DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center in Augusta, Georgia

CHIP REPORT | REPORT #20-00132-28 | DECEMBER 16, 2020

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Figure 1. *Charlie Norwood VA Medical Center in Augusta, Georgia (Source: https://vaww.va.gov/directory/guide/, accessed February 27, 2020)*

Abbreviations

ADPCS	Associate Director for 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 treatments decision
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 Charlie Norwood VA Medical Center and multiple outpatient clinics in Georgia and South Carolina. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

The OIG team looks at leadership and organizational risks, 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 March 2, 2020, at the Charlie Norwood VA Medical Center and Athens VA Clinic. The OIG held interviews and reviewed clinical and administrative 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 medical center'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 medical center 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 medical center's leadership team consisted of the Director, Chief of Staff, acting Associate Director for Patient Care Services (ADPCS), Associate Director, and acting Assistant Director. Organizational communications and accountability were managed through a committee reporting structure, with the Executive Leadership Board overseeing several working groups. The leaders monitor patient safety and care through the Quality, Safety, Value, and Innovation Council, which was responsible for tracking and trending quality of care and patient outcomes.

At the time of this inspection, the medical center's leadership—including the acting ADPCS and acting Assistant Director—had worked together as a group for seven months. The Director was permanently assigned in April 2018. The Chief of Staff and Associate Director had served in their positions since December 2018 and July 2015, respectively. The permanent ADPCS and the permanent Assistant Director had been detailed to the VISN since July 2019 and February 2019, respectively.[1]

The OIG noted that selected employee satisfaction survey results for the medical center were worse than VHA national averages, with similar trends noted for patient experience survey scores.

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.[2] The OIG did not identify concerns with sufficient supplies needed for patient care. However, two concerns related to lack of implementation of purchased communication equipment and supply cabinet functionality and processes were noted.

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 permanent ADPCS was assigned to the role on February 17, 2019. The permanent Assistant Director was assigned to the role on July 29, 2012.

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

The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[3]

The executive leaders were generally knowledgeable within their scopes of responsibility about VHA data and/or system-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures and CLC SAIL measures. In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

The OIG noted opportunities for improvement in five clinical areas reviewed and issued 20 recommendations that are directed to the Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director. These are briefly described below.

Quality, Safety, and Value

The medical center complied with requirements for the establishment of a committee responsible for quality, safety, and value oversight functions; review of aggregated data; and most peer review elements reviewed. The OIG found deficiencies with peer review processes and interdisciplinary review of utilization management data but did not issue additional recommendations since the medical center was actively addressing improvement actions from the previous February 2019 CHIP site visit.[4] The OIG also identified deficiencies with Quality, Safety, Value, and Innovation Council; peer review; and root cause analysis processes.

Medical Staff Privileging

The OIG noted continued work on previous CHIP review action plans, including the establishment of focused professional practice evaluation criteria in advance of the evaluation process and the completion of professional practice evaluations by providers with similar training and privileges; therefore, additional recommendations were not made. However, the OIG identified a deficiency with provider exit review processes.[5]

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[3] VHA Support Service Center, *Strategic Analytics for Improvement and Learning (SAIL) Value Model*, http://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.)

[4] VA OIG, *Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No 19-00013-15, November 21, 2019.

[5] The definitions of focused professional practice evaluation and ongoing professional practice evaluation 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."

Environment of Care

The OIG observed general compliance with inpatient mental health unit requirements and did not note any issues with the availability of medical equipment and supplies or accommodation and privacy for women veterans. The OIG noted the medical center's continued pursuit of action plans from the previous CHIP inspection conducted in February 2019 and identified additional vulnerabilities with general safety, cleanliness and infection prevention, and privacy.

Women's Health

The medical center complied with requirements for most of the provision of care indicators and selected staffing elements reviewed. The OIG noted that the medical center continues to work on improvements identified in the 2019 CHIP report related to tracking of cervical cancer data and communication of results to patients within the required time frame. The medical center has made improvements to the Women Veterans Health Committee but continues to have opportunities to ensure all required members attend meetings. During this site visit, the OIG identified deficiencies with the availability of gynecologic care coverage, the designation of community-based outpatient clinic women's health primary care providers, and the assignment of a women's health clinical liaison at each community-based outpatient clinic.

High-Risk Processes

The medical center met several of the administrative, quality assurance, and physical requirements for the reprocessing of reusable medical equipment. However, the OIG identified deficiencies with standard operating procedures; the annual risk analysis; equipment storage; and staff training, competencies, and ongoing education.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued 20 recommendations for improvement to the Medical Center Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this medical center. The intent is for medical center 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 Medical Center Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 79–80, and the responses within the body of the report for

the full text of the directors' comments). The OIG considers recommendations 12, 13, and 14 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

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 Charlie Norwood VA Medical Center 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 medical center 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] See figure 2. CHIP inspections address these processes during FY 2020 (October 1, 2019, through September 30, 2020); they may differ from prior years' focus areas.

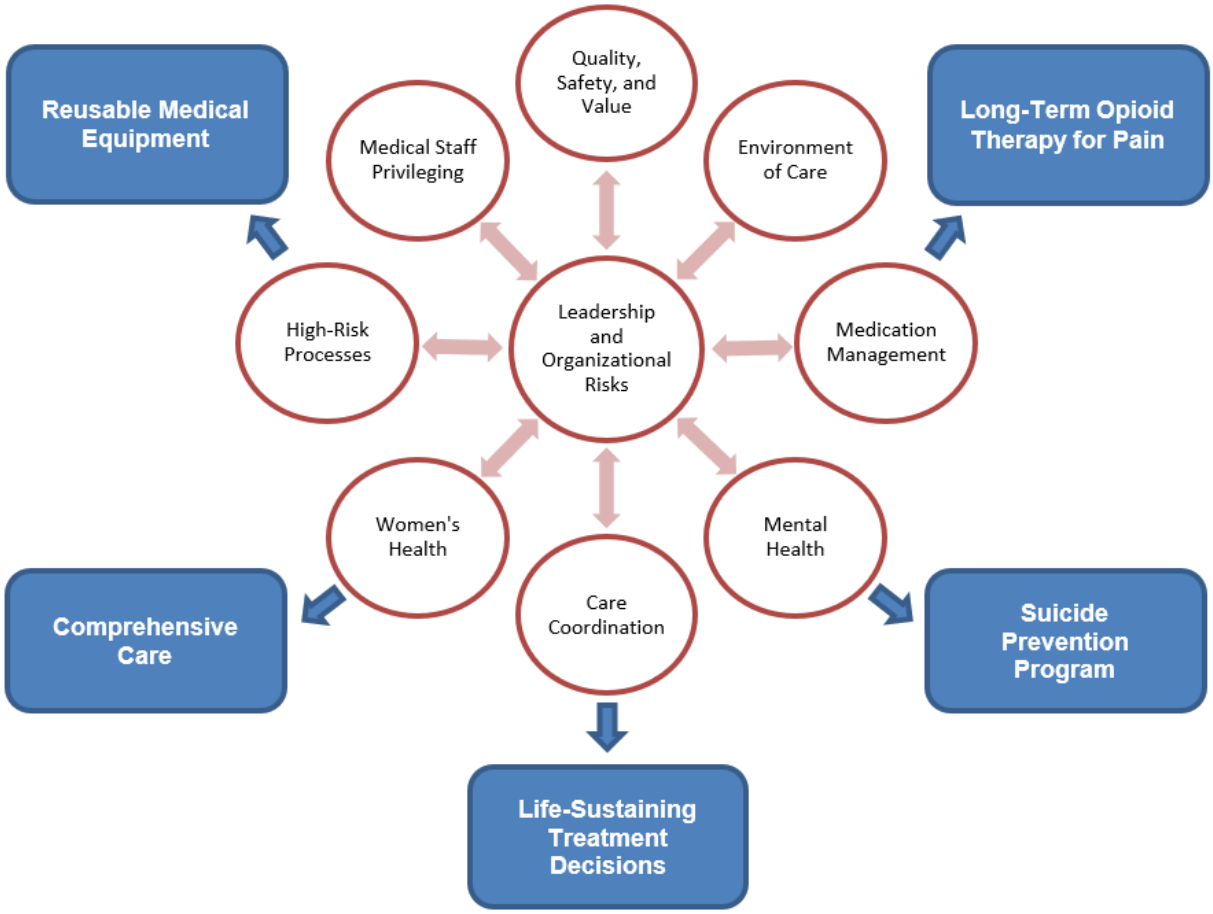

Figure 2. *Fiscal year (FY) 2020 comprehensive healthcare inspection of operations and services*
Source: VA OIG

Methodology

The Charlie Norwood VA Medical Center is a two-division facility. The Uptown Division provides a community living center (CLC), psychiatry services, outpatient services, and both blind and medicine rehabilitation; the Downtown Division provides acute medical/surgical inpatient, restorative/nursing home, and domiciliary care. The medical center also has multiple outpatient clinics in Georgia and South Carolina. Additional details about the types of care provided by the medical center 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 team also selected and physically inspected the Athens VA Clinic and the following areas of the medical center's Downtown and Uptown Divisions:

- Downtown Division
  - Emergency Department
  - Intensive care unit
  - Medical/surgical inpatient units
  - Outpatient clinic
  - Post-anesthesia care unit
  - Sterile processing services areas
- Uptown Division
  - Acute psychiatric unit
  - CLC[5]
  - Outpatient clinic

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

[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.

