



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the Atlanta VA
Health Care System in
Decatur, Georgia



MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

**Report suspected wrongdoing in VA programs and operations
to the VA OIG Hotline:**

www.va.gov/oig/hotline

1-800-488-8244



Figure 1. Atlanta VA Health Care System in Decatur, Georgia
(Source: <https://vaww.va.gov/directory/guide/>, accessed February 19, 2020)

Abbreviations

ADNPC	Associate Director for Nursing and Patient Care Services
CBOC	community-based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
FPPE	focused professional practice evaluation
FY	fiscal year
HRS	high risk for suicide
LIP	licensed independent practitioner
LST	life-sustaining treatments
LSTD	life-sustaining treatment decisions
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
RME	reusable medical equipment
SAIL	Strategic Analytics for Improvement and Learning
SLB	state licensing board
SOP	standard operating procedure
SPC	suicide prevention coordinator
SPS	Sterile Processing Services
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WH-PCP	women's health primary care provider



Report Overview

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

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

The OIG looks at leadership and organizational risks and at the time of the inspection, focused on the following clinical areas:

1. Quality, safety, and value
2. Medical staff privileging
3. Environment of care
4. Medication management (targeting long-term opioid therapy for pain)
5. Mental health (focusing on the suicide prevention program)
6. Care coordination (spotlighting life-sustaining treatment decisions)
7. Women's health (examining comprehensive care)
8. High-risk processes (emphasizing reusable medical equipment)

The unannounced visit was conducted during the week of February 24, 2020, at the Atlanta VA Health Care System and Blairsville VA Clinic. The OIG held interviews and reviewed processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this healthcare system's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this healthcare system and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

Leadership and Organizational Risks

At the time of the OIG's visit, the healthcare system's leadership team consisted of the Director, Deputy Director, Chief of Staff, Associate Director for Nursing and Patient Care Services (ADNPC), acting Associate Director for Operations (Associate Director), and acting Assistant Director. Organizational communications and accountability were managed through a committee reporting structure with the Leadership Council overseeing several working groups. The leaders monitor patient safety and care through the Quality, Safety, and Value Committee which was responsible for tracking and trending quality of care and patient outcomes.

At the time of the inspection, the healthcare system leaders were relatively new to their positions and had only been working together as a group for over a month. All the leaders had been in their positions for less than one year.

The OIG noted that employee satisfaction survey results were generally worse than the VHA averages, indicating that opportunities exist for system leaders to improve employee attitudes toward leaders and the workplace. However, it is important to note that the 2019 All Employee Survey results are not fully reflective of employee satisfaction with the current leaders who had either not yet assumed their positions or had only been in their positions for a short time when the survey was administered. Of the selected Inpatient, Patient-Centered Medical Home, and Specialty Care Survey questions reviewed, the OIG noted that the results were generally lower than the corresponding VHA averages for female and male patients alike, highlighting multiple opportunities for system leaders to improve patient satisfaction with the care provided.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.¹ However, the OIG noted concerns with the healthcare system's under-reporting of sentinel events and medication administration processes in the inpatient mental health unit.

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (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.

¹ The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

The data are presented as one way to “understand the similarities and differences between the top and bottom performers” within VHA.²

Except for the acting Assistant Director, the executive leaders were generally knowledgeable within their scopes of responsibility about VHA data and/or system-level factors contributing to specific poorly performing quality and efficiency measures. In addition, although the executive leadership team members, apart from the acting Assistant Director, were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and patient experiences, these leaders have multiple opportunities to improve quality of care and efficiency at the healthcare system.

The OIG noted opportunities for improvement in six clinical areas reviewed and issued 23 recommendations, including an incidental finding, that are directed to the System Director, Chief of Staff, and ADNPC. These are briefly described below.

Quality, Safety, and Value

The healthcare system complied with some of the requirements for quality, safety, and value (QSV) oversight functions. However, the OIG expressed concerns with deficiencies in QSV Committee, protected peer review, and root cause analysis processes.

Medical Staff Privileging

The healthcare system generally complied with some of the requirements for medical staff privileging. The OIG noted weaknesses with focused and ongoing professional practice evaluations and provider exit review processes.³

Medication Management

The OIG observed compliance with some elements of expected performance, including pain screening, documented justification for concurrent therapy with benzodiazepines, patient follow-up, and the use of a multidisciplinary pain management committee to oversee and monitor quality measures. However, the OIG found deficiencies with aberrant behavior risk assessments, urine drug testing, and informed consent.

² VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL) Value Model*, <https://vaww.vssc.med.va.gov/vsscenhancedproductmanagement/displaydocument.aspx?documentid=9428>. (The website was accessed on March 6, 2020, but is not accessible by the public.)

³ The definitions of focused professional practice evaluation and ongoing professional practice evaluations can be found within Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2). An ongoing professional practice evaluation is “the ongoing monitoring of privileged providers to confirm the quality of care delivered and ensures patient safety.” A focused professional practice evaluation is “a time-limited process whereby the clinical leadership evaluates the privilege-specific competence of a provider who does not yet have documented evidence of competently performing the requested privilege(s) at the facility.”

Mental Health

The healthcare system complied with requirements associated with tracking and follow-up of high-risk veterans. However, the OIG identified deficiencies with monthly outreach activities and suicide prevention training.

Women's Health

The healthcare system complied with requirements for most of the provision of care indicators and selected staffing elements reviewed. The OIG noted concerns with the Women's Health Patient Aligned Care Team staffing ratio, community-based outpatient clinic women's health primary care providers, and the Women Veterans Health Committee membership.

High-Risk Processes

The healthcare system met many of the requirements for the proper operations and management of reprocessing reusable medical equipment. However, the OIG identified deficiencies with gastroenterology endoscope storage and staff training.

Incidental Finding: Bar Code Medication Administration

At the time of the on-site visit, the OIG identified inappropriate scanning of duplicate patient wristbands with the bar code medication administration system as a "workaround" when administering patient medications in the inpatient mental health unit.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued 23 recommendations for improvement to the System Director, Chief of Staff, and ADNPC. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this system. The intent is for system leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The interim Veterans Integrated Service Network Director and Health Care System Director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 87–88, and the responses within the body of the report for the full text of the directors’ comments.) The OIG has received evidence of compliance and considers recommendations 6, 9, 18, 21, and 22 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.



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

Contents

Abbreviations ii

Report Overview iii

 Inspection Results iv

Purpose and Scope 1

Methodology 3

Results and Recommendations 5

 Leadership and Organizational Risks 5

 Quality, Safety, and Value 23

 Recommendation 1 26

 Recommendation 2 27

 Recommendation 3 28

 Recommendation 4 29

 Recommendation 5 30

 Recommendation 6 32

Medical Staff Privileging 33

 Recommendation 7 35

 Recommendation 8 36

 Recommendation 9 37

 Recommendation 10 37

Recommendation 1139

Recommendation 1240

Environment of Care41

Medication Management: Long-Term Opioid Therapy for Pain.....43

 Recommendation 1345

 Recommendation 1447

 Recommendation 1548

Mental Health: Suicide Prevention Program.....50

 Recommendation 1654

 Recommendation 1755

Care Coordination: Life-Sustaining Treatment Decisions56

Women’s Health: Comprehensive Care.....58

 Recommendation 1860

 Recommendation 1961

High-Risk Processes: Reusable Medical Equipment63

 Recommendation 2065

 Recommendation 2167

 Recommendation 2268

Incidental Finding: Medication Administration Workaround.....69

 Recommendation 2370

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings.....71

Appendix B: Healthcare System Profile76

Appendix C: VA Outpatient Clinic Profiles78

Appendix D: Patient Aligned Care Team Compass Metrics81

Appendix E: Strategic Analytics for Improvement and
Learning (SAIL) Metric Definitions.....83

Appendix F: Community Living Center (CLC) Strategic Analytics for Improvement and
Learning (SAIL) Measure Definitions.....85

Appendix G: Interim VISN Director Comments87

Appendix H: Healthcare System Director Comments88

OIG Contact and Staff Acknowledgments89

Report Distribution90



Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities providing healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Atlanta VA Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system 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 expectations for quality care delivery; and promoting a culture to sustain positive change.¹ Investments in a culture of safety and continuous quality improvement, in concert with robust leadership and communication, significantly contribute to positive patient outcomes.² Figure 2 illustrates the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

To examine risks to patients and the organization, the OIG focused on core processes in the following nine areas of administrative and clinical operations:

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (targeting long-term opioid therapy for pain)
6. Mental health (focusing on the suicide prevention program)
7. Care coordination (spotlighting life-sustaining treatment decisions)
8. Women's health (examining comprehensive care)
9. High-risk processes (emphasizing reusable medical equipment)³

¹ 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 September 25, 2019.)

² Jamie Leviton and Jackie Valentine, "How risk management and patient safety intersect: Strategies to help make it happen," *Institute for Healthcare Improvement and National Patient Safety Foundation (NPSF)*, March 24, 2015.

³ CHIP inspections address these processes during FY 2020 (October 1, 2019, through September 30, 2020); they may differ from prior years' focus areas.

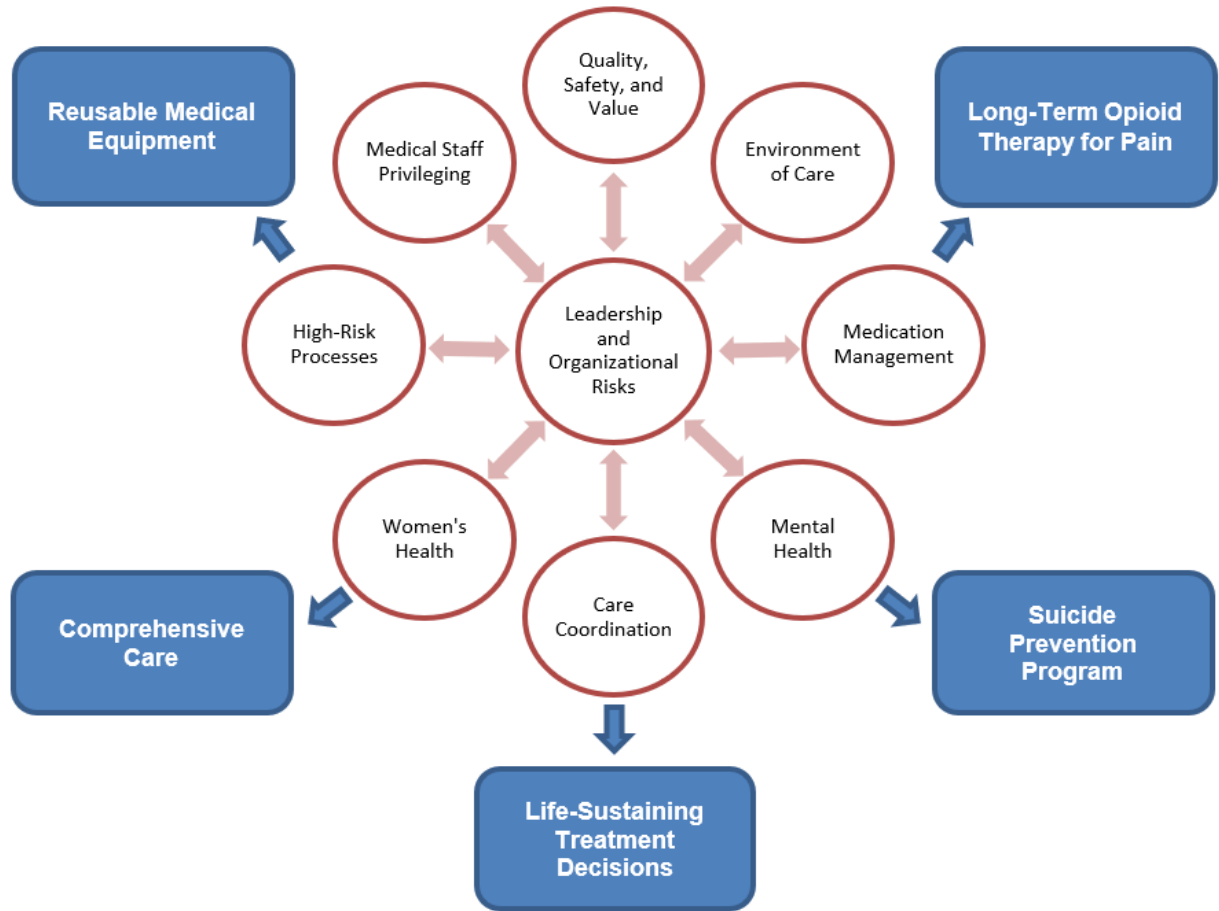


Figure 2. Fiscal Year (FY) 2020 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

Methodology

The Atlanta VA Health Care System includes multiple outpatient clinics in Georgia. Additional details about the types of care provided by the healthcare system can be found in Appendixes B and C.

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports.⁴

The OIG also selected and physically inspected the Blairsville VA Clinic and the following areas of the healthcare system:

- Acute psychiatric unit
- Community living center (CLC)⁵
- Emergency Department
- Medical inpatient units
- Outpatient clinic
- Post-anesthesia care unit
- Sterile processing services areas
- Surgical intensive care unit

The OIG inspection team interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection examined operations from January 28, 2017, through February 28, 2020, the last day of the unannounced multiday site visit.⁶ While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and

⁴ The OIG did not review VHA's internal survey results, instead focused on OIG inspections and external surveys that affect facility accreditation status.

⁵ According to VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers*, June 1, 2017, CLCs, previously known as nursing home care units, provide a skilled nursing environment and a variety of interdisciplinary programs for persons needing short- and long-stay services.

⁶ The range represents the time period from the prior Combined Assessment Program inspection to the completion of the unannounced, multiday CHIP site visit in February 2020.

methodology and makes recommendations to VA leadership, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the healthcare system completes corrective actions. The System Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that healthcare system leaders developed based on the reasons for noncompliance.

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can affect the healthcare system's ability to provide care in the clinical focus areas.⁷ To assess the healthcare system's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation surveys and oversight inspections
5. Identified factors related to possible lapses in care and healthcare system response
6. VHA performance data (healthcare system)
7. VHA performance data (CLCs)

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this healthcare system's reported organizational structure. The healthcare system has a leadership team consisting of the Director, Deputy Director, Chief of Staff, Associate Director for Nursing and Patient Care Services (ADNPC), acting Associate Director of Operations (Associate Director), and acting Assistant Director. The Chief of Staff and ADNPC oversee patient care, which requires managing service directors and chiefs of programs and practices.

⁷ L. Botwinick, M. Bisognano, and C. Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare Improvement, Innovation Series White Paper. 2006. www.IHL.org. (The website was accessed on November 6, 2019.)

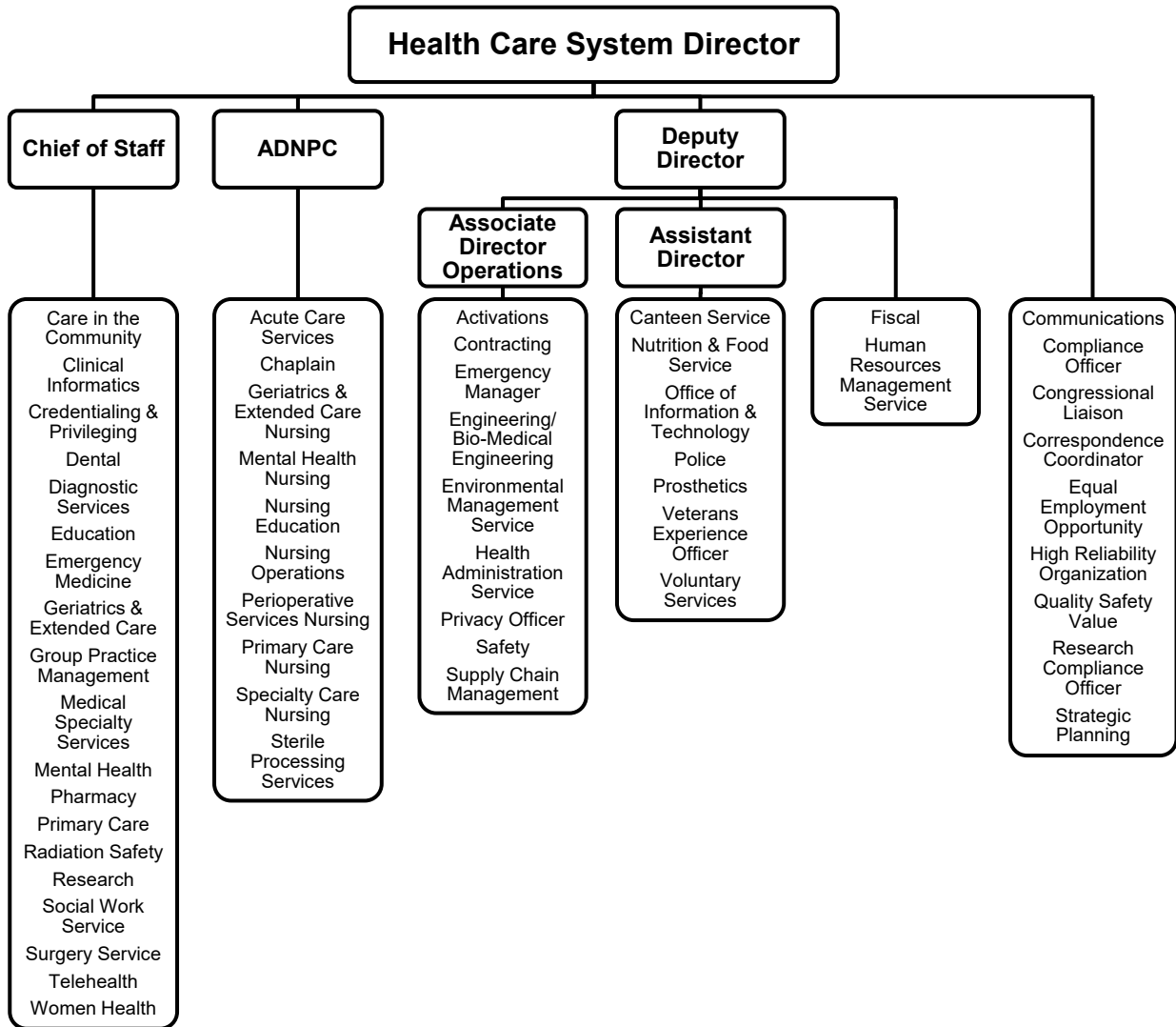


Figure 3. Healthcare System Organizational Chart
 Source: Atlanta VA Health Care System (received February 26, 2020)

At the time of the OIG site visit, the executive team were relatively new to their positions and had only been working together as a group for over a month. All the leaders had been in their positions for less than one year (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	May 26, 2019
Chief of Staff	January 5, 2020
Associate Director for Nursing and Patient Care Services	August 4, 2019
Deputy Director (new position)	August 18, 2019
Associate Director	November 17, 2019 (acting)
Assistant Director	October 1, 2019 (acting)

Source: Atlanta VA Health Care System Chief Human Resources Officer (received February 26, 2020)

To help assess the healthcare system executive leaders’ engagement, the OIG interviewed the Director, Deputy Director, Chief of Staff, ADNPC, acting Associate Director, and acting Assistant Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

The Director, Deputy Director, Chief of Staff, ADNPC, and acting Associate Director were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to specific poorly performing hospital Strategic Analytics for Improvement and Learning (SAIL) and Community Living Center (CLC) SAIL measures. In individual interviews, the executive leaders—except for the acting Assistant Director—were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and/or patient experiences. These are discussed in greater detail below.

