-style-type: none"> • None
Environment of Care	<ul style="list-style-type: none"> • Establishment of VISN policy that maintains a comprehensive environment of care program at the VISN level • Establishment of a VISN Emergency Management Committee • Assessment of inventory management programs through a quality control review once per FY • Facility-level CHIP indicators: <ul style="list-style-type: none"> ○ Parent facility ○ Community based outpatient clinic ○ Locked inpatient mental health unit ○ Emergency management 	<ul style="list-style-type: none"> • The VISN establishes a VISN emergency management committee and implementation of all committee requirements. 	<ul style="list-style-type: none"> • None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	<ul style="list-style-type: none"> • VISN quality management officer review of facility quarterly trend reports • Facility-level CHIP indicators: <ul style="list-style-type: none"> ○ Controlled substances coordinator reports ○ Pharmacy operations ○ Controlled substances inspector requirements ○ Controlled substances area inspections ○ Pharmacy inspections ○ Facility review of override reports 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

Appendix B: VISN 4 Profile

The table below provides general background information for VISN 4.

**Table B.1. Profile for VISN 4
(October 1, 2015, through September 30, 2018)**

Profile Element	VISN Data FY 2016 ⁵⁵	VISN Data FY 2017 ⁵⁶	VISN Data FY 2018 ⁵⁷
Total medical care budget in dollars	\$2,504,857,780	\$2,554,820,807	\$2,680,816,722
Number of:			
• Unique patients	298,003	299,315	306,491
• Outpatient visits	3,438,843	3,467,119	3,565,534
• Unique employees ⁵⁸	10,709	11,128	11,198
Type and number of operating beds:			
• Community living center	1,057	1,057	1,014
• Domiciliary	385	385	393
• Hospital	594	594	584
• Residential rehabilitation	42	42	42
Average daily census:			
• Community living center	697	704	684
• Domiciliary	304	315	298
• Hospital	363	385	344
• Residential rehabilitation	37	32	28

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

⁵⁵ October 1, 2015, through September 30, 2016.

⁵⁶ October 1, 2016, through September 30, 2017.

⁵⁷ October 1, 2017, through September 30, 2018.

⁵⁸ Unique employees involved in direct medical care (cost center 8200).

Appendix C: Survey Results

**Table C.1. Survey Results on Patient Attitudes within VISN 4
(October 1, 2017, through September 30, 2018)⁵⁹**

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	VHA	66.9
		VISN 4	66.1
		Altoona, PA	75.9
		Butler, PA	n/a
		Coatesville, PA	n/a
		Erie, PA	72.7
		Lebanon, PA	76.5
		Philadelphia, PA	55.3
		Pittsburgh, PA	68.3
		Wilkes-Barre, PA	68.2
		Wilmington, DE	70.6
Survey of Healthcare Experiences of Patients (inpatient): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	VHA	84.2
		VISN 4	85.0
		Altoona, PA	92.7
		Butler, PA	n/a
		Coatesville, PA	n/a
		Erie, PA	91.0
		Lebanon, PA	90.4
		Philadelphia, PA	79.6
		Pittsburgh, PA	85.9
		Wilkes-Barre, PA	86.9
		Wilmington, DE	85.2

⁵⁹ VA Butler Health Care Center and Coatesville VAMC do not provide inpatient medical services, therefore, the score is marked not applicable.

Questions	Scoring	Facility	Average Score
<i>Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	VHA	76.3
		VISN 4	83.0
		Altoona, PA	83.8
		Butler, PA	86.4
		Coatesville, PA	84.7
		Erie, PA	85.5
		Lebanon, PA	86.5
		Philadelphia, PA	79.8
		Pittsburgh, PA	85.9
		Wilkes-Barre, PA	80.3
		Wilmington, DE	78.1
<i>Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	VHA	76.5
		VISN 4	80.2
		Altoona, PA	83.5
		Butler, PA	81.2
		Coatesville, PA	81.9
		Erie, PA	85.9
		Lebanon, PA	81.9
		Philadelphia, PA	75.6
		Pittsburgh, PA	84.4
		Wilkes-Barre, PA	78.3
		Wilmington, DE	75.7