The inspection examined operations from February 16, 2019, through March 6, 2020, the last day of the unannounced multiday site visit.[6] While on site, the OIG referred concerns beyond the scope of the CHIP inspection to the OIG's hotline management team for further review.

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 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 medical center completes corrective actions. The Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that the medical center 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.

[6] The range represents the time period from the prior CHIP inspection to the completion of the unannounced, multiday CHIP site visit in March 2020.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA Medical Center. Leadership and organizational risks can affect the medical center's ability to provide care in the clinical focus areas.[7] To assess the medical center'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 medical center response
6. VHA performance data (medical center)
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 medical center's reported organizational structure. The medical center has a leadership team consisting of the Director, Chief of Staff, acting Associate Director for Patient Care Services (ADPCS), Associate Director, and acting Assistant Director. The Chief of Staff and acting ADPCS 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.IHI.org. (The website was accessed on November 6, 2019.)

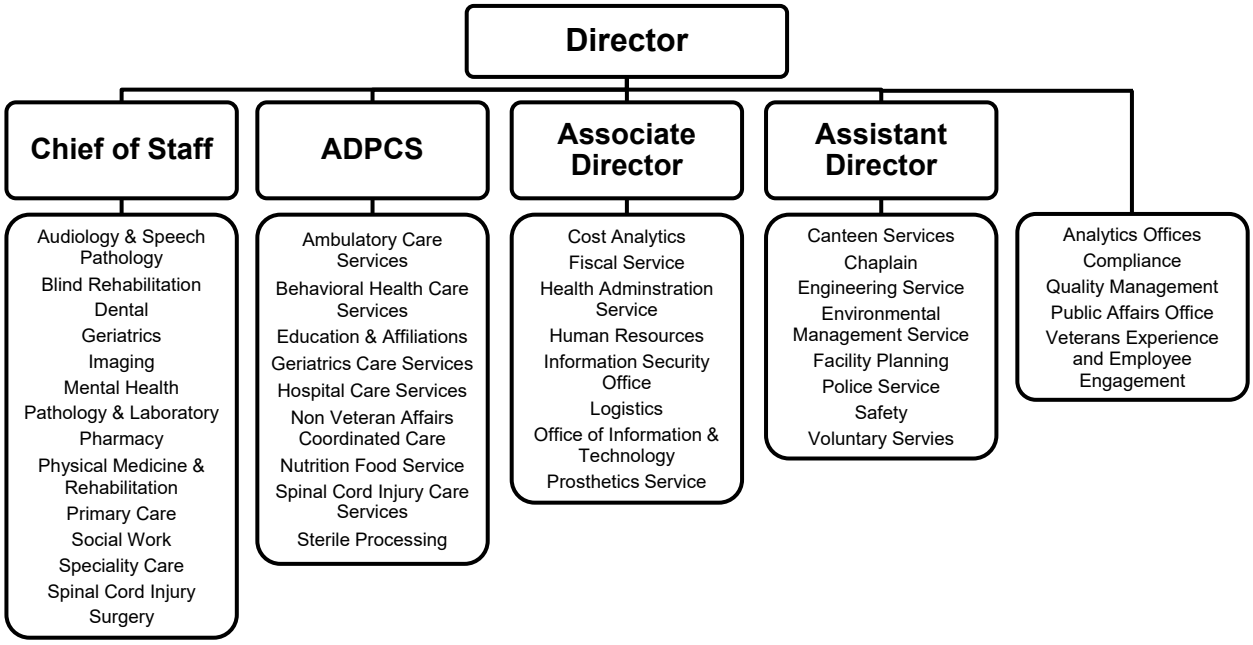

Figure 3. *Medical center organizational chart*
Source: Charlie Norwood VA Medical Center (received March 3, 2020)

The OIG noted that the permanent ADPCS and the permanent Assistant Director had been detailed to the VISN since July 15, 2019, and February 19, 2019, respectively. As a result, the executive team which included two acting leaders, had been working together as a group for approximately seven months at the time of the site visit (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	April 15, 2018
Chief of Staff	December 23, 2018
Associate Director for Patient Care Services	July 15, 2019 (acting) February 17, 2019 (permanent)
Associate Director	July 12, 2015
Assistant Director	February 19, 2019 (acting) July 29, 2012 (permanent)

Source: Charlie Norwood VA Medical Center Supervisory Human Resource Officer (received on March 4, 2020)

To help assess the medical center executive leaders' engagement, the OIG interviewed the Director, Deputy Chief of Staff (covering for the Chief of Staff during the week of the inspection), acting ADPCS, and Associate Director regarding their knowledge of various

performance metrics and their involvement and support of actions to improve or sustain performance.

The executive leaders were generally knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures and CLC SAIL measures. In individual interviews, the executive leadership team members were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

The Director serves as the chairperson of the Executive Leadership Board, which has the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board oversees various working groups such as the Health Care Delivery, Operational, and Organizational Health Councils.

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

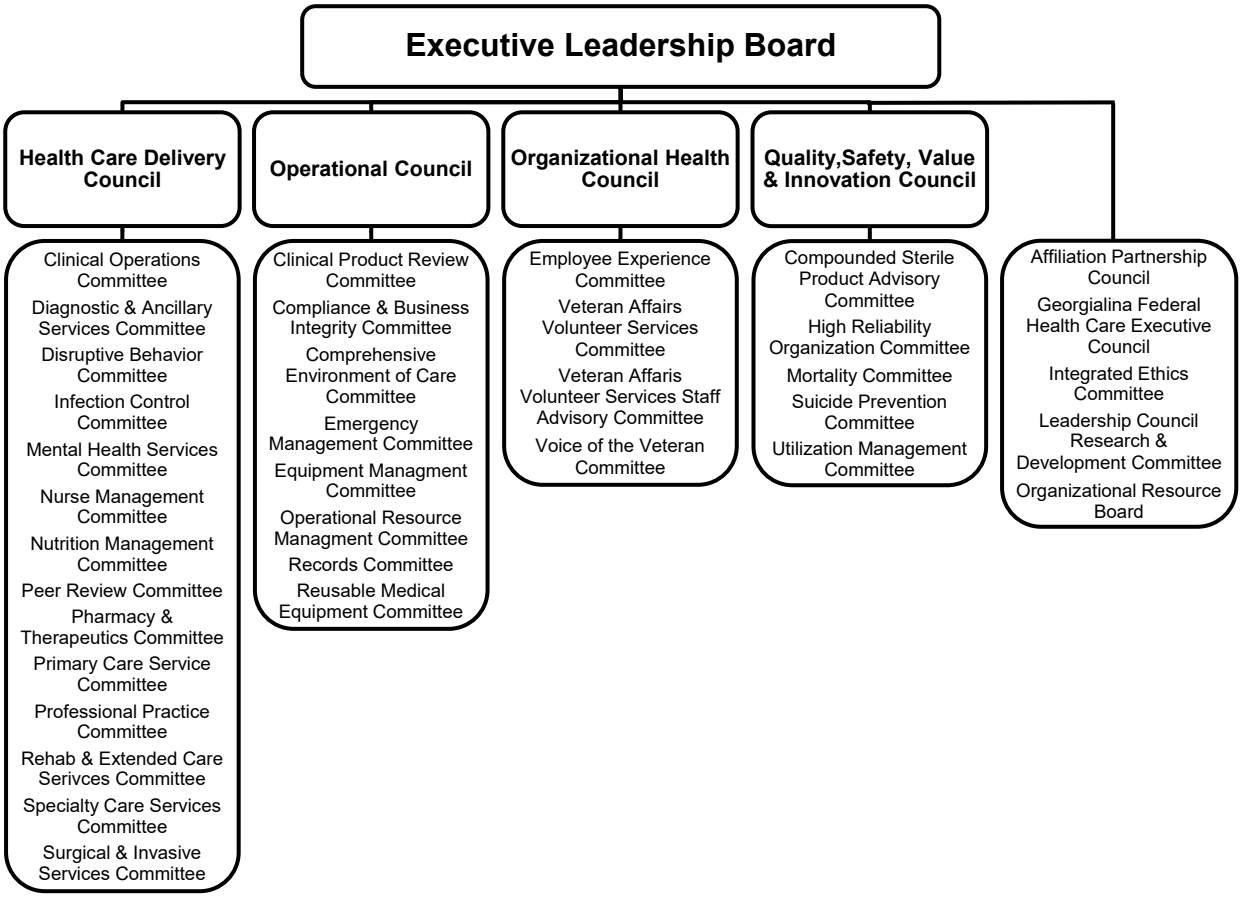

Figure 4. *Medical center's committee reporting structure*
Source: Charlie Norwood VA Medical Center (received on March 2, 2020)