The Director serves as the chairperson of the Leadership Council which has the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Leadership Council oversees various working groups such as the Resource Management Committee, Executive Committee of the Medical Staff, and Executive Committee of the Nursing Staff.

These leaders monitor patient safety and care through the Quality, Safety, and Value Committee (formerly known as Quality Management). The Quality, Safety, and Value Committee is responsible for tracking and trending quality of care and patient outcomes and reports to the Leadership Council (see figure 4).

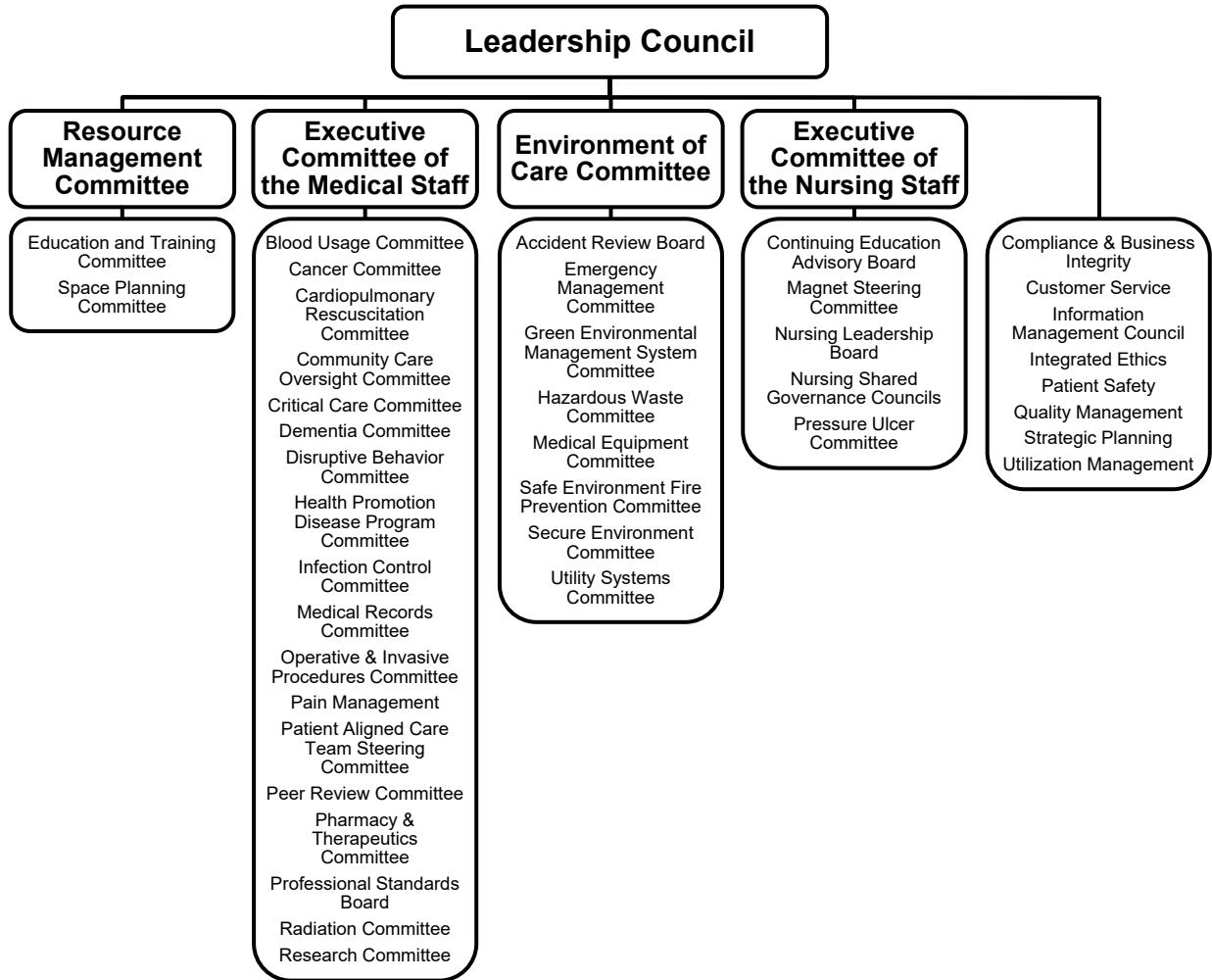


Figure 4. Healthcare System Committee Reporting Structure
 Source: Atlanta VA Health Care System (received February 27, 2020)

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 healthcare system leadership.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA’s All Employee Survey that relate to the period of

October 1, 2018, through September 30, 2019.⁸ Table 2 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA’s All Employee Survey. The OIG found the healthcare system average for the selected survey leadership questions was below the VHA average. However, although there appear to be various opportunities to improve employee attitudes, it is important to note that the 2019 All Employee Survey results are not fully reflective of employee satisfaction with the current leaders, who had either not yet assumed their positions or had only been in their positions for a short time when the survey was administered.⁹

Table 2. Survey Results on Employee Attitudes toward Healthcare System Leaders (October 1, 2018, through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADNPC Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: <i>Servant Leader Index Composite</i> ¹⁰	0–100 where higher scores are more favorable	72.6	68.0	75.6	54.0	61.4	55.8	74.0
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)	3.4	3.1	2.9	2.4	2.9	2.9	3.3
All Employee Survey: <i>My organization’s senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.2	3.2	2.8	3.0	3.1	3.4

⁸ Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADNPC, Associate Director, and Assistant Director. Data for the Deputy Director were not available because it was a newly established position and not assigned until August 2019.

⁹ 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.

¹⁰ According to the 2018 VA All Employee Survey Questions by Organizational Health Framework, the 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	Health-care System Average	Director Average	Chief of Staff Average	ADNPC Average	Assoc. Director Average	Asst. Director 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	3.3	3.5	3.0	3.3	3.1	3.3

Source: VA All Employee Survey (accessed January 21, 2020)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA’s All Employee Survey.¹¹ Note that the healthcare system averages for the selected survey questions were generally worse than the VHA averages. Again, although the 2019 All Employee Survey results are not fully reflective of employee satisfaction with the current leaders, opportunities appear to exist for system leaders to improve employee satisfaction and to create a culture where staff feel safe reporting concerns and doing the right thing.

Table 3. Survey Results on Employee Attitudes toward the Workplace (October 1, 2018, through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADNPC Average	Assoc. Director Average	Asst. Director 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	3.5	4.4	3.5	3.6	3.7	4.6
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	3.5	3.6	4.1	3.5	3.2	4.0

¹¹ Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADNPC, Deputy Director, and Assistant Director. Data for the Deputy Director were not available because it was a newly established position and not assigned until August 2019.

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADNPC Average	Assoc. Director Average	Asst. Director 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)	1.4	1.6	1.5	1.6	0.9	1.6	1.9

Source: VA All Employee Survey (accessed January 21, 2020)

Patient Experience

To assess patient experiences with the healthcare system, which directly reflect on its leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2018, through September 30, 2019. 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 VHA and the healthcare system.¹²

VHA also collects SHEP survey data from Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients’ attitudes toward their health care experiences (see table 4). The patient survey results for this system reflected generally lower care ratings than the VHA average, highlighting opportunities for leaders to improve patient experiences in all care settings.

¹² Ratings are based on responses by patients who received care at this healthcare system.

**Table 4. Survey Results on Patient Experience
(October 1, 2018, through September 30, 2019)**

Questions	Scoring	VHA Average	Healthcare System 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.	68.3	52.4
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.	84.9	78.7
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.	77.3	64.6
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.	78.0	65.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 23, 2019)

In 2015, women represented 9.4 percent of the total veteran population in the United States, and it is projected that women will represent 16.3 percent of living veterans by 2043. Further, from 2005 to 2015, the number of women veterans using VA health care increased by 46.4 percent, from almost 240,000 to 455,875.¹³ For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients’ experiences by gender (see tables 5–7), including those for Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG noted that the survey results were generally worse than the corresponding VHA averages regardless of the gender.

¹³ VA National Center for Veterans Analysis and Statistics, *The Past, Present and Future of Women Veterans*, February 2017.

**Table 5. Inpatient Survey Results on Experiences by Gender
(October 1, 2018, through September 30, 2019)**

Questions	Scoring	VHA ¹⁴		Healthcare System ¹⁵	
		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).	84.5	82.8	87.2	73.8
<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).	84.8	83.1	79.5	72.4
<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).	68.7	61.8	57.3	16.8

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed January 21, 2020)

¹⁴ The VHA averages are based on 48,259–48,798 male and 2,342–2,359 female respondents, depending on the question.

¹⁵ The healthcare system averages are based on 372–379 male and 34 or 35 female respondents, depending on the question.

Table 6. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2018, through September 30, 2019)

Questions	Scoring	VHA ¹⁶		Healthcare System ¹⁷	
		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).	51.2	43.3	43.6	29.7
<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).	59.9	49.7	54.9	32.8
<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).	71.6	65.7	66.2	56.2

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed January 21, 2020)

¹⁶ The VHA averages are based on 79,450–241,828 male and 5,762–13,041 female respondents, depending on the question.

¹⁷ The healthcare system averages are based on 774–2,304 male and 75–169 female respondents, depending on the question.

Table 7. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2018, through September 30, 2019)

Questions	Scoring	VHA ¹⁸		Healthcare System ¹⁹	
		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).	48.5	44.7	43.3	41.7
<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).	56.3	55.0	54.4	60.9
<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).	70.4	70.1	67.4	63.0

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed January 21, 2020)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders respond to identified problems.²⁰ Table 8 summarizes the relevant system inspections most recently performed by the OIG and The Joint Commission (TJC).²¹ Of note, at the time of the OIG visit, the system had closed all

¹⁸ The VHA averages are based on 65,968–208,722 male and 3,460–11,072 female respondents, depending on the question.

¹⁹ The healthcare system averages are based on 580–1,860 male and 56–151 female respondents, depending on the question.

²⁰ The Joint Commission conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.

²¹ According to VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017, TJC provides an “internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care.” TJC “has been accrediting VA medical facilities for over 35 years.” Compliance with TJC standards “facilitates risk reduction and performance improvement.”

recommendations for improvement issued since the previous OIG clinical assessment program review conducted in January 2017.²²

At the time of the site visit, the OIG also noted the system’s current accreditation by The Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.²³ Additional results included the Long Term Care Institute’s inspection of the system’s CLCs.²⁴

Table 8. Office of Inspector General Inspections/The Joint Commission Surveys

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (<i>Clinical Assessment Program Review of the Atlanta VA Medical Center, Decatur, Georgia, Report No. 16-00569-253, June 8, 2017</i>)	January 2017	21	0
OIG (<i>Delays and Deficiencies in Obtaining and Documenting Mammography Services at the Atlanta VA Healthcare System, Decatur, Georgia, Report No. 17-02679-283, September 13, 2018</i>)	May 2017 October 2017	7	0
TJC Hospital Accreditation	February 2019	38	0
TJC Behavioral Health Care Accreditation		4	0
TJC Home Care Accreditation		5	0
TJC For Cause Survey	March 2018	3	0
TJC For Cause Survey	November 2019	3	0

Source: OIG and TJC (inspection/survey results verified with the Accreditation Specialist on February 24, 2020)

²² VA OIG, *Clinical Assessment Program Review of the Atlanta VA Medical Center, Decatur, Georgia, Report No. 16-00569-253, June 8, 2017.*

²³ According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs*, May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities “provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies.” VHA’s commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs; According to the College of American Pathologists, for 70 years it has “fostered excellence in laboratories and advanced the practice of pathology and laboratory science.” College of American Pathologists. <https://www.cap.org/about-the-cap>. (The website was accessed on February 20, 2019.) In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

²⁴ The Long Term Care Institute states that it has been to over 4,000 healthcare facilities conducting quality reviews and over 1,145 external regulatory surveys since 1999. The Long Term Care Institute is “focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.” Long Term Care Institute. <http://www.ltci.org.org/about-us/>. (The website was accessed on March 6, 2019.)

Identified Factors Related to Possible Lapses in Care and Healthcare System Response

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. The OIG's review of the healthcare system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. However, the OIG noted two concerns related to the potential for patient harm—medication safety and the patient safety program.

During a physical inspection of the inpatient mental health unit, the OIG identified an incidental finding involving staff using duplicate patient wristbands as a “workaround” when administering medications which introduced the potential for medication errors and patient harm. While on site, QSV staff removed the wristbands immediately from the bar code medication administration (BCMA) carts, and the ADNPC stated that an action plan will be developed to prevent reoccurrence. Despite this, the OIG was concerned that this practice could be more widespread. See pages 69 and 70 of this report for detailed information.

Table 9 lists the reported patient safety events from January 23, 2017 (the prior OIG clinical assessment program inspection), through February 27, 2020.²⁵ The OIG acknowledges system leaders' and clinicians' efforts to be transparent by informing patients that an adverse event had occurred as evidenced by 28 institutional disclosures. However, the OIG determined that 6 of 28 disclosed adverse events met the definition of a sentinel event. This resulted in under-reporting of sentinel events at the healthcare system. Despite this, the OIG confirmed that in all cases, the system program managers conducted required investigations such as management reviews, root cause analyses, and peer reviews and took corrective actions including staff education and the removal of a provider.

²⁵ It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Atlanta VA Health Care System is a high complexity (1a) affiliated system as described in Appendix B.)

Table 9. Summary of Selected Organizational Risk Factors (January 28, 2017, through February 27, 2020)

Factor	Number of Occurrences
Sentinel Events ²⁶	1
Institutional Disclosures ²⁷	28
Large-Scale Disclosures ²⁸	0

Source: Atlanta VA Health Care System’s Risk and Patient Safety Managers (received February 27, 2020)

Veterans Health Administration Performance Data

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

Figure 5 illustrates the system quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2019. Of note, figure 5 uses blue and green data points to indicate high performance for the healthcare system (for example, in the areas of capacity, mental health (MH) population (popu) coverage, registered nurse (RN) turnover, and complications). Metrics that need improvement are denoted in orange and red (for example, MH continuity (of) care, specialty care (SC) care coordination, rating (of) hospital, and best place to

²⁶ The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient “death, permanent harm, or severe temporary harm and intervention required to sustain life.”

²⁷ According to VHA Directive 1004.08, *Disclosure of Adverse Events To Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an “administrative disclosure”) as “a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or [his or her] personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.”

²⁸ According to VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as “notifications”) as “a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.”

²⁹ VHA Support Service Center, *Strategic Analytics for Improvement and Learning (SAIL) Value Model*, <https://vaww.vssc.med.va.gov/vsscenhancedproductmanagement/displaydocument.aspx?documentid=9428>. (The website was accessed on March 6, 2020, but is not accessible by the public.)

work).³⁰ It is important to note that of the 30 quality of care measures, only seven indicated high performance for the healthcare system, indicating multiple opportunities for improvement.