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

n/a = Not applicable

**Table C.2. Inpatient Survey Results by Gender within VISN 4
(October 1, 2017, through September 30, 2018)⁶⁰**

Questions	Scoring	Facility	Male Average	Female Average
<i>During this hospital stay, how often did doctors treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	VHA	83.6	81.4
		VISN 4	83.0	90.9
		Altoona, PA	82.8	—
		Butler, PA	n/a	n/a
		Coatesville, PA	n/a	n/a
		Erie, PA	82.7	—
		Lebanon, PA	88.9	87.7
		Philadelphia, PA	83.2	90.6
		Pittsburgh, PA	81.9	100
		Wilkes-Barre, PA	81.3	57.4
		Wilmington, DE	87.0	—
<i>During this hospital stay, how often did nurses treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	VHA	82.7	81.9
		VISN 4	83.5	89.1
		Altoona, PA	89.9	—
		Butler, PA	n/a	n/a
		Coatesville, PA	n/a	n/a
		Erie, PA	91.4	—
		Lebanon, PA	87.6	88.2
		Philadelphia, PA	76	77.6
		Pittsburgh, PA	84.4	93.2
		Wilkes-Barre, PA	88.2	93.9
		Wilmington, DE	89.3	91.6

⁶⁰ Butler and Coatesville do not provide inpatient medical services, therefore, the score is marked not applicable. For Altoona and Erie, the number of respondents was too low to calculate a statistically reliable score, therefore, cells in the table for which data is not available are left blank.

Questions	Scoring	Facility	Male Average	Female Average
<i>Would you recommend this hospital to your friends and family?</i>	The reporting measure is calculated as the percentage of responses in the top category (Definitely yes).	VHA	67.4	59.5
		VISN 4	66.0	67.3
		Altoona, PA	73.9	—
		Butler, PA	n/a	n/a
		Coatesville, PA	n/a	n/a
		Erie, PA	71.8	—
		Lebanon, PA	76.3	78.9
		Philadelphia, PA	55.7	46.9
		Pittsburgh, PA	68.1	72.5
		Wilkes-Barre, PA	68.4	62.5
		Wilmington, DE	70.6	70.5

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 24, 2019)

Table C.3. Patient-Centered Medical Home Survey Results by Gender within VISN 4 (October 1, 2017, through September 30, 2018)⁶¹

Questions	Scoring	Facility	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	VHA	50.2	40.3
		VISN 4	59.8	49.7
		Altoona, PA	64.6	82.2
		Butler, PA	66.4	40.9
		Coatesville, PA	53.2	—
		Erie, PA	60.8	48.8
		Lebanon, PA	59.4	32.3
		Philadelphia, PA	55.4	47.3
		Pittsburgh, PA	60.2	56.5
		Wilkes-Barre, PA	62.3	63.1
		Wilmington, DE	61.8	36.4
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	VHA	58.8	49.8
		VISN 4	68.2	53.2
		Altoona, PA	73.5	74.2
		Butler, PA	78.9	58.1
		Coatesville, PA	73.1	54.4
		Erie, PA	66.8	59.2
		Lebanon, PA	67.7	63.9
		Philadelphia, PA	64.1	42.3
		Pittsburgh, PA	69.9	48.5
		Wilkes-Barre, PA	66.8	73.7
Wilmington, DE	65.6	41.6		

⁶¹ For Coatesville, the number of respondents was too low to calculate a statistically reliable score; therefore, the cell in the table for which data is not available is left blank.

Questions	Scoring	Facility	Male Average	Female Average
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	VHA	70.1	65.7
		VISN 4	78.6	69.6
		Altoona, PA	75.5	79.9
		Butler, PA	76.9	82.9
		Coatesville, PA	74.5	62.3
		Erie, PA	75.0	83.5
		Lebanon, PA	78.5	71.9
		Philadelphia, PA	88.8	56.9
		Pittsburgh, PA	81.9	81.0
		Wilkes-Barre, PA	69.4	84.8
		Wilmington, DE	72.8	54.2

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 24, 2019).

**Table C.4. Specialty Care Survey Results by Gender within VISN 4
(October 1, 2017, through September 30, 2018)⁶²**

Questions	Scoring	Facility	Male Average	Female Average
<i>In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	VHA	47.6	43.2
		VISN 4	53.1	63.5
		Altoona, PA	57.9	—
		Butler, PA	56.8	69.7
		Coatesville, PA	59.9	12.2
		Erie, PA	57.3	—
		Lebanon, PA	54.2	68.0
		Philadelphia, PA	48.9	80.6
		Pittsburgh, PA	57.6	37.7
		Wilkes-Barre, PA	48.5	64.6
		Wilmington, DE	50.4	79.5
<i>In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	VHA	55.2	50.7
		VISN 4	59.1	54.5
		Altoona, PA	66.1	61.0
		Butler, PA	61.8	72.9
		Coatesville, PA	58.4	54.9
		Erie, PA	73.2	67.8
		Lebanon, PA	60.8	46.2
		Philadelphia, PA	51.0	61.6
		Pittsburgh, PA	65.4	56.5
		Wilkes-Barre, PA	52.0	49.6
		Wilmington, DE	59.3	50.2

⁶² For Altoona and Erie, the number of respondents was too low to calculate a statistically reliable score; therefore, cells in the table for which data is not available are left blank.