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 medical center leadership.

To assess employee attitudes toward medical center 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 medical center, and selected executive leaders. It summarizes employee attitudes

[8] Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director.

toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center averages for the selected survey leadership questions were consistently lower than the VHA averages.[9] The same trend was noted for the Director.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite*[10]	0–100 where higher scores are more favorable	72.6	69.3	67.5	83.1	89.2	89.2	69.3
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.4	3.1	3.2	3.5	4.5	4.1	3.6
All Employee Survey: My organization's senior leaders maintain high standards of honesty and integrity.	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.3	3.3	3.6	4.5	4.2	4.0

[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	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.4	3.4	3.7	4.5	4.4	3.8

Source: VA All Employee Survey (accessed February 10, 2020)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[11] Note that the medical center average across the selected survey questions was slightly worse than the VHA average. Scores related to the Chief of Staff, ADPCS, Associate Director, and Assistant Director were similar to or better than those for VHA and the medical center. However, opportunities appear to exist for the Director to support a work environment where employees could disclose violations without fear of reprisal and experience less moral distress.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.6	3.5	4.3	5.0	4.3	3.8

[11] Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director. NOTE: the permanent ADPCS and the permanent Assistant Director had been detailed to the VISN since July 15, 2019, and February 19, 2019, respectively.

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination*).	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.5	4.1	3.9	4.7	4.5	3.6
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.4	1.5	1.8	1.2	1.5	1.0	1.0

Source: VA All Employee Survey (accessed February 10, 2020)

Patient Experience

To assess patient experiences with the medical center, which directly reflect on its leaders, the OIG team 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 Experiences of Patients 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 medical center's Uptown and Downtown divisions.[12]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG reviewed responses to four

[12] Ratings are based on responses by patients who received care at this medical center.

relevant survey questions that reflect patients' attitudes toward their healthcare experiences (see table 4). For this medical center, the patient survey results generally reflected lower ratings than VHA national averages.

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.3	61.8
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	81.9
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	77.3	74.4
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	78.0	74.8

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 the selected Inpatient,

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

Patient-Centered Medical Home, and Specialty Care Surveys. The OIG noted that the results for male respondents were generally lower than the corresponding VHA averages, while those for female respondents were more favorable for two of three selected inpatient and two of three selected specialty care questions. Both male and female patients reported lower levels of courtesy and respect from nurses while in the inpatient setting, and results from both genders were also less positive for all patient-centered medical home questions when compared to VHA nationally. During onsite discussions, the medical center leaders reported their efforts in conducting veteran town hall meetings and using Press Ganey survey data, which provides patient experience data in real-time.[14]

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

Questions	Scoring	VHA[15]		Medical Center[16]	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	82.8	81.7	91.5
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.8	83.1	78.8	74.7
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	68.7	61.8	61.3	68.5

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed February 3,2020)

[14] Press Ganey Associates is a company that develops and distributes patient satisfaction surveys.

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

[16] The medical center averages are based on 439–445 male and 31 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[17]		Medical Center[18]	
		Male Average	Female Average	Male Average	Female Average
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?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.2	43.3	40.5	34.7
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?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.9	49.7	55.2	41.7
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?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.6	65.7	70.3	64.9

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed February 3,2020)

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

[18] The medical center averages are based on 289–966 male and 31–79 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[19]		Medical Center[20]	
		Male Average	Female Average	Male Average	Female Average
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?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.5	44.7	42.8	75.1
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?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	55.0	55.0	67.0
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?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	70.4	70.1	70.6	67.8

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed February 3, 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.[21] Table 8 summarizes the relevant medical center inspections most recently published by the OIG at the time of the site visit. Since the February 2019 CHIP review, the medical center also received a focused OIG inspection that examined leadership, clinical, and administrative concerns. The

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

[20] The medical center averages are based on 392–1,401 male and 23–106 female respondents, depending on the question.

[21] 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. Charlie Norwood VA Medical Center's last TJC survey was conducted January 2019.

associated report, published in July 2019, issued 24 recommendations to the medical center and an additional three recommendations to the VISN.[22]

Additionally, there were no other Joint Commission inspections since the last OIG CHIP site visit; however, the OIG noted that the medical center had made further progress and closed all but four recommendations for improvement from the last Joint Commission survey in January 2019 and received notification of accreditation approval on April 1, 2019. The Quality Management Accreditation Specialist provided the OIG team with evidence of continued monitoring of implemented actions for the remaining open recommendations.

The OIG team also noted the medical center'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 medical center's CLCs[24] and the Paralyzed Veterans of America's inspection of the spinal cord injury/disease unit and related services.[25]

[22] VA OIG, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No 19-00497-161, July 11, 2019.

[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.ltciorg.org/about-us/. (The website was accessed on March 6, 2019.)

[25] The Paralyzed Veterans of America inspection took place on August 28–29, 2019. This veterans service organization review does not result in accreditation status.

Table 8. Office of Inspector General Inspections[26]

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No 19-00013-15, November 21, 2019.)	February 2019	24	22[27]
OIG (*Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No.19-00497-161, July 11, 2019.)	November and December 2018	27	20[28]

Source: OIG (inspection/survey results verified with the Accreditation Specialist on March 3, 2020)

Identified Factors Related to Possible Lapses in Care and Medical Center 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. Table 9 lists the reported patient safety events from February 16, 2019 (the prior OIG comprehensive healthcare inspection), through March 2, 2020.[29]

[26] Charlie Norwood VA Medical Center's last TJC survey was conducted in January 2019 and was reported in the OIG *Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center, Augusta, Georgia,* Report No 19-00013-15, November 21, 2019.

[27] As of November 2020, six recommendations from the 2019 CHIP inspection remain open.

[28] As of November 2020, 3 of the 24 recommendations issued to the medical center remain open.

[29] 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 Charlie Norwood VA Medical Center is a high-complexity (1a) affiliated system as described in appendix B.)

Table 9. Summary of Selected Organizational Risk Factors (February 16, 2019, through March 2, 2020)

Factor	Number of Occurrences
Sentinel Events[30]	1
Institutional Disclosures[31]	5[32]
Large-Scale Disclosures[33]	0

Source: Charlie Norwood VA Medical Center's Patient Safety Manager, Risk Manager, and the acting Chief of Quality Management (received March 2 and March 3, 2020 respectively)

Additionally, the OIG did not identify any supply issues that affected patient care; however, discussions with staff led to two related concerns that could impact clinical care.

The first concern is related to the medical center's purchase of the Vocera® Smartbadge system in 2016. OIG inspectors found that the devices were still not operational due to technology infrastructure limitations.[34] The Director reported that some staff had received training, but the system had not been implemented because the medical center's technology infrastructure could not support the system. The Director reported that in addition to the $2 million cost of the system, he recently authorized the spending of $600,000 to update the infrastructure at the

[30] 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."

[31] 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."

[32] For one institutional disclosure, the event occurred outside the review period for this CHIP site visit. The case was noted as a sentinel event in the February 2019 CHIP site visit report; however, at that time it was not identified as needing an institutional disclosure.

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

[34] Vocera® Smartbadge is a hands-free healthcare communication device that allow caregivers to continue to provide patient care and communicate with others. Vocera*, Vocera Smartbadge: Want seamless collaboration and unparalleled agility for patient care?* https://www.vocera.com/vocera-smartbadge. (This website was accessed on March 18, 2020.)