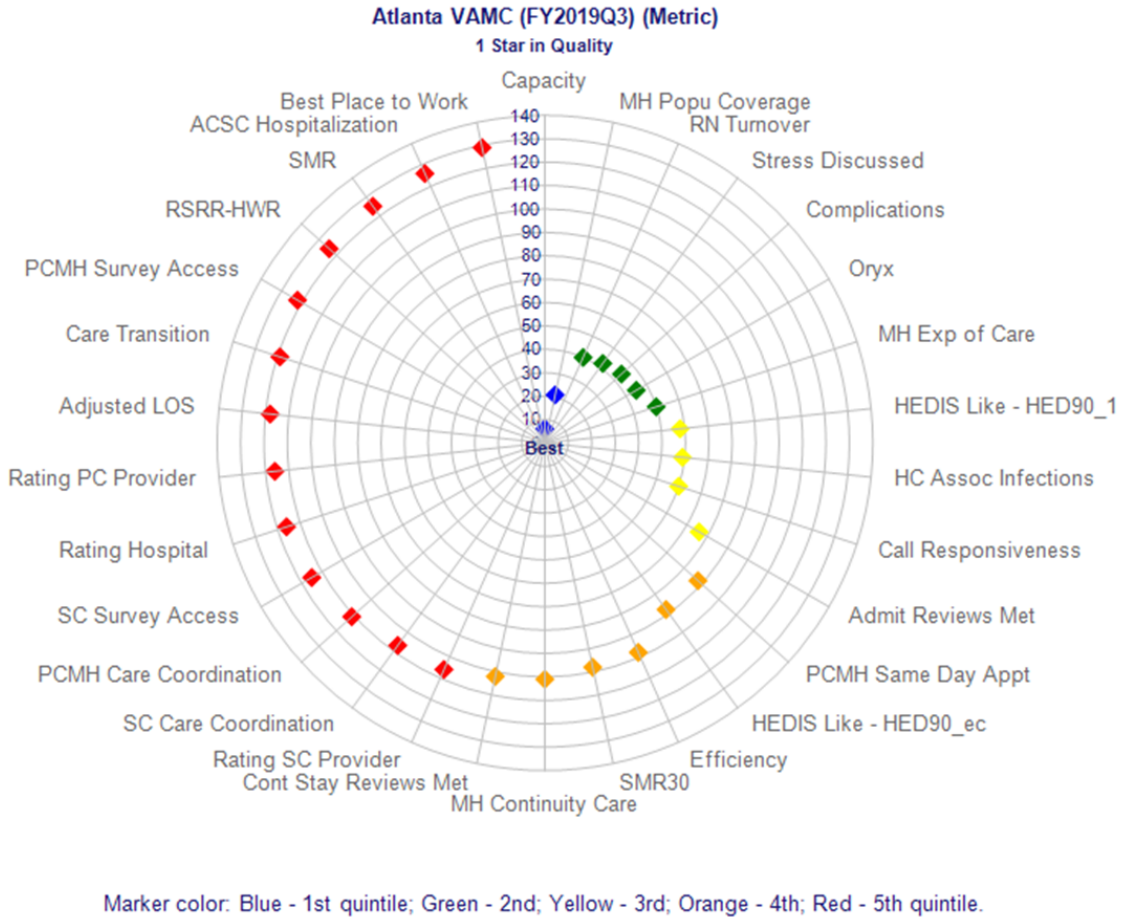


Figure 5. System Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)

Source: VHA Support Service Center

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

Veterans Health Administration Performance Data for Community Living Centers

The “CLC SAIL” Value Model is a tool to summarize and compare the performance of CLCs in the VA. The model leverages much of the same data used in the Centers for Medicare &

³⁰ For information on the acronyms in the SAIL metrics, please see Appendix E.

Medicaid Services’ (CMS) *Nursing Home Compare* and provides a single resource to review quality measures and health inspection results.³¹

Figures 6 and 7 illustrates the system’s CLC quality rankings and performance compared with other VA CLCs as of September 30, 2019. Figure 6 uses blue and green data points to indicate high performance for the Atlanta VA Health Care System CLC (for example, in the areas of physical restraints–long-stay (LS), moderate-severe pain–short-stay (SS), and urinary tract infections (UTI) (LS)). Metrics that need improvement are denoted in orange and red (for example, falls with major injury (LS), new or worse pressure ulcer (PU) (SS), and high-risk PU (LS)).³²

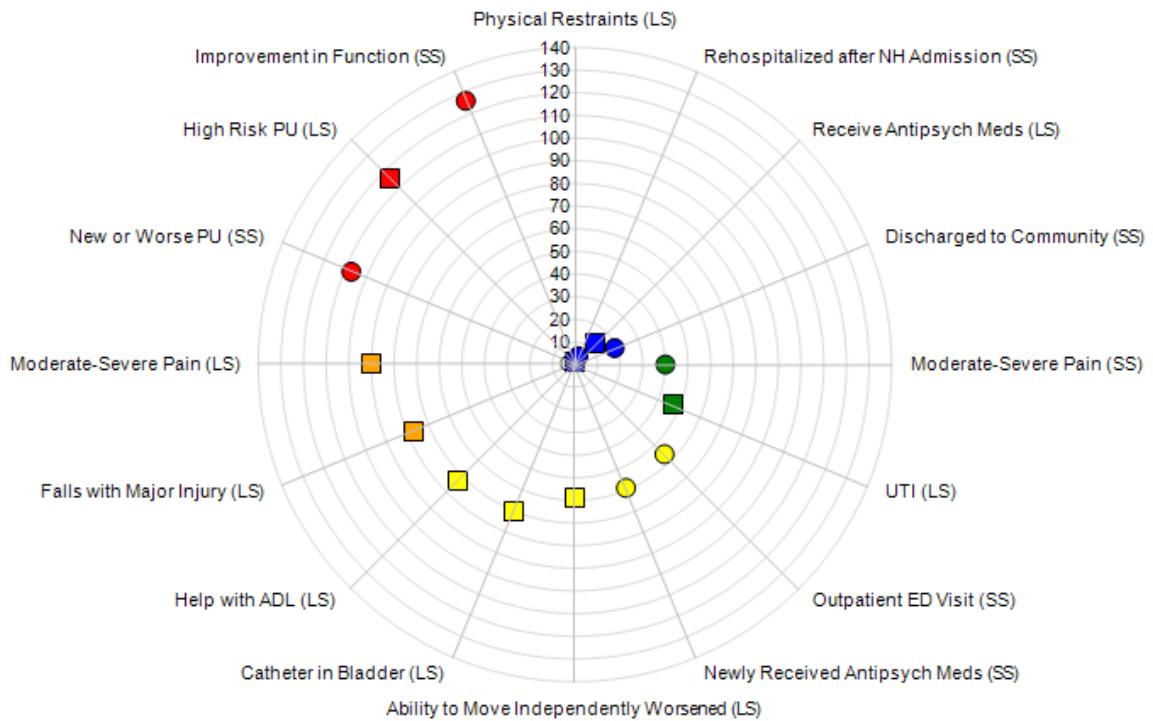


Figure 6. Atlanta CLC Quality Measure Rankings (as of September 30, 2019)

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.

³¹ According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, November 19, 2018, “In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several “star” ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes.”

³² For data definitions of acronyms in the SAIL CLC measures, please see Appendix F.

Figure 7 uses blue and green data points to indicate high performance for the Trinka Davis Veteran’s Village CLC (for example, in the areas of high risk pressure ulcer (PU) (LS), help with activities of daily living (ADL) (LS), and moderate-severe pain (LS)). For this CLC, there were no metrics denoted in orange or red that indicated the need for improvement.³³

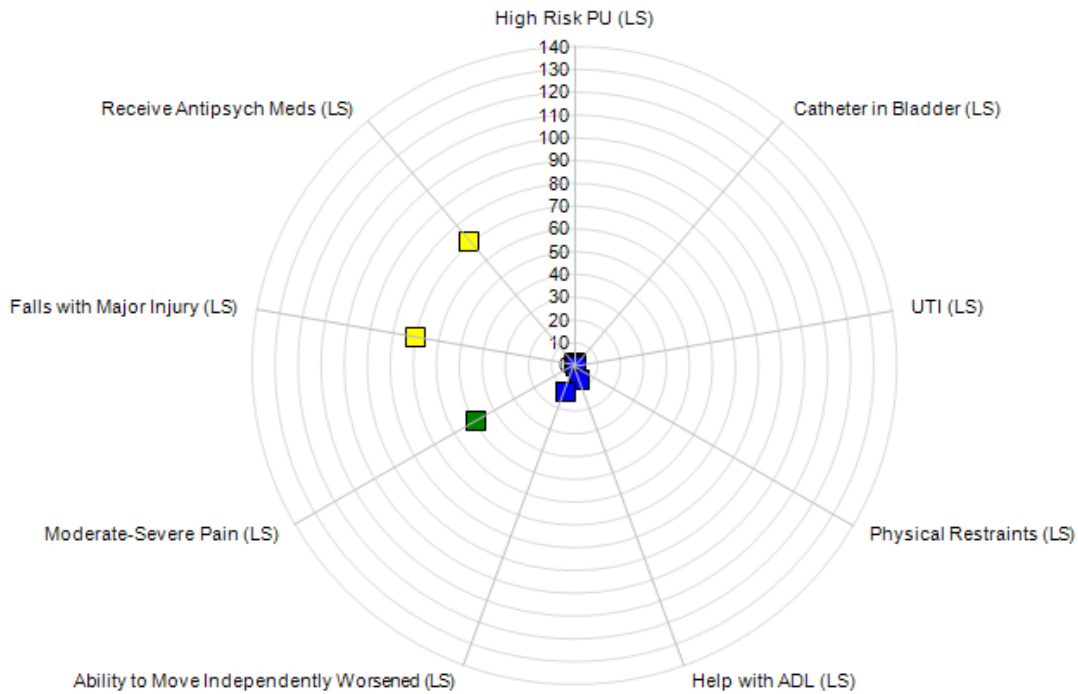


Figure 7. Trinka Davis Veteran’s Village CLC Quality Measure Rankings (as of September 30, 2019)

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 F.

Leadership and Organizational Risks Conclusion

At the time of OIG’s on-site visit, the system’s leaders were relatively new to their positions and had worked together as a team for less than two months. Specific survey items related to employees’ satisfaction revealed opportunities for system leaders to improve employee attitudes toward leaders and the workplace. Patient experience survey results generally reflected lower care ratings than the VHA average for female and male patients alike, highlighting opportunities for leaders to improve patient satisfaction with care provided in all care settings.

The OIG’s review of the system’s accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. However, the OIG noted concerns with the healthcare system’s under-reporting of sentinel events and medication administration processes in the inpatient mental health unit which had the potential for patient harm. Executive leaders

³³ For data definitions of acronyms in the SAIL CLC measures, please see Appendix F.

interviewed—except for the acting Assistant Director—were able to speak in depth about actions taken during the previous 12 months to improve performance, including employee satisfaction and patient experiences. In addition, although knowledgeable within their scopes of responsibility about VHA data and/or system-level factors contributing to specific poorly performing hospital SAIL and CLC measures, these leaders have multiple opportunities to improve quality of care and efficiency at the healthcare system.

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.³⁴ To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and to maintain Joint Commission accreditation.³⁵ Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.³⁶

To determine whether VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the healthcare system's committee responsible for quality, safety, and value (QSV) oversight functions; its ability to review data, information, and risk intelligence; and its ability to ensure that key QSV functions are discussed and integrated on a regular basis. Specifically, the OIG examined the following requirements:

- Review of aggregated QSV data
- Recommendation and implementation of improvement actions
- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the healthcare system's processes for conducting protected peer reviews of clinical care.³⁷ Protected peer reviews, when conducted systematically and credibly, reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.³⁸ The OIG examined the completion of the following elements:

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

³⁴ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

³⁵ VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

³⁶ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

³⁷ The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a critical review of care, performed by a peer, to evaluate care provided by a clinician for a specific episode of care, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements. In the context of protected peer reviews, "protected" refers to the designation of review as a confidential quality management activity under 38 U.S.C. 5705 as "a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for improving the quality of medical care or the utilization of health-care resources in VA facilities."

³⁸ VHA Directive 1190.

- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit³⁹
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee
- Quarterly review of the Peer Review Committee’s summary analysis by the Executive Committee of the Medical Staff

Next, the inspection team assessed the healthcare system’s utilization management (UM) program, a key component of VHA’s framework for quality, safety, and value, which provides vital tools for managing the quality and the efficient use of resources.⁴⁰ It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.⁴¹ Inspectors reviewed several aspects of the UM program:

- Completion of at least 80 percent of all required inpatient reviews
- Documentation of at least 75 percent of physician UM advisors’ decisions in the National UM Integration database
- Interdisciplinary review of UM data
- Implementation and monitoring of improvement actions recommended by the interdisciplinary UM group

Finally, the OIG reviewers assessed the healthcare system’s reports of patient safety incidents with related root cause analyses.⁴² Among VHA’s approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the healthcare system.⁴³ The healthcare system was assessed for its performance on several dimensions:

³⁹ VHA Directive 1190.

⁴⁰ According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019, UM reviews include evaluating the “appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.”

⁴¹ VHA Directive 1117(2).

⁴² The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. A root cause analysis is “a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls.”

⁴³ VHA Handbook 1050.01.

- Annual completion of a minimum of eight root cause analyses⁴⁴
- Inclusion of required content in root cause analyses
- Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
- Provision of feedback about root cause analysis actions to reporting employees
- Submission of annual patient safety report to healthcare system leaders

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents.⁴⁵

Quality, Safety, and Value Findings and Recommendations

The OIG found general compliance with many of the performance indicators above. However, the OIG identified deficiencies with the QSV Committee (formerly known as Quality Management), protected peer review, and root cause analysis processes.

At the time of the OIG inspection, VHA required that an interdisciplinary group review UM data. This group should have included, but was not limited to, “representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR [Chief Business Office Revenue-Utilization Review].”⁴⁶ The OIG found that from January 2019 through November 2019, UM data were reviewed by the Patient Flow Committee (formerly known as the Utilization Management Committee). However, the chief business office revenue-utilization review was not represented; and nursing, case management, and social work representatives did not consistently attend meetings. As a result, the committee performed reviews and analyses without the perspectives of key staff. The acting Deputy Chief of Staff, co-chair of the Patient Flow Committee, reported being unaware of the interdisciplinary membership requirements. On October 8, 2020, VHA changed the requirement for the review of UM data by a multidisciplinary committee with specific membership to the review of UM data by a “multidisciplinary committee, which may include representatives from” various services. Therefore, the OIG made no recommendation.⁴⁷

⁴⁴ According to VHA Handbook 1050.01, “the requirement for a total of eight [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of [root cause analyses] is driven by the events that occur and the [Safety Assessment Code] SAC score assigned to them. At least four analyses per fiscal year must be individual [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses].”

⁴⁵ For CHIP inspections, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

⁴⁶ VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019.

⁴⁷ VHA Directive 1117, *Utilization Management Program*, October 8, 2020.

TJC requires that the healthcare system's governing body provides structure and resources to support quality and safety. TJC also requires leaders to use and review data to evaluate performance and make improvements. Analyzing data helps leaders to understand performance patterns and trends so that effectiveness of improvements can be sustained, measured, and integrated into the system's quality and safety processes.⁴⁸ The OIG determined that prior to August 2019, at which time the QSV Committee was chartered, the healthcare system's Leadership Council reviewed quality data but did not ensure aggregated data were consistently discussed and integrated. In addition, when action items were recommended by the QSV Committee, there was no follow-up to determine if changes were implemented or monitored for effectiveness. This may have prevented quality care and patient safety process improvements at the healthcare system. The Deputy Chief of Quality Management reported that multiple executive leadership changes lessened the QSV Committee's ability to follow up and monitor performance improvement actions.

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures the Quality, Safety, and Value Committee consistently reviews and integrates aggregated quality, safety, and value data.

⁴⁸ TJC. Rationale for Leadership standards LD.01.03.01, 03.02.01, and 03.05.01, Leadership Introduction to Operations standards LD.03.07.01 through LD.04.03.11, and Performance Improvement standard PI.03.01.01.

Healthcare system concurred.

Target date for completion: December 31, 2020

Healthcare system response: The Healthcare System Director is the executive champion for the implementation and sustainment of this corrective action to ensure that the newly established Quality Executive Council (QEC) consistently reviews and integrates aggregated quality, safety, and value related data. The Executive Leadership Team (ELT) revised the Executive Committee Governance Reporting Structure and approved the charter establishing the Quality Executive Council (QEC) to replace the Quality, Safety, and Value (QSV) Committee effective March 1, 2020. The inaugural QEC meeting was held on March 3, 2020. The scheduled QEC monthly agenda is presented to the Director by the recorder for preapproval before each meeting to ensure aggregated QSV-related data is consistently presented for review and integration into each meeting. Outcomes of the aggregated QSV-related data and discussion is documented in the monthly QEC minutes for approval by the Chairs and the Director. The executive committee minutes reporting template has been standardized to include an executive summary report and open items tracker which is routed monthly for presentation to the Governing Board for oversight and tracking of issues to closure. Continuous monitoring will be conducted by Quality Management and reported to the Governing Board through this standardized reporting process until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the number of QEC minutes which contain integrated and aggregated QSV-related data; denominator is the total number of QEC minutes for the same review period. Reasons for noncompliance were considered in the development of this plan.

Recommendation 2

2. The System Director evaluates and determines any additional reasons for noncompliance and ensures improvement actions recommended by the Quality, Safety, and Value Committee are fully implemented and improvement changes are monitored.

Healthcare system concurred.

Target date for completion: December 31, 2020

Healthcare system response: The Healthcare System’s Director is the executive champion for the implementation and sustainment of this corrective action to ensure that improvement actions recommended by the Quality Executive Council (QEC) are fully implemented, tracked to closure, and monitored for sustainment. The Executive Leadership Team (ELT) revised the Executive Committee Governance Reporting structure and approved the charter establishing the Quality Executive Council (QEC) to replace the Quality, Safety, and Value (QSV) Committee effective March 1, 2020. The inaugural QEC meeting was held on March 3, 2020. The executive committee minutes reporting template has been standardized to include an executive summary report and open items tracker which is routed for presentation to the Governing Board monthly for oversight and tracking of issues to closure. Continuous monitoring is conducted by Quality Management and reported to the Governing Board through this standardized reporting process until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the QEC minutes which contain documentation of implementation and monitoring of identified improvement actions; denominator is the total number of QEC minutes for the same review period. Reasons for noncompliance were considered in the development of this plan.

VHA requires that final peer reviews are completed within 120 calendar days from the determination that a peer review is needed. “The exception for a delay, or an extension beyond 120 days, needs to be requested in writing, and approved by the VA medical facility Director.”⁴⁹ The OIG found that 13 of 20 reviews conducted from October 2018 through September 2019 were completed within 120 days. This likely prevented expedient improvements in patient care for the remaining seven cases reviewed. The Risk Manager reported that multiple changes in the healthcare system’s leadership made it difficult to obtain the signatures required for peer review extensions.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that final peer reviews are completed within 120 calendar days from the date it is determined a peer review is required and, if necessary, extensions are approved in writing by the System Director.

⁴⁹ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

Healthcare system concurred.