Questions	Scoring	Facility	Male Average	Female Average
<i>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?</i>	The measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	VHA	68.7	65.5
		VISN 4	72.7	76.9
		Altoona, PA	70.2	66.5
		Butler, PA	72.6	87.4
		Coatesville, PA	79.4	62.5
		Erie, PA	81.2	65.7
		Lebanon, PA	78.0	84.3
		Philadelphia, PA	69.4	83.8
		Pittsburgh, PA	73.0	71.8
		Wilkes-Barre, PA	68.4	62.5
		Wilmington, DE	70.6	79.4

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 24, 2019).

Appendix D: Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
<i>Combined Assessment Program Review of the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania, Report No. 15-04693-79, January 14, 2016</i>	October 2015	0	17	n/a	0
<i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania, Report No. 15-05148-75, January 12, 2016</i>	October 2015	0	4	n/a	0
<i>Combined Assessment Program Review of VA Butler Healthcare, Butler, Pennsylvania, Report No. 15-04706-104, January 28, 2016</i>	November 2015	0	7	n/a	0
<i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Butler Healthcare, Butler, Pennsylvania, Report No. 15-05161-98, February 11, 2016</i>	December 2015	0	7	n/a	0
<i>Combined Assessment Program Review of the Coatesville VA Medical Center Coatesville, Pennsylvania, Report No. 15-04708-115, February 9, 2016</i>	December 2015	0	10	n/a	0
<i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Coatesville VA Medical Center, Coatesville, Pennsylvania, Report No. 15-05163-106, February 9, 2016</i>	December 2015	0	4	n/a	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
<i>Clinical Assessment Program Review of the James E. Van Zandt VA Medical Center, Altoona, Pennsylvania, Report No. 16-00555-337, August 15, 2017</i>	March 2017	0	12	n/a	0
<i>Alleged Inappropriate Anesthesia Practices at the James E. Van Zandt VA Medical Center, Altoona, Pennsylvania, Report No. 16-00284-214, July 5, 2018</i>	June 2017	0	4	n/a	0
<i>Clinical Assessment Program Review of the Wilmington VA Medical Center, Wilmington, Delaware, Report No. 16-00548-361, September 20, 2017</i>	January 2017	0	20	n/a	0
<i>Quality of Care Concerns in the Hemodialysis Unit at the Wilmington VA Medical Center, Wilmington, Delaware, Report No. 17-03676-307, September 27, 2018</i>	July 2018	0	14	n/a	2
<i>Clinical Assessment Program Review of the Lebanon VA Medical Center Lebanon, Pennsylvania, Report No. 16-00571-207, April 24, 2017</i>	December 2016	0	13	n/a	0
<i>Comprehensive Healthcare Inspection Program Review of the Wilkes-Barre VA Medical Center Wilkes-Barre, Pennsylvania, Report No. 17-01855-81, February 1, 2018</i>	July 2017	0	3	n/a	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
<i>Comprehensive Healthcare Inspection Program Review of the Erie VA Medical Center, Erie, Pennsylvania, Report No. 18-00618-261, August 20, 2018</i>	April 2018	0	3	n/a	0
<i>Comprehensive Healthcare Inspection Program Review of the VA Pittsburgh Healthcare System Pennsylvania, Pittsburgh, Pennsylvania, Report No. 18-01154-27, December 17, 2018</i>	July 2018	0	4	n/a	4

Source: Inspection/survey results verified with the QSV Administrative Officer on June 25, 2019

n/a = Not applicable

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions⁶³

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

⁶³ 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 F: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions⁶⁴

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

⁶⁴ *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>. (The website was accessed on September 3, 2019, but is not accessible by the public.)

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 5, 2019

From: Director, VA Healthcare–VISN 4 (10N4)

Subj: Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 4: VA Healthcare–VISN 4, Pittsburgh, PA

To: Director, Office of Healthcare Inspections (54CH04)

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

I have reviewed and concur with the findings and recommendations in the report of the CHIP Review of the Veterans Integrated Service Network 4: VA Healthcare - VISN 4, Pittsburgh, PA.

(Original signed by:)

Timothy W. Liezert

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

OIG Contact and Staff Acknowledgments

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Ohio: Bill Johnson, David Joyce, Tim Ryan
Pennsylvania: Brendan Boyle, Matt Cartwright, Madeleine Dean, Michael Doyle, Dwight Evans, Brian Fitzpatrick, Chrissy Houlahan, John Joyce, Fred Keller,

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