Uptown and Downtown locations. The updated equipment was being tested at the time of the site visit.

The OIG also had concerns when two different BD Pyxis™ supply cabinet machines (one in the intensive care unit and one in the post-acute care unit) were found constantly beeping.[35] Medical center employees who use these two supply cabinets reported that they beep "all the time" and fingerprint access had not been functional for approximately three years. In each of the patient care areas inspected, OIG staff confirmed that remote monitoring of supply levels was not working and could inadvertently lead to an inadequate supply of patient care items and undetected loss or misuse. When questioned, the Director indicated awareness and reported that not all machines were initially connected to the network, logistics staff were receiving training for the equipment, and a team of staff were working to resolve the issues.

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.[36]

Figure 5 illustrates the medical center's 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 medical center (for example, in the areas of mental health (MH) continuity (of) care, patient-centered medical home (PCMH) same day appointment (appt), complications, and rating (of) specialty care (SC) provider). Metrics that need improvement are denoted in orange and red (for example, rating (of) primary care (PC) provider, health care (HC) associated (assoc) infections, care transition, and registered nurse (RN) turnover).[37]

[35] The BD Pyxis™ supply cabinets store medical supplies and help hospitals improve financial performance, streamline workflow, and facilitate regulatory compliance through efficient supply management. BD, *BD Pyxis*. https://www.bd.com/en-uk/products/supply-management. (This website was accessed on March 18, 2020.)

[36] VHA Support Service Center, *Strategic Analytics for Improvement and Learning (SAIL) Value Model*, http://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.)

[37] For information on the acronyms in the SAIL metrics, please see appendix E.

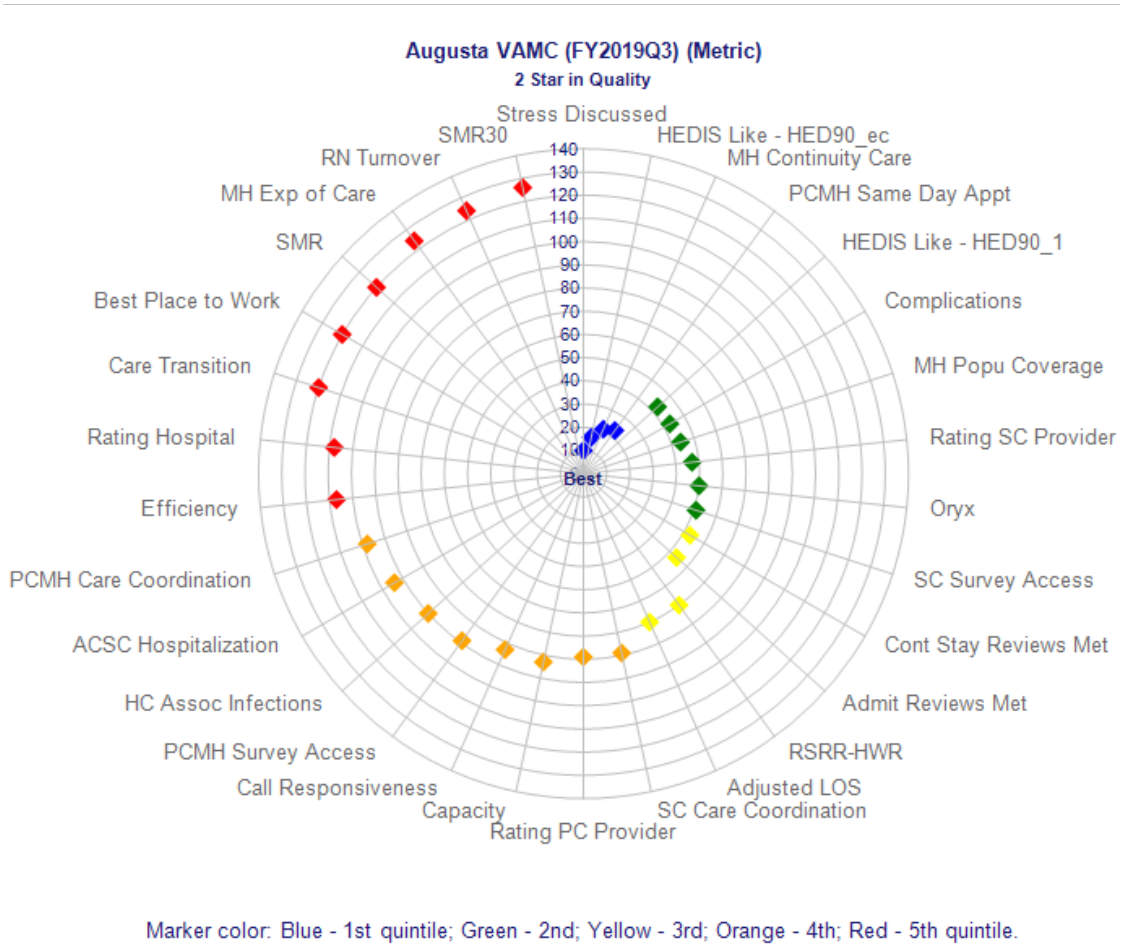

Figure 5. *Medical center quality of care and efficiency metric rankings (as of June 30, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

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 &

Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource to review quality measures and health inspection results.[38]

Figure 6 illustrates the medical center'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 Augusta CLC (for example, in the areas of physical restraints–long-stay (LS), catheter in bladder (LS), and urinary tract infections (UTI) (LS)). Metrics that need improvement are denoted in orange and red (for example, rehospitalized after nursing home (NH) admission–short-stay (SS), moderate-severe pain (LS), and outpatient emergency department (ED) visit (SS)).[39]

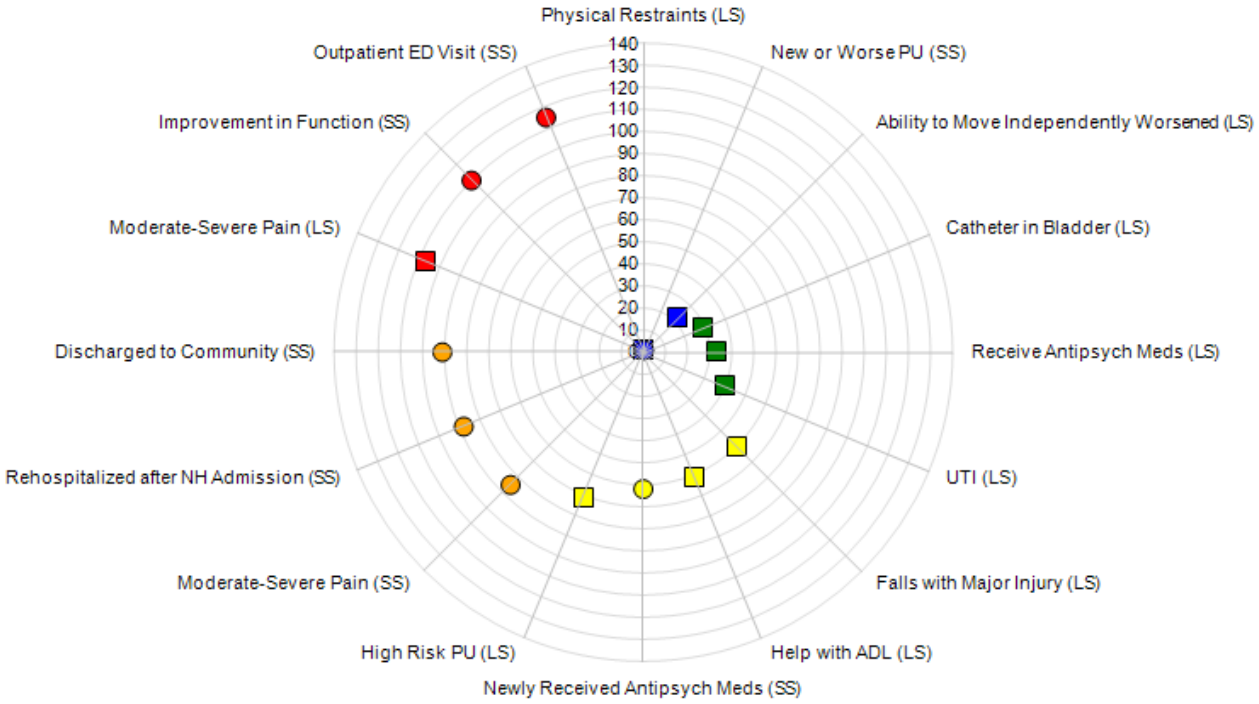

Figure 6. *Augusta CLC quality measure rankings (as of September 30, 2019)*
LS = Long-Stay Measure *SS = Short-Stay Measure*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

[38] 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."