Target date for completion: December 31, 2020

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of this corrective action to ensure that final peer reviews are completed within 120 calendar days from the determination date. The spreadsheet utilized by Risk Management was enhanced to improve tracking of peer review data to completion to track peer review completion data. Requests for necessary delay exceptions or extension for completion beyond 120 days are submitted to the Health Care System Director for written approval. Completion of data and timelines for each peer review are monitored during the Peer Review Committee and documented in the minutes with quarterly reporting to the Quality Executive Council (QEC). Continuous monitoring will occur until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the number of final peer reviews completed within 120 calendar days from the determination date to include written approvals of any necessary extension by the Healthcare System Director; denominator is the total number of peer reviews completed for the same review period. Reasons for noncompliance were considered in the development of this plan.

VHA also requires that when the Peer Review Committee recommends individual improvement actions, clinical managers implement the recommendations.⁵⁰ The OIG found evidence that clinical managers implemented the recommended actions in 4 of 15 peer reviews that documented a need for improvement. This likely prevented improvements in patient care in the remaining 11 cases reviewed. The Risk Manager reported that multiple changes in the healthcare system's leadership prevented implementation of Peer Review Committee-recommended improvement actions.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that clinical managers consistently implement improvement actions recommended from peer review activities.

⁵⁰ VHA Directive 1190.

Healthcare system concurred.

Target date for completion: December 31, 2020

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of this corrective action to ensure that clinical managers implement the recommended improvement actions of the Peer Review Committee. The Risk Managers developed an enhanced spreadsheet to track the Peer Review improvement actions and the assigned clinical managers for implementation. A status update of these improvement actions is reviewed during the monthly Peer Review Committee meeting with documentation in the minutes. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is documentation that peer review improvement actions are tracked during the Peer Review Committee meeting; denominator is the total number of Peer Review Committee meetings for the same review period. Reasons for noncompliance were considered in the development of this plan.

To ensure credibility, VHA requires root cause analyses to include several factors, such as participation by leaders, consideration of relevant literature, and identification of at least one root cause with a corresponding action and outcome measure.⁵¹ The OIG found that three of five root cause analyses reviewed included all required elements. This likely hindered the ability to identify underlying root causes of patient safety events and implementation of improvements necessary to reduce the likelihood of recurrence. The Patient Safety Manager reported that executive leaders decided not to complete one root cause analysis and postponed the second; however, there was no documentation to support this.

Recommendation 5

5. The System Director determines the reasons for noncompliance and ensures that root cause analyses include all required review elements.

⁵¹ VHA Handbook 1050.01.

Healthcare system concurred.

Target date for completion: December 31, 2020

Healthcare system response: The Healthcare System Director is the executive champion for the implementation and sustainment of this corrective action to ensure that root cause analyses (RCAs) include all required review elements. The National Center for Patient Safety (NCPS) has identified the required review elements for a complete RCA. The Patient Safety Managers use WEBSPOt as a mechanism for tracking and ensuring that all required review elements are addressed, as well as tracking submission of completed RCAs. The Patient Safety department abides by the WEBSPOt guidelines, and compliance is checked by the facility's Patient Safety Managers, Executive Leadership Team, and monitored by the NCPS via the WEBSPOt database. The use of WEBSPOt combined with internal processes/procedures ensure that RCAs include all required review elements as follows: (1) leadership participation; (2) documentation that individuals directly involved in adverse event/close call were excluded; (3) review and consideration of relevant literature; (4) root cause(s) with corresponding action(s) and outcome measure(s); and (5) concurrence and signature of Health Care System Director. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the total number of completed RCAs that contain all required review elements and are properly documented in WEBSPOt; denominator is the total number of completed RCAs during the same review period. Reasons for noncompliance were considered in the development of this plan.

VHA requires that a root cause analysis be timely and submitted to the National Center for Patient Safety within 45 days of becoming aware that it is required.⁵² The OIG found that only one of five root cause analyses reviewed was submitted within 45 days.⁵³ A delay in completion and submission of root cause analyses potentially hinders timely identification and correction of system vulnerabilities that contribute to patient harm events. The Patient Safety Manager stated multiple changes in executive leadership positions prevented timely submission.

⁵² VHA Handbook 1050.01.

⁵³ The National Center for Patient Safety (NCPS) is the Department of Veterans Affairs National Center for Patient Safety, established to lead VA's patient safety efforts and develop and nurture a culture of safety throughout Veterans Health Administration. The goal is nationwide reduction and prevention of inadvertent harm to patients as a result of their care. NCPS provides a confidential, non-punitive electronic reporting system that allows users from around the country to electronically document patient safety information. This centralized secure database allows for lessons to be learned that can benefit the entire VHA healthcare system.

Recommendation 6

6. The System Director evaluates and determines any additional reasons for noncompliance and ensures that the Patient Safety Manager submits each root cause analysis to the National Center for Patient Safety within 45 days.⁵⁴

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Healthcare System Director is the executive champion for the implementation and sustainment of this corrective action to ensure that each Root Cause Analysis (RCA) is submitted to the National Center for Patient Safety (NCPS) within 45 days. A spreadsheet was developed to facilitate tracking the date that Patient Safety became aware of an incident that required an RCA and the completion/submission date of the RCA to the NCPS. After an RCA is chartered, the RCA debrief is immediately scheduled and placed on the calendars of the Executive Leadership Team (ELT) and services involved for 45 days or less prior to the due date. Leadership support and review of processes has resulted in improvements. The recent hiring of a third Patient Safety Manager has further assisted in the timely completions of RCAs. All in-progress RCAs and closed RCAs with actions pending are reported monthly to the Patient Safety Committee which reports to the Quality Executive Council (QEC) with documentation in the minutes. Continuous monitoring of the timeliness of RCA completions and submissions is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the total number of RCAs completed and submitted to the NCPS within 45 days; denominator is the total number of RCAs submitted to the NCPS for the same review period. As of August 19, 2020, five (5) RCAs have been chartered since March 1, 2020, and four (4) have been completed and submitted to the NCPS within 45 days or less. A fifth RCA was chartered on July 30, 2020, and is on track for completion and submission to the NCPS within 45 days with an outbrief to the Director/Executive Leadership Team scheduled for September 3, 2020; the 'no later than' submission date to the NCPS to meet the 45-day timeline is September 9, 2020. Reasons for noncompliance were considered in the development of this plan.

Request closure of this recommendation based on supporting documentation.

⁵⁴ The OIG reviewed evidence sufficient to demonstrate that the healthcare system had completed improvement actions and therefore closed the recommendation before publication of the report.

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).⁵⁵

Clinical privileges need to be specific and based on the individual practitioner’s clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.⁵⁶

VHA defines the focused professional practice evaluation (FPPE) as “a time-limited period during which the medical staff leadership evaluates and determines the practitioner’s professional performance.” The FPPE process occurs when a provider is hired at the facility and granted initial privileges and before any new clinical privileges are granted. Additionally, VA facilities must continuously monitor the performance of their providers. VHA requirements state that “the on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered.”⁵⁷ The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
 - Establishment of criteria in advance
 - Use of minimum criteria for selected specialty LIPs⁵⁸
 - Clear documentation of the results and time frames
 - Evaluation by another provider with similar training and privileges
- OPPEs
 - Application of criteria specific to the service or section
 - Use of minimum criteria for selected specialty LIPs⁵⁹
 - Evaluation by another provider with similar training and privileges

⁵⁵ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

⁵⁶ VHA Handbook 1100.19.

⁵⁷ VHA Handbook 1100.19.

⁵⁸ VHA Acting Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

⁵⁹ VHA Acting DUSHOM Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

The OIG also determined whether service chiefs recommended continuing the LIPs' current privileges based in part on the results of OPPE activities and if the healthcare system's Executive Committee of the Medical Staff decided to recommend continuing privileges based on FPPE and OPPE results.

Further, VA must put processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former licensed practitioner's clinical practice, VA has an obligation to notify state licensing boards (SLBs) and to subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.⁶⁰ Further, "VA medical facility Directors must designate an individual, and backup, to be responsible for the SLB reporting process. This individual will be the subject matter expert (SME) for the facility...and ensure oversight of the exit review process, including receipt, review, and maintenance of the Provider Exit Review Forms."⁶¹ The OIG reviewers assessed whether the healthcare system's staff

- Designated an individual and backup responsible for the SLB reporting process,
- Completed forms within the required time frame and with required oversight, and
- Reported results to SLBs when indicated.

To determine whether the healthcare system complied with requirements, the OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members:

- One solo/few practitioner who underwent initial or reprivileging during the previous 12 months⁶²
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs privileged within 12 months before the visit
- Twenty LIPs who left the healthcare system in 12 months before the visit

Medical Staff Privileging Findings and Recommendations

The healthcare system generally complied with some of the requirements for medical staff privileging. The OIG noted weaknesses with FPPE, OPPE, and provider exit review processes.

⁶⁰ VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005.

⁶¹ VHA Notice 2018-05, *Amendment to VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards*, February 5, 2018.

⁶² VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers few practitioners as being less than three providers in the facility that are privileged in a particular specialty. The 12-month review period was from November 4, 2018, through November 4, 2019.

VHA requires the criteria for the FPPE process “to be defined in advance, using objective criteria accepted by the practitioner.”⁶³ The OIG found 3 of 10 practitioners’ profiles contained evidence that the LIPs were aware of the criteria for evaluation before service chiefs initiated the FPPE process. This could result in the remaining LIPs’ misunderstanding of FPPE expectations. The Associate Chief of Staff for Credentialing and Privileging reported noncompliance was due to the use of inadequate forms, which have since been updated and approved by the Executive Committee of the Medical Staff.

Recommendation 7

7. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures clinical managers define in advance, communicate, and document expectations for focused professional practice evaluations in practitioners’ profiles.

Healthcare system concurred.

Target date for completion: January 31, 2021

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of this corrective action to ensure that clinical service managers define in advance, communicate, and document Focused Professional Practice Evaluation (FPPE) expectations in the profiles of licensed independent healthcare practitioners. The healthcare system had self-identified that improvements to the FPPE process were needed. The facility’s FPPE template was updated in September 2018 which included an affirmation that a review of the FPPE elements with the practitioner occurred. To further strengthen this process, the FPPE elements are to be reviewed with the practitioner during their orientation to ensure all practitioners are aware of the criteria under evaluation. In August 2020, the Chief of Staff signed a memorandum to all Service Line/Service Chiefs reinforcing this requirement. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the number of FPPEs with documentation that FPPE elements were reviewed with the practitioner; denominator is the total number of FPPEs completed during the same review period. Reasons for noncompliance were considered in the development of this plan.

VHA requires FPPE results to be documented in LIP profiles.⁶⁴ The OIG found documented evidence of FPPE results in 7 of 10 LIP profiles. This resulted in the remaining LIPs providing care without a thorough competency evaluation, which could impact quality of care and patient

⁶³ VHA Handbook 1100.19.

⁶⁴ VHA Handbook 1100.19.

safety. Credentialing and privileging staff reported a lack of a systematic process to track and ensure completion of FPPEs.

Recommendation 8

8. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs complete and document focused professional practice evaluation results in licensed independent practitioners' profiles.

Healthcare system concurred.

Target date for completion: February 28, 2021

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of this corrective action to ensure that Service Chiefs complete and document Focused Professional Practice Evaluation (FPPE) in the profiles of all newly licensed independent healthcare practitioners. The facility's policy 11-92, *Focused Professional Practice Evaluation, Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation for Cause*, dated May 2, 2019, outlines the facility's requirements for FPPEs. Completion of the FPPE is the responsibility of the Service Line Manager which is turned into the Credentialing and Privileging Office within 120 days of the practitioner's start of clinical activity. Service Line/Service Managers have been educated on the FPPE process and requirements, receive an initial notification, and a reminder of the FPPE due date. To improve timely FPPE completion, the Credentialing and Privileging Office will provide a summary report on FPPE completion status to the Clinical Executive Council (CEC) monthly with documentation in the minutes. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the number of FPPE results completed and turned into the Credentialing and Privileging Office within 120 days for all newly hired licensed independent practitioners during the review period; denominator is the total number of newly hired licensed independent practitioners during the same review period. Reasons for noncompliance were considered in the development of this plan.

VHA requires that LIPs are evaluated on an ongoing basis by practitioners with similar training and privileges.⁶⁵ The OIG found that the OPPE of one solo LIP lacked evidence that a practitioner with similar training and privileges completed the evaluation. As a result, the LIP continued to deliver care without a thorough competency evaluation, which could impact quality care and patient safety. The Associate Chief of Staff for Credentialing and Privileging was unable to provide a reason for noncompliance.

⁶⁵ VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

Recommendation 9

9. The Chief of Staff determines the reasons for noncompliance and ensures that practitioners with similar training and privileges complete ongoing professional practice evaluations.⁶⁶

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of this corrective action to ensure that the Ongoing Professional Practice Evaluation (OPPE) of solo-practitioners is completed by a practitioner with similar training and privileges. The health care system had previously self-identified that improvements to the professional practice evaluation process of solo-practitioners were needed. The facility's Focused Professional Practice Evaluation (FPPE) template was updated in September 2018 to include the determination if a clinician was a solo-practitioner. Continuous monitoring is conducted until 100 percent compliance is sustained for two consecutive quarters (six months). The healthcare system currently has one (1) solo-practitioner whose OPPE for the previous two (2) review periods was completed by a practitioner from outside the facility who had similar training and privileges. Numerator is the total number of OPPEs for a solo-practitioner whose OPPE was completed by a practitioner with similar training and privileges; denominator is the total number of OPPEs completed for solo-practitioners. Reasons for noncompliance were considered in the development of this plan.

Request closure of this recommendation based on supporting documentation.

VHA requires that the determination to continue current privileges is based, in part, on OPPE activities such as direct observation, clinical pertinence reviews, and clinical discussions. The OIG found that service chiefs' determinations to continue privileges were based on OPPE activities for 10 of 20 LIPs who were repriviledged within the last 12 months. This resulted in the remaining 10 LIPs providing care without thorough competency evaluations. Credentialing and privileging staff stated that prior to Spring 2019, the Professional Standards Board's evaluation process did not include a review of supporting data along with the OPPE summary forms.

Recommendation 10

10. The Chief of Staff determines the reasons for noncompliance and makes certain that service chiefs' determinations to continue privileges are based in part on results of ongoing professional practice evaluation activities.

⁶⁶ The OIG reviewed evidence sufficient to demonstrate that the healthcare system had completed improvement actions and therefore closed the recommendation before publication of the report.

Healthcare system concurred.

Target date for completion: January 31, 2021

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of this corrective action to ensure that a Service Chief's determination to continue the privileges of a licensed independent healthcare practitioner is based in part on the practitioner's Ongoing Professional Practice Evaluation (OPPE) data. The facility's policy 11-92 *Focused Professional Practice Evaluation, Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation for Cause*, dated May 2, 2019, outlines the requirements for OPPE, to include the requirement for the use of supporting data. At the time of a practitioner's reappointment, the Professional Standards Board (PSB) will require supporting data to be submitted with the completed OPPE with documentation in the PSB minutes. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the number of practitioner OPPEs with accompanying supporting data submitted to the PSB for reappointment for the most recent OPPE review period; denominator is the total number of practitioner OPPEs submitted to the PSB for reappointment. Reasons for noncompliance were considered in the development of this plan.

VHA also requires the Executive Committee of the Medical Staff to review and evaluate LIPs' privileging requests. Committee minutes must indicate the materials reviewed and the rationales for the conclusions. The committee's recommendations are then submitted to the System Director for approval.⁶⁷

The OIG found that the Executive Committee of the Medical Staff's meeting minutes reflected its decisions to grant continuation of privileges prior to approval by the System Director for 5 of 10 newly hired and 9 of 20 repriviledged LIPs. The Executive Committee of the Medical Staff did not review the FPPEs for 5 newly hired LIPs and did not examine OPPE supporting data for 11 repriviledged LIPs prior to recommending continuation of privileges. This resulted in incomplete evidence to support the System Director's approval for continuing clinical privileges which could impact quality care and patient safety. Credentialing and privileging staff reported a lack of a systematic process to track and ensure the Executive Committee of the Medical Staff reviewed the completed FPPEs. Staff also stated that prior to Spring 2019, the Professional Standards Board's evaluation process did not include a review of supporting data along with the OPPE summary forms, which resulted in the Executive Committee of the Medical Staff reviewing incomplete documents and recommending continuation of privileges.

⁶⁷ VHA Handbook 1100.19.

Recommendation 11

11. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Executive Committee of the Medical Staff's decisions to recommend continuation of privileges are based on focused and ongoing professional practice evaluation results and documents its decision in the meeting minutes.

Healthcare system concurred.

Target date for completion: January 31, 2021

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of this corrective action to ensure that the decision of the Clinical Executive Council (CEC) (previously designated as the Executive Committee of the Medical Staff) to recommend continuation of a licensed independent healthcare practitioner's privileges is based on the practitioner's Focused and Ongoing Professional Practice Evaluation (FPPE/OPPE) results, and that this decision is documented in the CEC minutes. Reasons for noncompliance were considered in the development of this plan. The facility policy's 11-92 *Focused Professional Practice Evaluation, Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation for Cause*, dated May 2, 2019, outlines the requirements for FPPE/OPPE. At the time of reappointment, the Professional Standards Board (PSB) requires supporting data to be submitted with the completed OPPE. The PSB minutes are sent and approved by the CEC weekly. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the total number of CEC decisions to recommend continuation of the practitioner's privileges based upon the practitioner's FPPE/OPPE results; denominator is the total number of CEC decisions to recommend continuation of practitioner privileges.

VHA requires provider exit review forms, which document the review of a provider's clinical practice, to "be completed within 7 calendar days of the departure of a licensed health care professional from a VA facility."⁶⁸ The OIG found that exit review forms were completed within 7 calendar days for 10 of 20 practitioners who departed the healthcare system in the previous 12 months. Inconsistent performance of this process may result in delayed reporting of potential substandard care to SLBs. Credentialing and privileging staff cited an inadequate process to track providers to ensure timely completion of exit review forms as the reason for noncompliance.