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

Leadership and Organizational Risks Conclusion

With the permanent ADPCS and Assistant Director detailed to the VISN office in July 2019 and February 2019, respectively, the current executive leadership team—including the two staff members covering the ADPCS and Assistant Director positions in an acting capacity—had worked together for seven months at the time of the OIG's visit. Selected survey items revealed opportunities for the Director to improve employee satisfaction. Survey data indicated that patients were somewhat satisfied with the care provided. In individual interviews, the executive leaders were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve performance, employee satisfaction, and patient experiences. The OIG also reviewed the system's accreditation findings, sentinel events, and disclosures and did not identify any substantial organizational risk factors. However, the OIG identified significant concerns regarding systems/equipment purchased and the corresponding lack of full implementation to support clinical care. The Director was able to speak knowledgeably about the issues and discussed plans for resolution. The medical center leaders were generally knowledgeable within their scopes of responsibility about selected VHA data used by the SAIL and CLC SAIL models and should continue efforts to improve and sustain performance.

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.[40] 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.[41] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission (TJC)), 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.[42]

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 medical center 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, OIG inspectors 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 medical center's processes for conducting protected peer reviews of clinical care.[43] 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.[44] The OIG team examined the completion of the following elements:

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

[41] VHA Directive 1100.16.

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

[43] The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a critical review of care, performed by a peer, to evaluate care provided by a clinician for a specific episode of care, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements. 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."

[44] VHA Directive 1190.

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[45]
- 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 medical center'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.[46] 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.[47] 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 medical center's reports of patient safety incidents with related root cause analyses.[48] Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly

[45] VHA Directive 1190.

[46] 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."

[47] VHA Directive 1117(2).

[48] 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."

communicate potential and actual causes of harm to patients throughout the medical center.[49] The medical center was assessed for its performance on several dimensions:

- Annual completion of a minimum of eight root cause analyses[50]
- 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 the annual patient safety report to medical center 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.[51]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for the establishment of a committee responsible for QSV oversight functions and its review of aggregated data as well as most peer review elements reviewed. At the time of the site visit, the OIG found deficiencies with some peer review processes and the interdisciplinary review of UM data; however, no additional recommendations were issued because the medical center was actively addressing outstanding improvement actions from the previous February 2019 CHIP site visit.[52]

The OIG also identified additional deficiencies with QSV committee, peer review, and root cause analysis processes and issued subsequent recommendations.

VHA requires medical centers to establish a standing governing body committee responsible for quality, safety, and value functions and practices. The committee reviews relevant data and information and ensures that when actions are recommended by the committee, they are fully implemented and changes are monitored.[53] The OIG found that from March 2019 through

[49] VHA Handbook 1050.01.

[50] 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]."

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

[52] VA OIG, *Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No 19-00013-15, November 21, 2019. As of August 2020, the recommendation related to UM Committee attendance from the 2019 inspection was closed.

[53] VHA Directive 1100.16; TJC. Leadership standards LD.01.01.01, LD.02.01.01, and LD.03.01.01.

January 2020, the Quality, Safety, Value, and Innovation Council did not monitor implemented actions. A failure to evaluate if improvement actions were successful may have delayed or prevented improvement of quality care and patient safety processes. The Quality Management Health Systems Specialist explained the lack of documentation in the Quality, Safety, Value, and Innovation Council minutes by stating that once action items are fully implemented, charting by exception occurs and follow-up is only documented if an issue arises.[54]

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures the Quality, Safety, Value, and Innovation Council monitors implemented improvement actions.

Medical center concurred.

Target date for completion: April 26, 2021

Medical center response: The Medical Center Director evaluated Quality, Safety, Value, and Innovation Council's process of monitoring implemented improvement actions to identify reasons for noncompliance. On March 26, 2020, the Council re-established an Action Item Tracking Log to improve oversight of items needing tracking and follow-up. This tracking log is embedded in the Council's monthly minutes.

The Council will establish a Standing Business item on the monthly agenda beginning with the October 26, 2020 meeting to review the tracking log to ensure all items are being appropriately followed. Quality Management will conduct audits of the meeting minutes to ensure all items are recorded and followed-up on appropriately. These results will be reported to the Executive Leadership Board as part of the Council's regular report to the Board.

Will monitor until 6 consecutive months of Quality, Safety, Value, & Innovation Council meeting minutes reflect sustainment of this action.

VHA also requires peer review for all deaths "within 24 hours of admission (except in cases when death is anticipated and clearly documented, such as transfer from hospice care)."[55] The OIG found that from March 1, 2019, through January 31, 2020, four applicable deaths occurring within 24 hours of admission were not peer reviewed as required. This may have prevented timely identification of inconsistencies in the practices of one or more healthcare providers. The Risk Manager stated the Mortality Committee is responsible for review of all deaths, and

[54] According to the Free Dictionary by Farlex, charting by exception is defined as "a method of charting designed to minimize clerical activities; a notation is made only when there is a deviation from the baseline or expected outcome, or when a procedure or expected activity is to be omitted." https://medical-dictionary.thefreedictionary.com/.

[55] VHA Directive 1190.

clinicians conduct peer reviews as referrals are submitted. However, one death was not included in the mortality database and consequently missed. The Risk Manager and Mortality Committee reviewed a second death, but the Risk Manager indicated neither documented that the death occurred within 24 hours of admission. A third death involved a patient who died unexpectedly but had a do-not-resuscitate order; the Risk Manager stated the understanding that peer review was not required in patients with established do-not-resuscitate orders but could not provide evidence that the death was screened for potential peer review. The fourth death was already identified for peer review, but the Risk Manager reported that the case had not yet been assigned to a reviewer due to higher priority reviews.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that all applicable deaths that occur within 24 hours of admission are peer reviewed.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Chief of Staff evaluated the process of whereby all applicable deaths that occur within 24 hours of admission are peer reviewed. Standard work did not include daily screening of all deaths.

Quality Management implemented a standard process for the Risk Manager to screen all deaths daily using auto generated Occurrence Screen Reports to identify deaths within 24 hours of admission. Completion of peer review for deaths occurring less than 24 hours after admission are monitored monthly using a tracking tool and will be monitored until 90 percent compliance is maintained for six consecutive months.

To be thorough and ensure credibility, VHA requires root cause analyses to include several factors such as participation by leaders, analysis of the underlying systems to determine where redesigns might reduce risk, and identification of at least one root cause with a corresponding action and outcome measure. Additionally, WebSPOT (the VHA Patient Safety Information System) must be used to document the root cause analysis.[56] Of the five root cause analyses reviewed, the OIG found that none included an analysis of the underlying systems through a series of "why" questions to determine where redesigns might reduce risk; and three did not include a determination of potential improvement processes that could decrease the probability of future events. This likely affected evaluation of patient safety events and limited reviewers' ability to identify vulnerabilities and implement process improvements that could help prevent

[56] VHA Handbook 1050.01.

patient harm events. An employee who previously served as the Patient Safety Manager stated that the series of "why" questions are completed on a worksheet and not captured in WebSPOT, and that the patient safety team believed the determination of potential improvement processes was inherent in the root cause statement and action items.

Recommendation 3

3. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that root cause analyses include all required review elements and are properly documented in the VHA Patient Safety Information System.

Medical center concurred.

Target date for completion: March 31, 2021

Medical center response: The Medical Center Director evaluated the root cause analyses process to ensure all required review elements are included and are properly documented in the VHA Patient Safety Information System. Patient Safety Manager practices were reviewed and aligned with VA Handbook 1050.1. Patient Safety Managers audit Root Cause Analyses using the VHA required elements: participation by leaders, analysis of the underlying systems to determine where redesigns might reduce risk, consideration of relevant literature, and identification of at least one root cause with a corresponding action and outcome measure. Patient Safety Managers use the VHA Patient Safety Information System, Web SPOT to document required RCA [root cause analysis] elements. Implemented immediately after OIG exited Patient Safety Managers began the process of reviewing each other's RCA for completeness to include all aspects of required documentation. If not completed per VHA standards elements were corrected prior to closure in WebSpot. Action: By March 31, 2021-Each new RCA will be monitored prior to completion in WebSpot by Patient Safety Managers or Assistant QM/QM Chief for completeness including literature reviews and other requirements monthly x 6 and ongoing. Threshold 90%. Patient Safety Managers report RCA data to the Quality Safety Value Innovation Council.