⁶⁸ VHA Notice 2018-05.

Recommendation 12

12. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that provider exit review forms are completed within seven calendar days of licensed healthcare practitioners' departure from the healthcare system.

Healthcare system concurred.

Target date for completion: January 31, 2021

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of this corrective action to ensure that provider exit review forms are completed within seven (7) calendar days of the licensed independent healthcare practitioner's departure from the healthcare system. The Service Line/Service Managers were educated on the importance and reason for the exit reviews. Designated credentialing staff will monitor and report compliance with the timely completion of practitioner exit reviews monthly to the Clinical Executive Council (CEC) with documentation in the minutes. Designated credentialing staff also review the Gains and Losses (G&L) report to ensure all exit reviews have been obtained prior to inactivation of a departing practitioner's VetPro account. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is total number of exit reviews completed within seven (7) calendar days of the licensed independent healthcare practitioner's date of departure from the healthcare system; denominator is the total number of licensed independent healthcare practitioners who departed from the healthcare system. Reasons for noncompliance were considered in the development of this plan.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct Comprehensive Environment of Care Inspection Rounds and to resolve issues in a timely manner. The goal of the Comprehensive 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.⁶⁹

The purpose of this facet of the OIG inspection was to determine whether the healthcare system maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the healthcare system met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the inpatient mental health unit where patients with active suicidal ideation or attempts are treated. Inspectors reviewed several aspects of the healthcare system's environment:

- Healthcare system
 - General safety
 - Special use spaces
 - Environmental cleanliness and infection prevention
 - Privacy
 - Accommodation and privacy for women veterans
 - Logistics
- Inpatient mental health unit
 - General safety
 - Special use spaces
 - Environmental cleanliness and infection prevention
 - Privacy
 - Accommodation for women veterans
 - Logistics
- Community-based outpatient clinic (CBOC)
 - General safety

⁶⁹ VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.

- Special use spaces
- Environmental cleanliness and infection prevention
- Privacy
- Privacy for women veterans
- Logistics

During its review of the environment of care, the OIG inspected the Blairsville VA Clinic and the following eight patient care areas:

- Acute psychiatric unit
- CLC
- Emergency Department
- Medical inpatient units (9C and 10C)
- Post-anesthesia care unit
- Primary care clinic (Purple Team)
- Surgical intensive care unit

The inspection team reviewed relevant documents and interviewed key employees and managers.

Environment of Care Findings and Recommendations

The OIG determined that the healthcare system achieved the requirements listed above and did not identify issues with equipment and supplies; however, during a subsequent review of *VHA's COVID-19 Screening Processes and Pandemic Readiness March 19–24, 2020*, healthcare system leaders reported a need for additional test kits, N95 and surgical masks, and eye protection.⁷⁰ The OIG made no recommendations.

⁷⁰ VA OIG, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness March 19–24, 2020*, Report No. 20-02221-120, March 26, 2020.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.⁷¹ The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.⁷² Long-term opioid use is of particular concern in the veteran population where there is a high incidence of posttraumatic stress disorder, major depressive disorder, alcohol use, substance abuse, and suicide attempts.⁷³ These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.⁷⁴

VHA requires routine assessments of pain and the completion of an opioid risk assessment before initiating patients on long-term opioid therapy and recommends against the therapy for patients with untreated substance use disorders. VHA also recommends avoiding drugs capable of inducing fatal interactions, such as opioids with benzodiazepines.⁷⁵ Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.⁷⁶ To achieve VHA's vision of providing patient-driven healthcare, providers are also required to obtain informed consent from patients and to provide education about the risks, benefits, and alternatives prior to initiating long-term opioid therapy.⁷⁷ VHA recommends evaluating patients receiving continued opioid therapy for improvement of pain and opioid-related adverse events at least every three months and more frequently as doses increase.⁷⁸

The OIG reviewers assessed staff's provision of pain management using long-term opioid therapy:

- Completion of initial screening for pain
- Assessment of aberrant behavior risk
- Avoidance of concurrent therapy with benzodiazepines
- Completion of urine drug testing intervention, when indicated

⁷¹ World Health Organization. "Information sheet on opioid overdose," August 2018. https://www.who.int/substance_abuse/information-sheet/en/. (This website was accessed on November 6, 2019.)

⁷² Centers for Disease Control and Prevention. "Opioid Overdose, Understanding the Epidemic," December 19, 2018. <https://www.cdc.gov/drugoverdose/epidemic/>. (The website was accessed on November 6, 2019.)

⁷³ VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, Version 3.0. February 2017. <https://www.healthquality.va.gov/guidelines/Pain/cot/>. (The website was accessed on November 6, 2019.)

⁷⁴ VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain.

⁷⁵ According to the U.S. Department of Justice's Drug Enforcement Administration, benzodiazepines "are a class of drugs that produce central nervous system (CNS) depression and that are most commonly used to treat insomnia and anxiety." https://www.deadiversion.usdoj.gov/drug_chem_info/benzo.pdf. (The website was accessed on December 1, 2019.)

⁷⁶ VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain.

⁷⁷ VHA Directive 1005, *Informed Consent for Long-Term Opioid Therapy for Pain*, May 13, 2020.

⁷⁸ VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain.

- Documentation of informed consent
- Timely follow-up with patients included required elements

VHA also requires facilities to establish a multidisciplinary pain management committee “to provide oversight, coordination, and monitoring of pain management activities and processes.” Monitoring measures include, but are not limited to, adherence to published clinical practice guidelines, timeliness of treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment, patient satisfaction, and quality of life.⁷⁹ The OIG examined the following indicators for program oversight and evaluation:

- Performance of pain management committee activities
- Monitoring of quality measures
- Following the quality improvement process

The OIG interviewed key employees and managers and reviewed relevant documents and the electronic health records of 38 outpatients who had newly-dispensed (no VA dispensing in previous six months) long-term opioids for pain, daily or intermittently for 90 or more calendar days through VA from July 1, 2018, through June 30, 2019. The OIG considered whether providers acted in accordance with guidelines for the provision of pain management and the healthcare system’s oversight process for evaluating pain management outcomes and quality.

Medication Management Findings and Recommendations

The healthcare system addressed some of the indicators of expected performance, including pain screening, documented justification for concurrent therapy with benzodiazepines, patient follow-up, and the use of a multidisciplinary pain management committee to oversee and monitor required quality measures. However, the OIG found deficiencies with aberrant behavior risk assessments, urine drug testing, and informed consent.

VA/DoD clinical practice guidelines recommend providers follow up with patients within three months after initiating long-term opioid therapy to assess patients’ adherence to their pain management plans of care and effectiveness of interventions.⁸⁰ The OIG determined that providers completed follow-up within three months in 97 percent of the patients reviewed. Of those, the OIG determined that providers assessed adherence to the pain management plans of care in 86 percent and effectiveness of interventions in 79 percent of the patients.⁸¹ Failure to assess adherence and effectiveness of interventions can result in missed opportunities to evaluate the risks and benefits of continued opioid therapy. The Pain Committee co-chairpersons attributed the noncompliance to providers’ lack of attention to detail and competing priorities

⁷⁹ VHA Directive 2009-053, *Pain Management*, October 28, 2009.

⁸⁰ VA/DoD *Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

⁸¹ Confidence intervals are not included because the data represents every patient in the study population.

due to increased patient workload. The OIG made no recommendations related to assessment of adherence to the pain management plans of care and effectiveness of interventions due to the low number of outpatients who completed follow-up appointments during the review period.

VA/DoD clinical practice guidelines also recommend that providers complete an aberrant behavior risk assessment, including history of substance abuse, psychological disease, and aberrant drug-related behaviors,⁸² prior to initiating long-term opioid therapy.⁸³ The OIG determined that providers documented psychological disease in 86 percent and aberrant drug-related behaviors in 72 percent of the patients reviewed.⁸⁴ This may have resulted in providers prescribing opioids for patients at high-risk for misuse. The Pain Committee co-chairpersons stated behavior risk assessments were not completed consistently due to providers' lack of attention to detail and competing priorities caused by increased patient workload.

Recommendation 13

13. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that providers complete an aberrant behavior risk assessment that includes psychological disease and aberrant drug-related behaviors on all patients prior to initiating long-term opioid therapy.

⁸² *Pain Management, Opioid Safety, VA Educational Guide* (2014). July 2014. Examples of aberrant drug related behaviors include “lost prescriptions, multiple requests for early refills, unauthorized dose escalation, apparent intoxication, and frequent accidents.”

⁸³ *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

⁸⁴ Confidence intervals are not included because the data represents every patient in the study population.

Healthcare system concurred.

Target date for completion: March 31, 2021

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of actions to ensure that an aberrant behavior risk assessment that includes psychological disease and aberrant drug-related behaviors is completed and documented on all patients prior to initiating long-term opioid therapy. The healthcare system disagreed with the criteria used for aberrant behavior risk assessment which was based on the VA Pain Management Opioid Safety Education Guide (2014). This guide is not VA policy and contains examples of aberrant behavior such as alcohol use, illegal drugs, attention deficit disorder, and depression.

A VISN7 improvement initiative in support of the Opioid Safety Initiative (OSI) was the “One Note” template for Controlled Substances Monitoring which consolidates the numerous opioid precautions including assessment of aberrant behavior (history of substance abuse, psychological disease, and aberrant drug-related behaviors). In June 2019, the healthcare system started implementation of the “One Note” template by introducing all providers to the “One Note” for prescribing controlled substances; mandatory use of the “One Note” template became effective in May 2020. As such, providers are more involved in the evaluation of aberrant behaviors in comparison to Fiscal Year 2019, however, this remains part of the team approach to patient care.

The healthcare system will continue to monitor the completion and documentation of aberrant behavior risk assessment. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is number of patients where completion of an aberrant behavior risk assessment (includes psychological disease and aberrant drug-related behaviors) occurred prior to initiating LTOT [Long-term opioid therapy]; denominator is the total number patients initiated on LTOT for same review period. Reasons for noncompliance were considered in the development of this plan.

VA/DoD clinical practice guidelines recommend that providers conduct a “UDT [urine drug test] prior to initiating or continuing LOT [long-term opioid therapy] and periodically thereafter.”⁸⁵ The OIG determined that providers conducted initial urine drug screening in 81 percent of the patients reviewed.⁸⁶ This resulted in providers’ inability to identify whether the remaining 19 percent of patients had substance use disorders, determine potential diversion, and to ensure patients adhered to the prescribed medication regimen. As reported previously, the Pain Committee co-chairpersons attributed the noncompliance to providers’ lack of attention to detail and competing priorities due to increased patient workload.

⁸⁵ VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain.

⁸⁶ Confidence intervals are not included because the data represents every patient in the study population.

Recommendation 14

14. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers consistently conduct urine drug testing as required for patients on long-term opioid therapy.

Healthcare system concurred.

Target date for completion: February 28, 2021

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of this corrective action to ensure urine drug testing (UDT) are consistently conducted as required for patients on long-term opioid therapy (LTOT). In 2015, the facility approved a robust panel for comprehensive UDT that included not only the in-house UDT screen, but also tested for alcohol and opioid metabolites to minimize overlooking a new diagnosis of substance use disorder potential diversion. Since 2016, the healthcare system has utilized “one click” ordering within the electronic health record, which allowed the provider to order UDT panels every three (3) months for one year at a time. In June 2019, the healthcare system introduced the “One Note” template for Controlled Substances Monitoring to all providers; mandatory use of the “One Note” template became effective in May 2020. The “One Note” automatically pulls recent UDT results (if available) and provides easy to order recurring UDT panels for the provider. Per the Opioid Safety Initiative (OSI) Dashboard Report, the healthcare system’s LTOT patients with a completed drug screen has been greater than 90 percent throughout Fiscal Year 2019. Per the latest data available for Fiscal Year 2020 Quarter 3, the healthcare system’s UDT rate is above the national average. Of note, the current global COVID-19 pandemic led to the creation of a risk-benefit analysis for patient safety of requiring a LTOT patient to provide an updated UDT. The provider’s deliberate assessment of a LTOT patient as being low or average risk combined with the results of the patient’s previous UDTs may warrant a temporary postponement of the UDT when the risk of presenting to the facility laboratory outweighs the benefits. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the number of LTOT patients who had a UDT completed; denominator is the total number of LTOT patients reviewed during the same review period. Reasons for noncompliance were considered in the development of this plan.

VHA requires providers to obtain and document informed consent prior to the initiation of therapeutic treatments that have a significant risk of complication or morbidity, including long-term opioid therapy.⁸⁷ VHA also recommends that informed consent conversations cover the

⁸⁷ VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, revised September 20, 2017.

risks and benefits of opioid therapy as well as alternative therapies.⁸⁸ The OIG determined that providers documented informed consent prior to initiating long-term opioid therapy in 67 percent of the patients reviewed.⁸⁹ The remaining 33 percent of patients, therefore, may have been receiving treatment without knowledge of the risks associated with long-term opioid therapy, including opioid dependence, tolerance, addiction, and intentional or unintentional fatal overdose. Again, the Pain Committee co-chairpersons cited providers' lack of attention to detail and competing priorities caused by increased patient workload as the reasons for noncompliance.

Recommendation 15

15. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers consistently obtain and document informed consent prior to initiating patients on long-term opioid therapy.

⁸⁸ VHA Directive 1005.

⁸⁹ Confidence intervals are not included because the data represents every patient in the study population.

Healthcare system concurred.

Target date for completion: December 31, 2020

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of this corrective action to ensure that providers consistently obtain and document informed consent prior to initiating patients on long-term opioid therapy (LTOT). VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, states that a new informed consent must be obtained “if there is a significant deviation from the treatment plan to which the patient originally consented or if there is a change in the patient’s condition or diagnosis that would reasonably be expected to alter the original informed consent.” Unless the original treatment has been deviated or there is a change in the Veterans condition or diagnosis, a new consent form is not warranted. As the VHA is an integrated health care system, the handbook also does not specify that a new informed consent is required when there is a change of provider.

Per the Strategic Tool for Opioid Risk Mitigation (STORM), the facility’s compliance for informed consent for LTOT has been greater than 92 percent. To ensure continued compliance, the healthcare system began implementation of the “One Note” template for Controlled Substances Monitoring in June 2019, and fully mandated its use in May 2020. One Note pulls required actions, to include informed consent, into the documentation before prescribing LTOT. Due to the current global COVID-19 pandemic, the facility has converted most face-to-face appointment to alternate virtual modalities, i.e. telephonic and VA Video Connect (VVC). Therefore, since patients are not physically present to sign the informed consent, verbal consent is obtained. The content of the consent is verbally reviewed and discussed with the patient who acknowledges understanding and consents to the treatment as planned; appropriate documentation in the electronic health record occurs.

Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is number of patients on LTOT where an informed consent was obtained from the patient prior to initiating LTOT; denominator is total number of patients initiated on LTOT for the same review period. Reasons for noncompliance were considered in the development of this plan.

Mental Health: Suicide Prevention Program

In 2017, suicide was the 10th leading cause of death, with approximately 47,000 lives lost across the United States.⁹⁰ The suicide rate was 1.5 times greater for veterans than for non-veteran adults and estimated to represent approximately 22 percent of all suicide deaths in the United States.⁹¹ Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.⁹²

VHA has identified suicide prevention as a top priority and implemented various evidence-based approaches to reduce the veteran suicide rate. In addition to expanded mental health services and community outreach, VHA has developed comprehensive screening and assessment processes to identify at-risk patients.⁹³

VHA requires that each medical center and very large CBOC have a full-time suicide prevention coordinator (SPC) to track and follow up with high-risk veterans, develop a process for responding to referrals from hotlines such as the Veteran Crisis Line, and conduct community outreach activities.⁹⁴ The OIG examined various requirements related to SPCs:

- Assignment of a full-time SPC
- Tracking and follow-up of high-risk veterans
 - Patients' completion of four appointments within the required time frame
 - Safety plan completion within the required time frame
 - Mental health teams' contacts with patients for missed appointments
- Provision of suicide prevention training for nonclinical employees at new employee orientation
- Completion of at least five outreach activities per month

VHA also requires that any patient determined to be at high risk for suicide be added to the facility high-risk list and have a High Risk for Suicide (HRS) Patient Record Flag (PRF) placed

⁹⁰ Centers for Disease Control and Prevention. *Preventing Suicide*.

<https://www.cdc.gov/violenceprevention/suicide/fastfact.html>. (The website was accessed on March 4, 2020.)

⁹¹ Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016*, September 2018; Department of Veterans Affairs, *National Strategy for Preventing Veteran Suicide 2018-2028*.

⁹² Veterans who recently used VHA services are defined as having an encounter in the calendar year of death or in the previous year; Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016*.

⁹³ *VA Office of Mental Health and Suicide Prevention Guidebook*, June 2018.

⁹⁴ According to VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015, very large CBOCs are those that serve more than 10,000 unique veterans each year. The Veterans Crisis Line connects veterans with qualified responders through a confidential toll-free hotline, online chat, and text-messaging service to receive confidential support 24 hours a day. Community outreach activities are described in VHA Handbook 1160.01.

in his or her electronic health record “as soon as possible but no later than 1 business day after such determination by the SPC.”⁹⁵ According to VHA, “Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death... The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions.”⁹⁶ The HRS PRF is reviewed at least every 90 days and depending on changes to the suicide risk status will remain active or be removed.⁹⁷ Additionally, VHA requires designated high-risk patients to have a completed suicide safety plan and four face-to-face visits with an acceptable provider within the first 30 days of designation.⁹⁸

The OIG noted that from July 1, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA required that “Any patient determined to be High Risk for Suicide [by the licensed independent provider] must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination.”⁹⁹ However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management changed the requirement for the HRS PRF placement to be “as soon as possible but no later than 1 business day after determination by the SPC.”¹⁰⁰ VHA further provided additional clarifying information:

- The “SPC exclusively controls the HRS-PRF and must limit their use to patients who meet the criteria of being placed on the facility high-risk suicide list.”
- “The time frame of placing the flag begins once the SPC makes the determination that an HRS-PRF is warranted.”
- The SPC’s determination process “may be beyond 24 hours after a referral, due to case consultation and review.”¹⁰¹

The OIG is concerned that the updated requirement may result in delayed placement of HRS PRFs for at-risk patients. Without defined time frames for SPC determination that the HRS PRF

⁹⁵ VHA DUSHOM Memorandum, *Update to High Risk for Suicide Patient Record Flag Changes*, January 16, 2020.

⁹⁶ VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

⁹⁷ *VA’s Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide*, January 5, 2018; VHA DUSHOM Memorandum, *High Risk for Suicide Patient Record Flag Changes*, October 3, 2017.

⁹⁸ A safety plan is a written list of coping strategies and support sources for use during or preceding suicidal crises. Face-to-face visits may be performed as telephone visits if requested by the patient. The requirement for four face-to-face visits within 30 days of designation can be found in *VA’s Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide*.

⁹⁹ VHA DUSHOM Memorandum, *High Risk for Suicide Patient Record Flag Changes*, October 3, 2017.

¹⁰⁰ VHA DUSHOM Memorandum, *Update to High Risk for Suicide Patient Record Flag Changes*, January 16, 2020.

¹⁰¹ VHA, *Response to Questions by VA OIG Office of Healthcare Inspections from February 12, 2020*, received February 19, 2020.

is warranted, patients identified as at-risk for suicide could have flags placed in his or her chart several days after referral. For example, the current requirement would allow for a patient to be identified as high risk for suicide and referred to the SPC on Monday, the SPC to assess the patient for risk and determine the need for an HRS PRF on the following Friday, and the SPC to place an HRS PRF on the subsequent Monday (a week after referral).

On March 27, 2020, VHA also updated existing policy requirements to allow the review of HRS PRFs to “occur no earlier than 10 days before and no later than 10 days after the 90-day due date.”¹⁰²

Inspectors examined the completion of several requirements:

- Review of HRS PRFs within the required time frame
- Completion of at least four mental health visits within 30 days of HRS PRF placement
- Appropriate follow-up for no-show high-risk appointments
- Completion of suicide safety plans with the required elements within the required time frame

All VHA employees must complete suicide risk and intervention training within 90 days of entering their position. Clinical staff (including physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and Vet Center counselors) must complete Suicide Risk Management Training for Clinicians, and nonclinical staff must complete Operation S.A.V.E. training.¹⁰³ VHA also requires that all staff receive annual refresher training.¹⁰⁴ In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.¹⁰⁵

To determine whether the healthcare system complied with OIG-selected suicide prevention program requirements, the inspection team interviewed key employees and reviewed

- Relevant documents;

¹⁰² VHA Notice 2020-13, *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*, March 27, 2020.

¹⁰³ Operation S.A.V.E. is a VA gatekeeper training program provided by suicide prevention coordinators to veterans and those who serve veterans. The acronym “S.A.V.E” summarizes the steps needed to take in recognizing and responding to a veteran in suicidal crisis. The training was designed for non-clinical employees and includes food service workers, registration clerks, volunteers, and police. It should also be viewed by ancillary/support staff or any other category not covered by the clinical training.

¹⁰⁴ VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017.

¹⁰⁵ The training was designed for nonclinical employees and includes food service workers, registration clerks, volunteers, and police. It should also be viewed by ancillary/support staff or any other category not covered by the clinical training. VHA DUSHOM Memorandum, *Suicide Awareness Training*, April 11, 2017.

- The electronic health records of 40 randomly selected outpatients whose electronic health records were flagged as high risk for suicide from July 1, 2018, to June 30, 2019; and
- Staff training records.

Mental Health Findings and Recommendations

The healthcare system complied with requirements associated with tracking and follow-up of high-risk veterans. However, the OIG found deficiencies.

With VHA's original requirement that was in place when these patients received care—that “Any patient determined to be High Risk for Suicide must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination”¹⁰⁶—the OIG estimated that 28 percent of HRS PRFs were placed within 24 hours of referral to the SPC.¹⁰⁷ Based on the current updated requirement that the SPC be responsible for determining placement of the HRS PRF (without a defined timeframe for doing so), the OIG calculated that the average time from referral to HRS PRF placement for the patients reviewed was 3 days (observed range was 0–6 days).

VHA requires that each facility and very large CBOC (“those that serve more than 10,000 unique veterans each year”) has at least one full-time SPC.¹⁰⁸ Consultatively, the OIG found that the healthcare system's two very large CBOCs—Atlanta VA and Fort McPherson— did not have a full-time SPC. Lower-than-ideal staffing could mean that at-risk patients do not receive the appropriate quality and coordination of care. During a discussion, the Mental Health Service Line Chief reported a lack of understanding the requirement and a belief that current staffing was sufficient. The OIG made no recommendation.

Additionally, the OIG noted concerns with monthly outreach activities and suicide prevention training.

VHA also requires the SPC to deliver five community outreach activities each month.¹⁰⁹ From October through December 2019, the OIG noted that the SPC completed 11 of the 15 required outreach activities.¹¹⁰ Failure to conduct outreach could negatively impact at-risk veterans who have not received mental health services at the VA. The Mental Health Service Line Chief and

¹⁰⁶ VHA DUSHOM Memorandum, *High Risk for Suicide Patient Record Flag Changes*, October 3, 2017.

¹⁰⁷ The OIG estimated that 95 percent of the time, the true compliance rate is between 13.9 and 41.7 percent, which is statistically significantly below the 90 percent benchmark.

¹⁰⁸ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008 (amended November 16, 2015).

¹⁰⁹ *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care Suicide Prevention Coordinator Guide*.

¹¹⁰ October 1, 2019, through December 31, 2019.

acting Deputy Chief attributed the noncompliance to staffing issues and competing patient care priorities.

Recommendation 16

16. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Suicide Prevention Coordinator delivers at least five outreach activities each month.

Healthcare system concurred.

Target date for completion: January 31, 2021

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of this corrective action to ensure that at least five (5) outreach activities are conducted each month by the Suicide Prevention Coordinators. Five (5) additional staff were recruited for the facility's Suicide Prevention Program (3-Regional Suicide Prevention Coordinators and 2-Suicide Prevention Case Managers), and all were onboarded by July 5, 2020. These personnel are supporting the Suicide Prevention Program (SPP) outreach requirement of five (5) activities per month. One Regional Suicide Prevention Coordinator has been designated as the lead for outreach activities and is required to submit bi-weekly reports to the Suicide Prevention Program Manager, and which includes suicide prevention focused outreach activities conducted by the Recovery Implementation Program. The outreach activities are then reported monthly to the Suicide Prevention Committee with documentation in the minutes. Of note, traditional community outreach activities have been suspended due to the current global COVID-19 pandemic. Virtual outreach opportunities are being explored and monthly mailings continue to occur. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is number of outreach activities conducted per month; denominator is five (5) per month. Reasons for noncompliance were considered in the development of this plan.

Additionally, VHA requires that all employees complete suicide risk and intervention training within 90 days of entering their position and annual refresher training thereafter.¹¹¹ The OIG found that three of five employees completed the required initial training within 90 days of being hired. In addition, 11 of 18 employees completed annual refresher training at or within one year of initial training. Lack of training for all employees could prevent optimal care to veterans who are at risk for suicide. For employees that did not complete initial training within 90 days of hire, system managers attributed the noncompliance to staff forgetting to sign the orientation attendance sheet or supervisors excusing attendance. In addition, system managers reported a

¹¹¹ VHA Directive 1071.

lack of oversight and follow through from service line managers as the reason for not meeting the annual refresher training requirement.

Recommendation 17

17. The System Director evaluates and determines any additional reasons for noncompliance and ensures all staff receive initial and annual refresher suicide prevention training.

Healthcare system concurred.

Target date for completion: January 31, 2021

Healthcare system response: The Healthcare System Director is the executive champion for the implementation and sustainment of this corrective action to ensure that all new employees receive initial suicide prevention training within the first 90 days of employment, either during New Employee Orientation (NEO) or via completion of the assigned Talent Management System (TMS), and that all current employees complete annual refresher training. A Suicide Prevention Training delinquency report is generated monthly by the Education Service Line. The training delinquency report is reviewed during the Suicide Prevention Committee (SPC) meeting, and committee members from the program areas are assigned to address their delinquencies. Compliance for Suicide Prevention training is reported monthly to the Quality Executive Council (QEC). Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Of note, during this global COVID-19 pandemic, NEO has been modified, presentations have been abbreviated and not all previously scheduled presentations are provided “live” during NEO. In lieu of, new employees are assigned to complete the appropriate TMS course for Suicide Prevention Training. For new employees, numerator is the number of new employees who complete Suicide Prevention Training within 90 days of hire; denominator is the total number of new employees for the same review period. For existing employees, numerator is the number of employees who completed their annual Suicide Prevention training; denominator is the total number of employees required to complete their annual Suicide Prevention training for the same review period. Reasons for noncompliance were considered in the development of this plan.

Care Coordination: Life-Sustaining Treatment Decisions

Life-sustaining treatments (LSTs) are intended to extend the life of a patient expected to die soon without medical intervention. LSTs may include artificial nutrition, hydration, and mechanical ventilation. VHA issued the life-sustaining treatment decisions (LSTD) handbook to standardize practices related to discussing and documenting goals of care and LSTD. Per VHA, the goal is to encourage personalized, proactive, patient-driven treatment plans for veterans with serious illness by “...eliciting, documenting, and honoring patients’ values, goals, and preferences.”¹¹²

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.¹¹³ Implementation requirements included initiating conversations about the goals of care. A goals of care conversation is a discussion between a healthcare provider and a patient or surrogate to help define the patient’s values, goals, and preferences for care and, based on the discussion, make choices about starting, limiting, or ceasing LSTs.¹¹⁴ VHA requires practitioners to initiate goals of care conversations with high-risk patients—including hospice patients or their surrogates—within a time frame that meets the medical needs of the patient or at the time of a triggering event.¹¹⁵

The OIG noted that from July 12, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA policy defined the elements of a goals of care conversation to be documented in an LST progress note in the electronic health record, which included

- Decision-making capacity,
- Identification of a surrogate if the patient loses decision-making capacity,
- Patient or surrogate understanding of the patient’s condition,
- Goals of care,
- Plan of care for the use of LST, including whether cardiopulmonary resuscitation will be attempted in the event of cardiac arrest, and
- Informed consent for the LST plan.

¹¹² VHA Handbook 1004.03(1), *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients’ Values, Goals and Preferences*, January 11, 2017, amended March 19, 2020.

¹¹³ According to VHA Handbook 1004.03(1), the medical facility must fully implement handbook requirements within 18 months of publication.

¹¹⁴ According to VHA Handbook 1004.03(1), a surrogate is legally authorized under VA policy to serve as the decision maker on behalf of the patient should the patient lose decision-making capacity.

¹¹⁵ VHA Directive 1139, *Palliative Care Consult Teams (PCCT) And VISN Leads*, June 14, 2017, defines hospice patients as individuals diagnosed with a terminal condition with a life expectancy of six months or less if the disease runs its projected course. According to VHA Handbook 1004.03(1), triggering events requiring goals of care conversations include those “prior to referral or following admission (e.g., within 24 hours) to VA or non-VA hospice.”

However, on March 19, 2020, VHA amended the requirements related to documenting patients' goals of care. Although the elements of the goals of care conversation are still required, the LST progress note must document at a minimum

- Decision-making capacity,
- Goal(s) of care,
- Plan of care for the use of LST, and
- Informed consent for the LST plan.

The OIG is concerned that VHA's updated requirement could mislead practitioners to only address those goals of care conversation elements that are required to be documented in the LST progress note.

The healthcare system was assessed for its adherence to requirements for goals of care conversations:

- Completion of LSTD notes
- Timely documentation of LSTD
- Inclusion of required elements in LSTD documentation
- Completion of LSTD note/orders by an authorized provider or delegation to a designee met all requirements

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.¹¹⁶ Inspectors examined if the healthcare system established an LSTD committee that was comprised of a multidisciplinary membership, which included representation from Ethics Consultation Service, and reviewed proposed LST plans.

To determine whether the healthcare system complied with the OIG-selected requirements related to LSTD for hospice patients, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 37 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

Care Coordination Findings and Recommendations

Generally, the healthcare system achieved the requirements listed above. The OIG made no recommendations.

¹¹⁶ VHA Handbook 1004.03(1).

Women’s Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.¹¹⁷

According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans are anticipated to increase.¹¹⁸ To help the VA better understand the needs of the growing women’s veteran population, efforts have been made by VHA to identify and address the urgent needs “by examining health care use, preferences, and the barriers Women Veterans face in access to VA care.”¹¹⁹ Additionally, a VA report in 2016 on suicide among veterans pointed out concerning trends in suicide among women veterans and discussed “the importance of understanding suicide risk among women veterans and developing gender-tailored suicide prevention strategies.”¹²⁰

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment. Facilities must, therefore, ensure availability of appropriate resources, services, and staffing ratios.¹²¹ VHA also requires delivery of quality care to all women veterans accessing VA emergency services. In addition, VHA requires facilities to establish a multidisciplinary women veteran health committee that “develops and implements a Women’s Health Program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans.”¹²²

To determine whether the healthcare system complied with OIG-selected VHA requirements to provide comprehensive healthcare services to women veterans, the inspection team reviewed relevant documents and interviewed selected managers and staff on the following requirements:

- Provision of care requirements

¹¹⁷ National Center for Veterans Analysis and Statistics, “VETPOP2016 LIVING VETERANS BY AGE GROUP, GENDER, 2015-2045,” Table 1L. https://www.va.gov/vetdata/Veteran_Population.asp. (The website was accessed on November 14, 2019.)

¹¹⁸ National Center for Veterans Analysis and Statistics, “Veteran Population,” May 3, 2019. https://www.va.gov/vetdata/docs/Demographics/VetPop_Infographic_2019.pdf. (The website was accessed on September 16, 2019.)

¹¹⁹ U.S. Department of Veterans Affairs, “Study of Barriers for Women Veterans to VA Health Care,” Final Report, April 2015. https://www.womenshealth.va.gov/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf. (The website was accessed on September 16, 2019.)

¹²⁰ U.S. Department of Veterans Affairs, Health Services Research & Development, Forum, *Concerning Trends in Suicide Among Women Veterans Point to Need for More Research on Tailored Interventions*, Suicide Prevention, Spring 2018. <https://www.hsrp.research.va.gov/publications/forum/spring18/default.cfm?ForumMenu=Spring18-5>. (The website was accessed on September 16, 2019.)

¹²¹ VHA Directive 1330.01(3), *Health Care Services for Women Veterans*, February 15, 2017, amended June 29, 2020.

¹²² VHA Directive 1330.01(3).

- Designated Women’s Health Patient Aligned Care Team established
- Primary Care Mental Health Integration services available
- Gynecologic care coverage available 24/7
- Gynecology care accessible
- Facility women health primary care providers designated
- CBOC women’s health primary care providers designated
- Emergency contraception accessible
- Oversight of program and monitoring of performance improvement data
 - Women Veterans Health Committee established
 - Quarterly meetings held
 - Core members attend
 - Quality assurance data collected and tracked
 - Reports made to clinical executive leaders
- Assignment of required staff
 - Women Veterans Program Manager
 - Women’s Health Medical Director or clinical champion
 - Maternity Care Coordinator
 - Women’s health clinical liaison at each CBOC

Women’s Health Findings and Recommendations

The healthcare system complied with requirements for most of the provision of care indicators and selected staffing elements reviewed. However, the healthcare system did not meet the recommended Women’s Health Patient Aligned Care Team staffing ratio of at least 3:1 (3 full-time equivalent staff to each women’s health primary care provider) reportedly due to multiple nursing and medical staff assistant vacancies.¹²³ The Women’s Health Medical Director was aware of the staffing recommendations and stated that job offers have been made to candidates and that many of the vacant positions were in various phases of the recruitment/selection process; therefore, the OIG made no recommendation.

Additionally, the OIG noted concerns with CBOC-designated women’s health primary care providers and the Women Veterans Health Committee membership.

¹²³ VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017.

VHA requires that each CBOC has at least two women’s health primary care providers or that arrangements for leave coverage are in place when there is only one designated provider.¹²⁴ The OIG found that the Austell CBOC had only one women’s health primary care provider and no evidence of plans for leave coverage, which could limit the system’s ability to provide comprehensive healthcare services to women veterans. The Women’s Health Medical Director and Women Veteran Program Manager cited insufficient staffing as the reason for noncompliance and reported that a primary care provider at the CBOC is a candidate for women’s health primary care provider designation.

Recommendation 18

18. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that the Austell community-based outpatient clinic has at least two designated women’s health primary care providers or arrangements for leave coverage when there is only one designated provider.¹²⁵

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of this corrective action to ensure that the Austell VA Clinic has at least two designated women’s health primary care providers (WH-PCPs) or arranges for coverage when there is only one designated WH-PCP due to projected absences. As of June 30, 2020, the Austell VA Clinic has two (2) designated WH-PCPs and is in compliance with VHA Directive 1330.01, *Healthcare Services for Women Veterans*. Both primary care providers completed a minimum of 20 hours of women’s health continuing medical education courses in Talent Management System (TMS) based on self-assessment of individual learning needs. Upon completion, a Women’s Health Primary Care Provider Competency Validation Form affirms each provider’s proficiency in the core concepts of primary care women’s health to provide comprehensive primary care for women. Continuous monitoring is conducted to ensure 100 percent compliance is sustained. Numerator is the number of designated WH-PCPs at the Austell VA Clinic; denominator is two (2). Reasons for noncompliance were considered in the development of this plan.

Request closure of this recommendation based on the supporting documentation.

VHA requires that the Women Veterans Health Committee meets quarterly, reports to executive leadership, and has a core membership. That membership includes a women veterans program

¹²⁴ VHA Directive 1330.01(3).