VHA requires that the Patient Safety Manager or designee provide timely feedback to staff who submit close call and adverse event reports that result in a root cause analysis.[57] In three of four applicable root case analyses, the OIG found that the Patient Safety Manager could not provide evidence that feedback was given to staff who reported the events or concerns. This likely resulted in missed opportunities to establish employee trust in the medical center and positively

[57] VHA Handbook 1050.01.

reinforce a culture of safety. The Patient Safety Manager felt that feedback is provided in a series of ways but could not provide supporting documentation.

Recommendation 4

4. The Medical Center Director determines the reasons for noncompliance and ensures the Patient Safety Manager or designee provides feedback to staff who submit patient safety incidents that result in a root cause analysis.

Medical center concurred.

Target date for completion: March 31, 2021

Medical center response: The Medical Center Director evaluated the RCA feedback process to staff who submit patient safety incidents. Patient Safety Manager (PSM) practices have been aligned with VHA Handbook 1050.01 requirements. Patient Safety Managers provide feedback to staff who submit close call and adverse event reports resulting in an RCA in the quarterly Patient Safety Newsletter. Implemented immediately after OIG completed their review Patient Safety Managers sent follow up emails to reporters of close calls and events that result in an RCA to inform them to reach out to Patient Safety for further information. Also, each RCA lessons learned are shared at monthly Patient Safety Calls/and/or Patient Safety Newsletters Quarterly and copy of newsletter placed in RCA Case Folder. By March 31, 2021 newsletters including any lessons learned will be placed in appropriate case folder by Patient Safety manager on an ongoing basis—monitored x 6 months for 90% compliance.

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).[58]

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.[59]

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."[60] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[61]
  - 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 LIPs[62]
  - Evaluation by another provider with similar training and privileges

[58] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[59] VHA Handbook 1100.19.

[60] VHA Handbook 1100.19.

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

[62] 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 medical center'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.[63] 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."[64] The OIG reviewers assessed whether the medical center'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 medical center 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 months[65]
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs privileged within 12 months before the visit
- Twenty LIPs who left the medical center in 12 months before the visit

Medical Staff Privileging Findings and Recommendations

The medical center continues to work on action plans related to both the establishment of FPPE criteria in advance of the evaluation process itself and the completion of these initial and ongoing evaluations by providers with similar training and privileges as noted in the previous 2019 CHIP

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

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

[65] 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.

review; therefore, the OIG made no repeat recommendations.[66] However, the OIG identified a deficiency with provider exit review processes.

VHA requires provider exit review forms, which document the review of a provider's clinical practice, to be "completed within 7 calendar days of departure of any licensed health care professional" from a VA facility.[67] Additionally, VHA requires that first- or second-line supervisors sign the exit review form.[68] For the 20 providers who departed the medical center in the previous 12 months, the OIG found that 10 forms were not completed within seven calendar days. When exit forms are signed more than seven days after the provider departs the medical center, a failure to potentially identify and report unacceptable or substandard care in a timely manner to the SLBs may result. The Deputy Chief of Staff reported that supervisors did not consistently complete the forms on time because they confused the provider exit review form with other human resources exit forms.

Recommendation 5

5. The Medical Center 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 professionals' departure from the medical center.

Medical center concurred.

Target date for completion: March 31, 2021

Medical center response: The Medical Center Director evaluated and implemented an automated standard work process to makes certain that provider exit review forms are completed within seven calendar days of licensed healthcare professionals' departure from the medical center in accordance with VHA Handbook 1100.18. The Credentialing staff is responsible for compliance and report Exit Review Form status completion monthly to the Executive Committee of the Medical Staff (ECMS) meeting. Metric: Achieve >90% compliance for completion of Exit Form <7 days for departing Providers. The numerator of Exit Form Completed <7 days over Total number of Exit Forms completed for a given month.

[66] VA OIG, *Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No 19-00013-15, November 21, 2019. As of August 2020, the recommendations remain open.

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

[68] VHA Notice 2018-05.

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 medical center maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the medical center 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 medical center's environment:

- Medical centers
  - 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 team inspected the Athens VA Clinic and the following patient care areas at the Downtown and Uptown Divisions of the medical center:

- Downtown Division
  - Emergency Department
  - Intensive care unit
  - Medical/surgical inpatient units
  - Outpatient clinic
  - Post-anesthesia care unit
- Uptown Division
  - Acute psychiatric unit
  - CLC
  - Outpatient clinic

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

Environment of Care Findings and Recommendations

The OIG observed general compliance with requirements for the inpatient mental health unit and did not note any issues with the availability of medical equipment and supplies or accommodation and privacy for women veterans. The OIG noted the medical center continues to have opportunities to improve environmental cleanliness and safety. For example, the OIG identified that three patient rooms at the Uptown Division's CLC unit 3C had floors with holes located under the head and foot of the patients' beds, making it difficult to adequately clean and properly disinfect care areas. However, the medical center continues to implement action plans from the previous CHIP visit conducted in February 2019; therefore, repeat recommendations were not made.[70]

[70] VA OIG, *Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No 19-00013-15, November 21, 2019. As of November 2020, Environment of Care recommendations 7 and 8 are closed.

The OIG identified additional deficiencies with general safety, environmental cleanliness and infection prevention, and privacy.

VA requires that physical security planning is conducted annually and includes steps for "protection of persons, resources, and property; prevention of criminal loss or theft of vulnerable supplies, equipment, and property; and practical and economical application of technical security aids to augment optimum utilization of police officers for protection of VA facilities."[71] During the inspection, the OIG found that two entrances at the back of the Emergency Department were unlocked, allowing patient/visitor access. The associated department hallways were not supervised by staff and were not visible from the nursing station. Both doors led directly into the Emergency Department, where critical equipment and patient care rooms are located. According to the Chief of Police, no specific assessment of Emergency Department access had been conducted; the front doors—which are kept locked—were meant to prevent medical center staff from using the areas as a pass-through to other locations in the medical center.

Recommendation 6

6. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures the Chief of Police conducts a physical security evaluation of the Emergency Department.

[71] VA Handbook 0730, *Security and Law Enforcement,* August 11, 2000.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Director ensures the Chief of Police conducts annual Physical Security Surveys of the Emergency Department Medication Rooms, and a Bi-Annual Vulnerability Assessment as part of the larger Facility. The Security Enhancement of the Emergency Room and its annexed area, which is under way, will provide VA Police instantaneous control of ED entrances and exits, live and recorded video monitoring, real-time awareness of authorized and attempted accesses, and system settings or component failures. VA Police have a maintenance contract technician on site every Wednesday for system repairs and upgrades beyond the capability of Police. Dispatchers and two monitoring stations within the ED will have the ability to "Lock Down" the area with a couple mouse clicks. Police continuously patrol through the ED 24/7. Only Medical Center staff with valid Personal Identification Verification badges, enrolled and programmed with ED access will be able to open any ED door. This project will be completed by December 31, 2020 with door security controls being integrated by the servicing contractor of the security system as they are installed. (Each reader installed can be connected to the system independently, programmed and added to the ED access level independently, not having to wait for full project completion prior to functional employment. The two doors in question can be secured as soon as the readers are installed.) The facility is not replacing any doors on the ED project, but adding Physical Access Control System (PACS) components to the existing doors as well as cameras. The decision for the new PACS door controls (security) are based on the OIG CHIP findings, The Director's desire for better security of the annexed area and the ability to tie into our existing PACS / Lenel system which affords much higher security control and oversight than simple keypads or door locks. There is no VA Handbook 0730/4 requirement for the Emergency Department Physical Security Survey (PSS) or any other inpatient unit. Required is the PSS for Medication rooms (Ward and Treatment Rooms) and the two in the ED were completed June 3rd.

The Occupational Safety and Health Administration (OSHA) requires the posting of hazard warning signs on all access doors where potentially infectious materials are present.[72] OSHA also prohibits eating, drinking, or other acts of personal care in work areas where there is likelihood of occupational exposure to hazardous materials.[73] The OIG identified several areas

[72] According to the Occupational Safety and Health Administration's *Bloodborne pathogens* standard, "When other potentially infectious materials or infected animals are present in the work area or containment module, a hazard warning sign incorporating the universal biohazard symbol shall be posted on all access doors. The hazard warning sign shall comply with paragraph (g)(1)(ii) of this standard." 29 C.F.R. 1910.1030(e)(2)(ii)(D) and (g)(1)(ii).