¹²⁵ The OIG reviewed evidence sufficient to demonstrate that the healthcare system had completed improvement actions and therefore closed the recommendation before publication of the report.

manager; a women’s health medical director; “representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership.”¹²⁶

The OIG reviewed the Women Veterans Health Committee meeting minutes from July through December 2019 and noted a lack of representation from medical and/or surgical subspecialties. Additionally, representatives from primary care, business office/non-VA medical care, and executive leadership did not attend any of the meetings. This resulted in a lack of expertise and oversight in data review and analysis as the committee planned and carried out improvements for quality and equitable women veterans care. The Women Veterans Program Manager and Women’s Health Medical Director attributed the noncompliance to system failures in replacing the medical and/or surgical representative and competing priorities for members who did not consistently attend committee meetings.

Recommendation 19

19. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that required members are assigned and consistently attend Women Veterans Health Committee meetings.

¹²⁶ VHA Directive 1330.01(3).

Healthcare system concurred.

Target date for completion: March 31, 2021

Healthcare system response: The Chief of Staff is the executive champion for the implementation and sustainment of this corrective action to ensure that required members are assigned and consistently attend the Women Veterans Health (WVH) Committee meetings. The Chair and Co-Chair of the WVH Committee identified participants who are required or “core” committee members, and the charter was updated to reflect these required members. An attendance roster is used to track attendance by the committee member (or alternate). The scheduled dates for the recurring WVH Committee meetings were sent to all committee members as a calendar invite; a reminder is sent a few days prior to each scheduled meeting. Appointed members have been instructed to designate an alternate to attend in the event of a committee member’s excused absence. Due to the global COVID-19 pandemic, virtual attendance at the WVH Committee meetings is available. Continuous monitoring of the WVH Committee meeting minutes and attendance tracker is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the total number of required members (or alternate) who attended the WVH Committee meeting; denominator is the total number of required members on the WVH Committee. Reasons for noncompliance were considered in the development of this plan.

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have a Sterile Processing Services (SPS) “to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment...”¹²⁷ The goal of SPS is to “...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections.”¹²⁸ To ensure this, VHA requires facilities to conduct the following activities:

- Maintain a current inventory list of all RME
- Have standard operating procedures (SOPs) that are based on current manufacturer’s guidelines and reviewed at least triennially
- Use CensiTrac[®] Instrument Tracking System for tracking reprocessed instruments¹²⁹
- Perform annual risk analysis and report results to the VISN SPS Management Board
- Monitor data for reprocessing and storing RME
- Conduct annual airflow/ventilation system inspections¹³⁰

VHA requires strict controls that closely monitor climate, storage, and sterilization parameters and additionally requires that quality assurance documentation of this monitoring be maintained for a minimum of three years.¹³¹ The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.¹³²

In addition, RME reprocessing areas must be clean, restricted, and airflow-controlled. All areas where RME reprocessing occurs must have safety data sheets, an unobstructed eyewash station, personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.¹³³

¹²⁷ VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.

¹²⁸ Association for Professionals in Infection Control and Epidemiology, *APIC Text of Infection Control and Epidemiology*, Chapter 107: Sterile Processing, April 26, 2019. https://text.apic.org/toc/infection-prevention-for-support-services-and-the-care-environment/sterile-processing#book_section_17348. (The website was accessed on May 14, 2019.)

¹²⁹ VHA DUSHOM Memorandum, *Instrument Tracking Systems for Sterile Processing Services*, January 1, 2019.

¹³⁰ VHA Directive 1116(2).

¹³¹ VHA Directive 1116(2); VHA DUSHOM Memorandum, *Interim Guidance for Heating, Ventilation and Air Conditioning (HVAC) Requirements Related to Reusable Medical Equipment (RME) Reprocessing and Storage*, September 5, 2017.

¹³² VHA Directive 7704(1), *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, February 16, 2016.

¹³³ VHA Directive 1116(2).

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued annual and essential staff competency assessments, and monthly continuing education. This ensures that staff have sufficient aptitude, knowledge, and skills to effectively and safely reprocess and sterilize RME.¹³⁴

To determine whether the healthcare system complied with OIG-selected requirements, the inspection team examined relevant documents and training records; conducted physical inspections of the SPS, Gastroenterology SPS, and clean storage areas; and interviewed key managers and staff on the following:

- Requirements for administrative processes
 - RME inventory file is current
 - SOPs are based on current manufacturer's guidelines and reviewed at least triennially
 - CensiTrac[®] System used
 - Risk analysis performed and results reported to the VISN SPS Management Board
 - Airflow checks made
 - Eyewash station checked
 - Daily cleaning schedule maintained
- Monitoring of quality assurance
 - High-level disinfectant solution tested
 - Bioburden tested
- Physical inspections of reprocessing and storage areas
 - Traffic restricted
 - Airflow monitored
 - Personal protective equipment available
 - Area is clean
 - Eating or drinking in the area prohibited
 - Equipment properly stored
 - Required temperature and humidity maintained

¹³⁴ VHA Directive 1116(2).

- Completion of staff training, competency, and continuing education
 - Required training completed in a timely manner
 - Competency assessments performed
 - Monthly continuing education received

High-Risk Processes Findings and Recommendations

Generally, the healthcare system met many of the above requirements for the proper operations and management of reprocessing RME. However, the OIG noted concerns with the storage of gastroenterology endoscopes and staff training.

VHA requires strict temperature and humidity ranges in clean and sterile storage areas of 66–72 degrees Fahrenheit with a relative humidity of 20–60 percent.¹³⁵ During a physical inspection of the gastroenterology area, the OIG found that the temperature and humidity readings in the two clean endoscope rooms were outside of the required parameters. Failure to achieve air quality standards can lead to the spread of healthcare-associated infections. The Gastroenterology Nurse Manager and staff reported that they were unaware that the temperature and humidity readings were not within acceptable limits because the monitoring system failed to alert staff of the out-of-range readings.

Recommendation 20

20. The Associate Director for Nursing and Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that temperature and humidity ranges are monitored and maintained in the gastroenterology clean scope rooms.

¹³⁵ VHA DUSHOM Memorandum, *Interim Guidance for Heating, Ventilation and Air Conditioning (HVAC) Requirements Related to Reusable Medical Equipment (RME) Reprocessing and Storage*, September 5, 2017.

Healthcare system concurred.

Target date for completion: December 31, 2020

Healthcare system response: The Associate Director for Nursing and Patient Care Services is the executive champion for the implementation and sustainment of this corrective action to ensure that the temperature and humidity ranges of the gastroenterology (GI) clean scope rooms are monitored to ensure appropriate air quality standards are met. The Information Technology (IT) department reinstalled the CheckPoint software to all computers in the GI Lab, to include the GI Nurse Manager. As of March 2020, all computers in the GI Lab receive “real-time” audible alerts. The GI Nurse Manager verified CheckPoint access for all required staff and re-educated staff on proper monitoring to include documentation of corrective actions. Temperature and humidity monitoring have been added to the nursing daily assignment sheet. Assigned nursing staff are responsible to perform a daily CheckPoint login to review the temperature and humidity readings and to take corrective actions for system alerts. The GI Nurse Manager or designee reviews assigned responsibility, aggregates the weekly CheckPoint compliance report, and submits results weekly to the SPS Chief Nurse or designee for aggregation and monthly reporting to the Reusable Medical Equipment (RME) Committee for further review with documentation in the minutes. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the total number of operational days per month where CheckPoint login occurred to review temperature and humidity; denominator is the total number of operational days for the same month. Reasons for noncompliance were considered in the development of this plan.

Since March 23, 2016, VHA has required that “...all new SPS employees must complete the SPS Level 1 training program within 90 days of hire.”¹³⁶ Of the five selected SPS employees hired after March 23, 2016, the OIG found that three completed the training within 90 days of hire. This could result in improper cleaning of the RME and compromise patient safety. The Chief Nurse, SPS reported that one staff did not complete training due to competing priorities and short staffing, and the Gastroenterology Nurse Manager stated the second employee was not initially assigned to reprocess RME; but the employee completed the training within 90 days of RME assignment. However, the Nurse Manager was unable to provide the date when the employee was assigned to reprocess RME.

¹³⁶ VHA Directive 1116(2).

Recommendation 21

21. The Associate Director for Nursing and Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that all new Sterile Processing Services employees complete Level 1 training within 90 days of hire.¹³⁷

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Associate Director for Nursing and Patient Care Services is the executive champion for the implementation and sustainment of this corrective action to ensure that all new Sterile Processing Services (SPS) employees complete the Talent Management System (TMS) Level 1 training within 90 days of hire. During the onboarding of new SPS employees, the SPS Chief Nurse conducts an audit of the new employee's orientation records to ensure that all TMS Level 1 training modules have been completed within 90 days of hire and prior to starting on-the-job training in restricted areas. Monthly compliance audits are conducted with data outcomes reported quarterly to the Reusable Medical Equipment (RME) Committee with documentation in the minutes. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the total number of new SPS employees who completed the TMS Level 1 training within 90 days of hire; denominator is total number of newly hired SPS employees during the same review period.

Reasons for noncompliance were considered in the development of this plan.

Request closure of this recommendation based on supporting documentation.

VHA requires SPS staff to receive continuing education monthly.¹³⁸ From November 2019 through January 2020, the OIG found evidence of monthly continuing education for 3 of 10 selected staff who reprocess RME. This resulted in a potential knowledge gap in reprocessing duties for the remaining employees. The Chief Nurse, SPS acknowledged that four staff failed to attend training offered during the month, and the Gastroenterology Nurse Manager was reportedly unaware of the monthly training requirement for the remaining three staff.

¹³⁷ The OIG reviewed evidence sufficient to demonstrate that the healthcare system had completed improvement actions and therefore closed the recommendation before publication of the report.

¹³⁸ VHA Directive 1116(2).

Recommendation 22

22. The Associate Director for Nursing and Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that all staff who reprocess reusable medical equipment complete monthly continuing education.¹³⁹

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Associate Director for Nursing and Patient Care Services is the executive champion for the implementation and sustainment of this corrective action to ensure that all staff who reprocess reusable medical equipment (RME) complete the required monthly continuing education. The monthly training calendar was standardized to ensure that the required continuing education sessions are offered during the first week of every month for maximum staff participation and targeted compliance. A make-up training session(s) is scheduled before the end of the same month for those employees who were unable to attend the initial training session. Supervisors are responsible for ensuring that required staff completed the monthly training as scheduled and maintain supporting documentation on file. RME continuing education compliance outcomes are reported monthly to the SPS Chief Nurse and through the RME Committee with documentation in the minutes. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the number of SPS employees who reprocess RME scopes who completed continuing education for the month; denominator is the total number of SPS employees who reprocess RME scopes each month. Reasons for noncompliance were considered in the development of this plan.

Request closure of this recommendation based on supporting documentation.

¹³⁹ The OIG reviewed evidence sufficient to demonstrate that the healthcare system had completed improvement actions and therefore closed the recommendation before publication of the report.

Incidental Finding: Medication Administration Workaround

Patient Safety: Bar Code Medication Administration Concerns

“BCMA [Bar code medication administration] is a medication administration process that uses bar-code technology to support nurses administering medications by automating the process of the “5 rights”: right patient, right medication, right dose, right route, and right time.”¹⁴⁰ At the time of medication administration, nurses verify information by scanning the patient’s identification (ID) wristband and the medication container which contains a bar code unique to each patient. The BCMA electronic system then compares the scanned information against the medication order. When used as intended, the BCMA system can drastically reduce errors by electronically validating that the correct medication is given to the correct patient at the right time.¹⁴¹

The OIG found seven duplicate patient ID wristbands in two BCMA carts in the inpatient mental health unit. This could allow staff nurses to scan patient wristbands as a “workaround” (a deviation from standard procedure) without actually scanning the wristband on each of the seven patients when administering medications. A licensed vocational nurse stated this “workaround” was used when a patient was not readily available, presumably to avoid delayed medication administration documentation. Once the patient is back on the unit, the nurse could then administer the “held” medication. The OIG is concerned with this practice because of the lack of assurance that the correct patient is scanned and receives the right medication or that the medication would appear that it was given at the right time when administration was actually delayed. “Workarounds” have significant associations with medication administration errors in hospitals using BCMA technology and can result in patient harm events.¹⁴² While the OIG was still on site, QSV staff removed the wristbands immediately from the BCMA carts, and the ADNPC stated that an action plan would be developed to prevent reoccurrence.

¹⁴⁰ Kandace Kelly et al., “Creating a Culture of Safety Around Bar-Code Medication Administration: An Evidence-Based Evaluation Framework,” *Journal of Nursing Administration* 46, no. 1 (January 2016): 30–37. https://www.nursingcenter.com/journalarticle?Article_ID=3264449. (The website was accessed on June 23, 2020.)

¹⁴¹ Department of Veterans Affairs Office of Information and Technology, *Bar Code Medication Administration (BCMA) GUI User Manual*, Version 3.0 February 2004 (Revised April 2019). [https://www.va.gov/vdl/documents/Clinical/PharmBar_Code_Med_Admin_\(BCMA\)/PSB_3_UM_CHAPTERS_1_THRU_6.pdf](https://www.va.gov/vdl/documents/Clinical/PharmBar_Code_Med_Admin_(BCMA)/PSB_3_UM_CHAPTERS_1_THRU_6.pdf). (The website was accessed on March 17, 2020.)

¹⁴² *Journal of the American Medical Informatics Association*, “Association between workarounds and medication administration errors in bar-code-assisted medication administration in hospitals,” Volume 25, Issue 4, April 2018, Pages 385–392, <https://doi.org/10.1093/jamia/ocx077>. (The website was accessed on March 17, 2020.)

Recommendation 23

23. The Associate Director for Nursing and Patient Care Services determines the reasons for noncompliance and ensures that nursing staff refrain from scanning duplicate wristbands and follow VHA bar code medication administration processes.

Healthcare System concurred.

Target date for completion: December 31, 2020

Healthcare system response: The Associate Director for Nursing and Patient Care Services is the executive champion for the implementation and sustainment of this corrective action to ensure that nursing refrain from scanning duplicate wristbands and follow VHA bar code medication administration processes. Upon the identification of this unsafe practice, an immediate on-the-spot correction occurred with the removal of these wristbands from two medication carts. The Nurse Manager implemented staff education to emphasize the patient safety concerns associated with this unsafe practice and the potential safety risk of administering a medication(s) to the wrong patient. The education included a review of relevant facility policies and the expectation of compliance. Medication Administration is included as a required competency. Annual competencies were completed in June/July 2020; all Mental Health nurses were documented as competent in Medication Administration. Inoperable medication carts may have contributed to the need for this workaround. At the time of the review, there were three (3) operational medication carts with a requirement for ten (10) medication carts; an additional seven (7) medication carts were received in late May 2020, thereby allowing nurses to physically go to each patient to administer medications using the bar code administration process. A daily inspection checklist was developed to document medication cart checks for any duplicate wristbands during the hand-off communication at the beginning of each shift; the checklist has been incorporated as standard work. At the time of the review, there were three (3) critical vacant positions for two Assistant Nurse Managers and one (1) Nurse Educator; all three (3) positions have been filled. Printing of armbands are now limited to the Medical Support Assistants (MSAs) and the Administrative Officer on Duty (AOD); nursing staff no longer have the ability to print wristbands. Continuous monitoring is conducted until 90 percent compliance is sustained for two consecutive quarters (six months). Numerator is the number of days per month in which there were no infractions of duplicate wristbands found on the medication carts; denominator is the total number of days per month. Reasons for noncompliance were considered in the development of this plan.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

The intent is for system 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	Requirements	Conclusion
Leadership and Organizational Risks	<ul style="list-style-type: none"> • Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Factors related to possible lapses in care and healthcare system response • VHA performance data (facility or system) • VHA performance data for CLCs 	Twenty-three OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the System Director, Chief of Staff, and ADNPC. See details below.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • QSV Committee • Protected peer reviews • UM reviews • Patient safety 	<ul style="list-style-type: none"> • QSV Committee consistently discusses and integrates aggregated QSV data. • QSV Committee's recommended improvement actions are fully implemented and monitored. • Peer Review Committee's recommended improvement actions are implemented. 	<ul style="list-style-type: none"> • Final peer reviews are completed within 120 calendar days and any necessary extensions are approved in writing by the System Director. • Root cause analyses include all required elements. • Each root cause analysis is submitted to the National Center for Patient Safety within 45 days.
Medical Staff Privileging	<ul style="list-style-type: none"> • FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards 	<ul style="list-style-type: none"> • Clinical managers define in advance, communicate, and document FPPE expectations in practitioners' profiles. • Service chiefs complete and document FPPE results in providers' profiles for all newly hired LIPs. • Providers with similar training and privileges complete OPPEs of LIPs. • Service chiefs' determination to continue privileges is based in part on OPPE data. 	<ul style="list-style-type: none"> • Executive Committee of the Medical Staff's decisions to recommend continuation of privileges are based on FPPE/OPPE results and the committee's decision is reflected in meeting minutes. • Provider exit review forms are completed within seven calendar days of LIPs' departure from the healthcare system.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	<ul style="list-style-type: none"> • Healthcare system <ul style="list-style-type: none"> ○ General safety ○ Special use spaces ○ Environmental cleanliness and infection prevention ○ Privacy ○ Accommodation and privacy for women veterans ○ Logistics • Inpatient mental health unit <ul style="list-style-type: none"> ○ General safety ○ Special use spaces ○ Environmental cleanliness and infection prevention ○ Privacy ○ Accommodation for women veterans ○ Logistics • Community-based outpatient clinic <ul style="list-style-type: none"> ○ General safety ○ Special use spaces ○ Environmental cleanliness and infection prevention ○ Privacy ○ Privacy for women veterans ○ Logistics 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	<ul style="list-style-type: none"> • Provision of pain management using long-term opioid therapy • Program oversight and evaluation 	<ul style="list-style-type: none"> • Providers complete an aberrant behavior risk assessment that includes psychological disease and aberrant drug-related behaviors prior to initiating long-term opioid therapy. • Providers consistently conduct urine drug testing for patients on long-term opioid therapy. • Providers consistently obtain and document informed consent prior to initiating long-term opioid therapy. 	<ul style="list-style-type: none"> • None
Mental Health: Suicide Prevention Program	<ul style="list-style-type: none"> • Designated facility suicide prevention coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • The Suicide Prevention Coordinator delivers at least five outreach activities each month. • Staff receive initial and annual suicide prevention refresher training.
Care Coordination: Life-Sustaining Treatment Decisions	<ul style="list-style-type: none"> • LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Comprehensive Care	<ul style="list-style-type: none"> • Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements 	<ul style="list-style-type: none"> • The Austell CBOC has at least two designated women's health primary care providers or arrangements for leave coverage when there is only one designated provider. 	<ul style="list-style-type: none"> • Required members are assigned and consistently attend Women Veterans Health Committee meetings.
High-Risk Processes: Reusable Medical Equipment	<ul style="list-style-type: none"> • Administrative processes • Quality assurance monitoring • Physical inspection • Staff training 	<ul style="list-style-type: none"> • Temperature and humidity ranges are monitored and maintained in the gastroenterology clean scope rooms. 	<ul style="list-style-type: none"> • New SPS employees complete Level 1 training within 90 days of hire. • All staff who reprocess RME complete monthly continuing education.
Incidental Finding: Medication Administration Workaround	<ul style="list-style-type: none"> • Patient Safety: Bar Code Medication Administration concerns 	<ul style="list-style-type: none"> • Nursing staff refrain from scanning duplicate wristbands and follow VHA bar code medication administration processes. 	<ul style="list-style-type: none"> • None