[73] Per the Occupational Safety and Health Administration *Bloodborne pathogens* standard, "Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure." 29 C.F.R. 1910.1030(d)(2)(ix).

that lacked appropriate signage to indicate storage of biohazardous materials.[74] The OIG also noted an equipment decontamination room with proper biohazard signage but found personal employee items such as coffee mugs, purses, and bags in the work space.[75] The Chief of Environmental Management Service stated there had been signage in those locations before, and was unaware that staff were placing personal items in the room where equipment was being cleaned.

Recommendation 7

7. The Assistant Director determines the reasons for noncompliance and ensures signage is in place for all areas where biohazards are present.

Medical center concurred.

Target date for completion: July 31, 2021

Medical center response: The Chief of Safety has conducted a 100 percent review of all biohazard rooms ensuring proper documentation and labeling of the outer doors. The Environmental Management Service has placed biohazard stickers at entry doors. No later than October 31, 2020, a question will be added to the performance logic environmental rounds inspection to assist in monitoring compliance. Target for compliance will be 100%. Findings will be reported monthly to the Comprehensive Environment of Care Committee.

Recommendation 8

8. The Assistant Director determines the reasons for noncompliance and ensures that occupational exposure to hazardous materials is minimized in decontamination areas.

[74] Uptown Division: dirty utility rooms 2G and 1A. Downtown Division: Emergency Department and 6D.
[75] Room 4A110.

Medical center concurred.

Target date for completion: March 13, 2021

Medical center response: The Assistant Director has evaluated the finding and instituted measures to ensures that occupational exposure to hazardous materials is minimized in decontamination areas. In accordance with Medical Center Policy 137-18-01, Environmental, Safety, and Sanitation Inspection Program, the Chief of Environmental Management Service (EMS) addressed the issue of personal belongings in the Reusable Medical Equipment room, March 13, 2020 with the respective staff, who immediately removed personal items.

EMS Supervisors will conduct weekly rounds of assigned areas to monitor compliance no later than October 31, 2020. Each set of rounds will be documented using an inspection log. Compliance target will be set at 90% and must be maintained for six consecutive months. The Chief of Environmental ensures rounds are conducted. Findings and actions are reported to the Comprehensive Environment of Care Committee monthly.

TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices and keep furnishings and equipment safe.[76] The OIG inspected the Athens VA Clinic and noted areas with a significant amount of dust throughout the clinic; dirty/dusty heating, air conditioning, and ventilation grills; and damaged doors and door trims. Additionally, the medication room was not secured, and one housekeeping closet had no lock. These conditions resulted in concerns about the cleanliness and safety of the patient care environment. The clinic administrator reported that the housekeeper who consistently cleaned the clinic had recently resigned and that contracted services had assumed the cleaning duties. The clinic administrator further explained that communications were ongoing with the contractor about opportunities for improvement. The clinic administrator was not able to provide a reason for noncompliance for the unsecured doors.

Recommendation 9

9. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures that a safe and clean environment is maintained throughout the Athens VA Clinic.

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

Medical center concurred.

Target date for completion: April 30, 2021

Medical center response: The Contracting Officer Representative (COR) and Athens Community Based Outpatient Clinic (CBOC) Manager have reviewed the contract for environmental services. High and low dusting requirements are documented in the agreement.

Each month the Athens CBOC supervisor completes Environment of Care (EOC) inspections. Documentation of findings and actions are submitted to the service level chief for review. Service chiefs forward EOC documentation to their executive leader.

The medical center's Environmental Management Service (EMS) will begin monthly EOC rounds by October 31, 2020. The Chief of EMS or designee will inspect minimum 20 areas with an emphasis on high and low dusting. Compliance target will be set at 90% for 6 consecutive months. Supplemental EOC Rounding will be reported to the Comprehensive Environment of Care Committee.

Recommendation 10

10. The Associate Director determines the reasons for noncompliance and ensures that the medication room and housekeeping supply closet at the Athens VA Clinic are secured at all times.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The CBOC Manager is working with the COR, Contracting, Engineering, and OIT [Office of Information & Technology] to facilitate remodeling of the doors at the Athens CBOC. This work includes replacing and installing locks on the identified doors. Contracting was initiated and tentatively will be completed November 2020. Construction is tentatively expected for completion December 2020.

TJC also requires the protection of patient health information against "unauthorized access, use, [and] disclosure."[77] During the inspection of the Athens VA Clinic, the OIG identified the potential for a significant privacy breach. One room used for lab specimen collection was open, unattended, and contained stacks of laboratory labels which included patients' personally identifiable information. Outside this room were patients and visitors awaiting laboratory services. The room remained unattended for over five minutes. The staff member assigned to the room returned and described the process used by this staff member to prepare work as well as

[77] VHA Handbook 6500, Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program, March 10, 2015.

secure personally identifiable information, which was inconsistent with the OIG's observations of potential unauthorized access. The OIG informed the Director and acting ADPCS after the inspection of the privacy concerns. The Director took immediate staffing and security actions to ensure personally identifiable information was secured.

Recommendation 11

11. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that personally identifiable information is protected at the Athens VA Clinic.

Medical center concurred.

Target date for completion: January 2, 2021

Medical center response: The Medical Center Director evaluated management and oversight of protection of personally identifiable information at the Athens CBOC. This issue involved one employee who did not secure her personal work area during the OIG visit. This issue of non-compliance was addressed through education and retraining. The manager has implemented random spot checks for noncompliance and to ensure personally identifiable information is protected at the Athens CBOC. Medical Center Policies 9303 Sanctions for Violations of Information Security and Privacy and 0300 Privacy Policies and Procedures are used as guidance for supervisory response to findings.

All Athens CBOC staff were provided refresher information via email links to Medical Center Policies 9303 Sanctions for Violations of Information Security and Privacy and 0300 Privacy Policies and Procedures September 8, 2020. Rounding audit will be completed weekly with compliance target set at 90% for 3 consecutive months.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[78] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[79] 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.[80] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[81]

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.[82] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[83] 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.[84] 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.[85]

The OIG reviewers assessed providers' 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

[78] 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.)

[79] 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.)

[80] *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.)

[81] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain.*

[82] 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.)

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

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

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

- Completion of urine drug testing with intervention, when indicated
- 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.[86] 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 15 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 team considered whether providers acted in accordance with guidelines for the provision of pain management and the medical center's oversight process for evaluating pain management outcomes and quality.

Medication Management Findings and Recommendations

The OIG found the medical center addressed many of the indicators of expected performance, including the use of a multidisciplinary pain management committee to oversee and monitor required quality measures. The OIG found deficiencies with pain screenings, aberrant behavior risk assessments, concurrent benzodiazepine therapy, urine drug testing, informed consent, and patient follow-up, but did not issue recommendations due to the small sample size available for review.

VHA requires that "all elements of pain management must be documented in the patient record," including completion of "routine screening for the presence and intensity of pain" prior to dispensing of long-term opioid therapy.[87] The OIG determined that providers conducted routine pain screening in 87 percent of the electronic health records reviewed.[88] This resulted in inconsistent recognition and assessment of pain intensity and its effects on function and quality

[86] VHA Directive 2009-053, *Pain Management*, October 28, 2009.

[87] VHA Directive 2009-053.

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

of life. The Chiefs of Pharmacy and Primary Care stated that providers did not complete pain screenings when established patients requested pain medication through secure email and did not have an in-office appointment with the provider.

VA/DoD clinical practice guidelines recommend completion of an aberrant behavior risk assessment that includes a history of substance abuse, psychological disease, and aberrant drug-related behaviors prior to initiating long-term opioid therapy.[89] The OIG determined that providers completed aberrant behavior risk assessments in 27 percent of the electronic health records reviewed.[90] This may have resulted in providers prescribing opioids for patients at high risk for misuse. The Chiefs of Pharmacy and Primary Care reported the Patient Aligned Care Team allows for collaborative team-based care where nurses may complete screenings—including aberrant behavior risk assessments—rather than strictly providers.