Appendix B: Healthcare System Profile

The table below provides general background information for this high complexity (1a) affiliated¹ healthcare system reporting to VISN 7.²

**Table B.1. Profile for Atlanta VA Health Care System (508)
(October 1, 2016, through September 30, 2019)**

Profile Element	Healthcare System Data FY 2017 ³	Healthcare System Data FY 2018 ⁴	Healthcare System Data FY 2019 ⁵
Total medical care budget in dollars	\$825,908,665	\$893,205,119	\$942,384,531
Number of:			
• Unique patients	112,614	115,785	121,111
• Outpatient visits	1,426,154	1,435,114	1,495,469
• Unique employees ⁶	3,762	3,911	4,050
Type and number of operating beds:			
• Community living center	107	107	107
• Domiciliary	61	61	61
• Medicine	118	118	118
• Mental health	40	40	40
• Residential rehabilitation	11	11	11
• Surgery	34	34	34
Average daily census:			
• Community living center	87	82	86
• Domiciliary	49	49	55
• Medicine	83	94	95
• Mental health	32	32	32
• Residential rehabilitation	6	5	5

¹ Associated with a medical residency program.

² The VHA medical centers are classified according to a facility complexity model; a designation of “1a” indicates a facility with “high volume, high risk patients, most complex clinical programs, and large research and teaching programs.”

³ October 1, 2016, through September 30, 2017.

⁴ October 1, 2017, through September 30, 2018.

⁵ October 1, 2018, through September 30, 2019.

⁶ Unique employees involved in direct medical care (cost center 8200).

Profile Element	Healthcare System Data FY 2017 ³	Healthcare System Data FY 2018 ⁴	Healthcare System Data FY 2019 ⁵
<ul style="list-style-type: none"> Surgery 	18	16	15

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse

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

Appendix C: VA Outpatient Clinic Profiles¹

The VA outpatient clinics in communities within the catchment area of the healthcare system provide primary care integrated with women’s health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table C.1. provides information relative to each of the clinics.

Table C.1. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2018, through September 30, 2019)²

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ³ Provided	Diagnostic Services ⁴ Provided	Ancillary Services ⁵ Provided
Flowery Branch, GA	508GE	18,877	10,913	Dermatology Eye Infectious disease Podiatry Neurology Rheumatology	n/a	Dental Nutrition Pharmacy
Austell, GA	508GF	13,953	8,546	Dermatology Eye Infectious disease Poly-Trauma	n/a	Nutrition Pharmacy

¹ Includes all outpatient clinics in the community that were in operation as of August 27, 2019.

² The definition of an “encounter” can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. An encounter is a “professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.”

³ Specialty care services refer to non-primary care and non-mental health services provided by a physician.

⁴ Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

⁵ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ³ Provided	Diagnostic Services ⁴ Provided	Ancillary Services ⁵ Provided
Stockbridge, GA	508GG	19,353	9,070	Dermatology Infectious disease	n/a	Nutrition Pharmacy Weight management
Lawrenceville, GA	508GH	19,677	9,861	Dermatology Eye Infectious disease	n/a	Nutrition Pharmacy Weight management
Newnan, GA	508GI	14,864	5,592	Dermatology Eye Infectious disease	n/a	Nutrition Pharmacy Weight management
Blairsville, GA	508GJ	10,448	3,756	Dermatology Eye Infectious disease Neurology	n/a	Nutrition Pharmacy Weight management
Carrollton, GA	508GK	10,093	6,992	Dermatology Endocrinology Eye Infectious disease Orthopedics Otolaryngology Podiatry Rheumatology	n/a	Nutrition Pharmacy Social work Weight management
Rome, GA	508GL	6,978	3,230	Dermatology Eye Infectious disease	n/a	Pharmacy

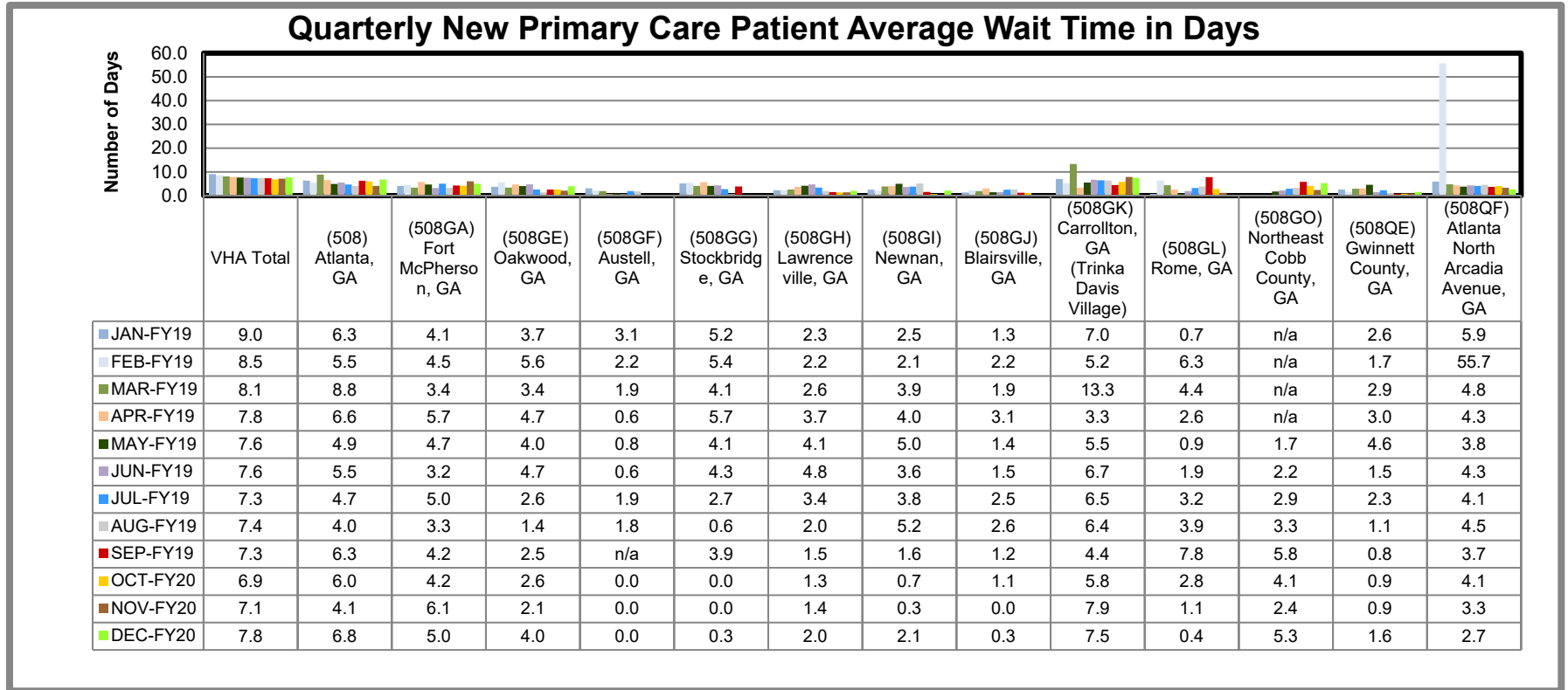
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ³ Provided	Diagnostic Services ⁴ Provided	Ancillary Services ⁵ Provided
Marietta, GA	508GO	3,854	236	n/a	n/a	Nutrition Pharmacy
East Point, GA	508QB	24	4,193	n/a	n/a	n/a
Atlanta, GA	508QC	n/a	18,208	n/a	n/a	n/a
East Point, GA	508QD	n/a	888	Orthopedics	n/a	n/a
Lawrenceville, GA	508QE	8,571	8,510	n/a	n/a	Pharmacy
Decatur, GA	508QF	40,603	17,857	Anesthesia Dermatology Eye Infectious disease Poly-trauma Rheumatology	n/a	Dental Nutrition Pharmacy Weight management

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

n/a = not applicable

Appendix D: Patient Aligned Care Team Compass Metrics¹

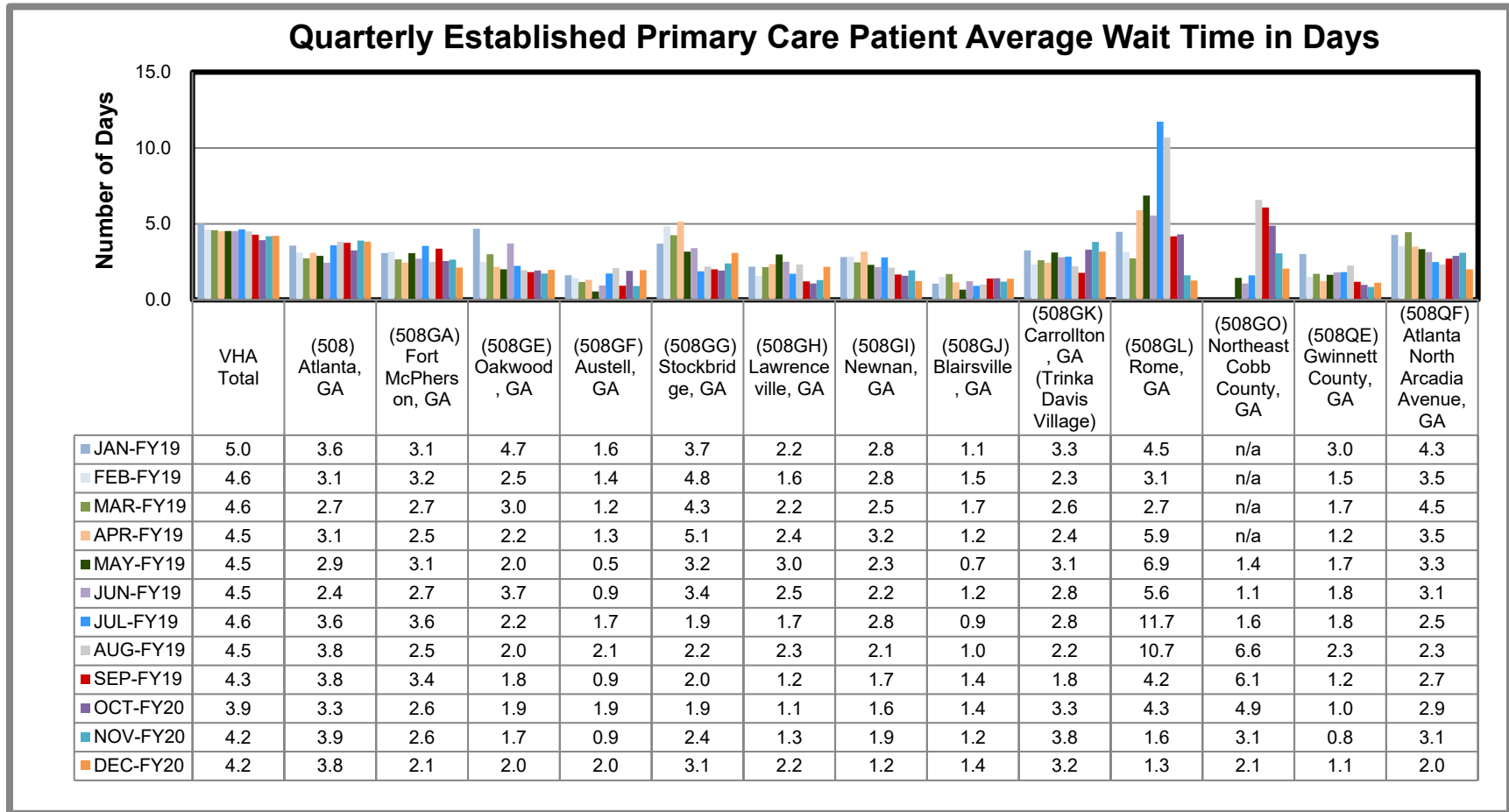


Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness. The OIG has on file the healthcare system’s explanation for the increased wait times in February 2019 for the Atlanta North Arcadia Avenue (508QF) clinic.

Data Definition: “The average number of calendar days between a New Patient’s Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.” Note that prior to FY15, this metric was calculated using the earliest possible create date.

¹ Department of Veterans Affairs, *Patient Aligned Care Teams Compass Data Definitions*, accessed October 21, 2019.



Source: VHA Support Service Center

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

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

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions¹

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
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
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
HC assoc infections	Health care associated infections	A lower value is better than a higher 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 continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value

¹ VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated September 30, 2019). <https://vaww.vssc.med.va.gov/vsscenhancedproductmanagement/displaydocument.aspx?documentid=9428>. (The website was accessed on March 6, 2020, but is not accessible by the public.)

Measure	Definition	Desired Direction
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
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
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
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
SC care coordination	SC (specialty care) care coordination	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
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
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

Appendix F: Community Living Center (CLC) Strategic Analytics for Improvement and Learning (SAIL) Measure Definitions¹

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.
Discharged to Community (SS)	Short-stay measure: percentage of short-stay residents who were successfully discharged to the community.
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.

¹ *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated December 12, 2019). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>. (The website was accessed on January 13, 2020, but is not accessible by the public.)

Measure	Definition
Outpatient ED visit (SS)	Short-stay measure: percent of short-stay residents who have had an outpatient emergency department (ED) visit.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych med (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
Rehospitalized after NH Admission (SS)	Short-stay measure: percent of residents who were re-hospitalized after a nursing home admission.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

Appendix G: Interim VISN Director Comments

Department of Veterans Affairs Memorandum

Date: October 1, 2020

From: Interim Network Director, VA Southeast Network (10N7)

Subj: Comprehensive Healthcare Inspection of the Atlanta VA Health Care System, Decatur, GA

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

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

1. I have had the opportunity to review the Draft Report - Comprehensive Healthcare Inspection of the Atlanta VA Health Care System, Decatur, GA.
2. VISN 7 submits concurrence to each recommendation and the attached Atlanta VA Health Care System submission. VISN 7 concurs with the Atlanta VA Health Care System submission requesting closure of recommendations 6, 9, 18, 21 and 22.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

Joe D. Battle
Interim Network Director

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: September 30, 2020

From: Director, Atlanta VA Health Care System (508/00)

Subj: Comprehensive Healthcare Inspection of the Atlanta VA Health Care System,
Decatur, GA

To: ~~Interim~~ Director, VA Southeast Network (10N7)

I have reviewed the draft report of the OIG Comprehensive Healthcare Inspection of the Atlanta VA Health Care System, conducted February 24-28, 2020. I appreciated the review team's professionalism, dedication to quality improvement, and constructive feedback to allow us to grow and improve as an organization. Thank you for the opportunity to review our processes to ensure we continue to provide excellent care to our Veterans.

Respectfully request closure of five (5) recommendations where corrective actions have been completed. The healthcare system's responses and supporting documentation in support of Recommendations 6, 9, 18, 21, and 22 are included in the attachment.

For the remaining recommendations, corrective action plans have been developed and target completion dates established as detailed in the attached document.

(original signed)

Ann R. Brown, FACHE
Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
----------------	---

Inspection Team	Martynee Nelson, MSW/LCSW, Team Leader Debra Naranjo, DNP, RN Deborah Owens, PhD Simonette Reyes, BSN, RN Joy Smith, BS, RDN
------------------------	--

Other Contributors	Daisy Arugay-Rittenberg, MT Elizabeth Bullock Shirley Carlile, BA Alicia Castillo-Flores, MBA, MPH Limin Clegg, PhD Jennifer Frisch, MSN, RN Justin Hanlon, BS LaFonda Henry, MSN, RN-BC Erin Johnson, BA Susan Lott, MSA, RN Scott McGrath, BS Larry Ross, Jr., MS Krista Stephenson, MSN, RN Robyn Stober, JD, MBA Marilyn Stones, BS Caitlin Sweany-Mendez, MPH, BS Robert Wallace, ScD, MPH
---------------------------	---

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 7: VA Southeast Network
Director, Atlanta VA Health Care System (508/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Kelly Loeffler, David Perdue
U.S. House of Representatives: Rick W. Allen; Sanford D. Bishop, Jr.; Buddy Carter; Doug Collins; Drew Ferguson; Jody Hice; Hank Johnson; Barry Loudermilk; Lucy McBath; Austin Scott; David Scott; Rob Woodall

OIG reports are available at www.va.gov/oig.