VA/DoD clinical practice guidelines recommend avoiding co-administration of a drug which could induce "fatal drug-drug interactions" such as opioid and benzodiazepine combinations.[91] The OIG found that providers did not document justification for two patients concurrently prescribed opioid and benzodiazepine medications.[92] This may have resulted in an increased risk of harm and potentially fatal drug interactions. The Chiefs of Pharmacy and Primary Care were not able to provide a reason why there was no documentation discussing the concurrent use of benzodiazepines and opioid therapy.

VA/DoD clinical practice guidelines also recommend that providers "obtain UDT [urine drug testing] prior to initiating or continuing LOT [long-term opioid therapy] and periodically thereafter."[93] The OIG found that providers conducted initial urine drug screening within the required time frame in only 53 percent of the electronic health records reviewed.[94] This resulted in providers' inability to identify whether patients had substance use disorders or ensure adherence to the prescribed medication regimen. The Chiefs of Pharmacy and Primary Care reported that providers accommodated patient preferences for scheduling; therefore, urine drug testing was not always completed within the required time frame.

VHA requires providers to obtain and document informed consent prior to the initiation of "long-term opioid therapy for pain."[95] VA/DoD also recommends that the "informed consent

[89] *Pain Management, Opioid Safety, VA Educational Guide* (2014), July 2014, defines aberrant drug related behaviors as "lost prescriptions, multiple requests for early refills, unauthorized dose escalation, apparent intoxication, and frequent accidents.

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

[91] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

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

[93] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

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

[95] VHA Directive 1005.

conversation cover the risks and benefits of opioid therapy, as well as alternative therapies."[96] The OIG determined that providers documented informed consent prior to initiating long-term opioid therapy in 53 percent of the electronic health records reviewed.[97] The remaining 47 percent of patients may have received treatment without knowledge of the risks associated with long-term opioid therapy, including dependence, tolerance, addiction, and unintentional fatal overdose. The Chiefs of Pharmacy and Primary Care reported the electronic consent system is unreliable; when the electronic system fails to operate, paper consents were not readily available, and providers were not trained on contingency processes.

VA/DoD practice guidelines also recommend that providers evaluate the "benefits of continued opioid therapy and risk for opioid-related adverse events at least every three months" after initiating long-term opioid therapy.[98] Follow-up can also help providers assess adherence to care plans and the effectiveness of interventions.[99] The OIG found that providers followed up with patients for pain management and assessed adherence to plans of care and effectiveness of interventions within the required timeframe in 40 percent of the electronic health records reviewed.[100] Failure to follow up can result in missed opportunities to assess patients' adherence to the therapy plan, effectiveness of treatment, and risks of continued opioid therapy. The Chiefs of Pharmacy and Primary Care reported that timeliness of follow-up was affected by patient factors and provider turnover and created challenges with continuity of care when reassigning provider panels. Additionally, the chiefs noted that the current template does not have alerts to remind providers to document the follow-up elements of pain assessment.

[96] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

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

[98] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

[99] VHA Directive 2009-053.

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

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.[101] 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.[102] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[103]

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.[104]

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.[105] 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

[101] Centers for Disease Control and Prevention. *Preventing Suicide*. https://www.cdc.gov/violenceprevention/suicide/fastfact.html. (The website was accessed on March 4, 2020.)

[102] 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*.

[103] 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.*

[104] *VA Office of Mental Health and Suicide Prevention Guidebook*, June 2018.

[105] 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."[106] 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."[107] 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.[108] 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.[109]

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."[110] 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."[111] 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."[112]

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

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

[108] *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.

[109] 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*.

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

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

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

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 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."[113]

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.[114] VHA also requires that all staff receive annual refresher training.[115] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[116]

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

[114] 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.

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

[116] 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.

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

- Relevant documents;
- The electronic health records of 36 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 medical center complied with requirements associated with a designated SPC, training, and community outreach activities. 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"[117]—the OIG estimated that 25 percent of HRS PRFs were placed within one business day of referral to the SPC.[118] 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 further calculated that the average time from referral to HRS PRF placement for the patients reviewed was 5 days (observed range was 0–16 days).

Further, the OIG noted concerns with reviewing HRS PRFs within the required time frame. VHA required that all patients with an HRS PRF be re-evaluated at least every 90 days and there is documented justification for continuing or discontinuing the flag.[119] The OIG estimated that only 25 percent of patients with an HRS PRF were re-evaluated at least every 90 days.[120] However, based upon the updated requirement that HRS PRFs be reviewed up to 10 days prior to or after the due date for re-evaluation[121], the OIG found that all but one of the patients were reviewed within the expected time frame (observed range was 74–99 days).

Due to VHA's updated requirements, the OIG made no recommendations.

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

[118] The OIG estimated that 95 percent of the time, the true compliance rate is between 11.4 and 40.0 percent, which is statistically significantly below the 90 percent benchmark.

[119] VHA Directive 2008-036.

[120] The OIG estimated that 95 percent of the time, the true compliance rate is between 11.8 and 39.5 percent, which is statistically significantly below the 90 percent benchmark.

[121] VHA Notice 2020-13.

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."[122]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD handbook by July 12, 2018.[123] 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.[124] 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.[125]

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.

[122] 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.

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

[124] 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.

[125] 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 medical center 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.[126] Inspectors examined if the medical center 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 medical center 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 49 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

Care Coordination Findings and Recommendations

The OIG found the medical center generally complied with requirements for the supervision of designees and the LSTD Committee. Additionally, with VHA's original requirements that were

[126] VHA Handbook 1004.03(1).

in place when these patients received care, the OIG estimated that 67 percent of patients' LST progress notes addressed previous advance directive(s), state-authorized portable orders, and/or LST notes.[127]

However, VHA deleted requirements for the documentation of these elements in the LST progress note. The OIG did not issue a recommendation but remains concerned that this change could result in practitioners not addressing important goals of care conversation elements.

[127] The OIG estimated that 95 percent of the time, the true compliance rate is between 52.4 and 80.4 percent, which is statistically significantly below the 90 percent benchmark.

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[128] 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.[129] 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."[130] 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."[131]

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.[132] 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."[133]

To determine whether the medical center 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:

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[128] 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.)

[129] 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.)

[130] 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.)

[131] 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.hsrd.research.va.gov/publications/forum/spring18/default.cfm?ForumMenu=Spring18-5. (The website was accessed on September 16, 2019.)

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

[133] VHA Directive 1330.01(3).

- Provision of care requirements
  - 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's 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 medical center complied with requirements for most of the provision of care indicators and selected staffing elements reviewed. At the time of the site visit, the OIG noted that the medical center continues to work on improvements identified in the 2019 CHIP report related to tracking of cervical cancer data and communication of results to patients within the required time frame.[134] The medical center has made improvements to the Women Veterans Health Committee from the 2019 inspection but continues to have opportunities to ensure all required members attend meetings. The OIG made no repeat recommendations.

[134] VA OIG, *Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No 19-00013-15, November 21, 2019. As of April 2020, recommendations related to tracking cervical cancer screening data and communicating abnormal results from the 2019 inspection were closed.

During this current site visit, the OIG identified weaknesses with gynecologic care coverage, CBOC women's health primary care providers, and women's health clinical liaisons at each CBOC.

VHA requires facilities to have processes and procedures in place for 24 hours a day/7 days per week coverage for ED and facility call coverage for gynecologic care. This includes development and implementation of "written polices and standard operating procedures for managing obstetric and gynecologic emergencies." VHA further states that the policies "must clearly describe on-site capabilities and processes/protocols for emergent patient transfer."[135] The OIG determined the medical center does not provide gynecological care coverage 24 hours a day/7 days per week, nor are there written policies or standard operating procedures for managing obstetric and/or gynecologic emergencies. The medical center's Women's Health Clinic has a gynecologist on staff who does not provide care after hours. This could result in the lack of available comprehensive women's healthcare services. The Chief Nurse and the acting Chief of Community Care stated there are multiple facilities in the area available for after-hours gynecological care, but there was no specific memorandum of understanding or operational policy in place at the time of the OIG visit.

Recommendation 12

12. The Chief of Staff determines the reasons for noncompliance and ensures that policies and procedures are in place for 24 hours a day, 7 days per week gynecological care.[136]

Medical center concurred.

Target date for completion: Completed

Medical center response: The medical center has in place a Standard Operating Procedure (SOP) for emergent and non-emergent transfers to include patients with gynecological needs with an affiliate hospital for provision of gynecologic care 24 hours a day, seven days per week.

VHA requires that each CBOC has at least two designated women's health primary care providers or arrangements for leave coverage when CBOCs have only one provider.[137] The OIG found that two of four CBOCs (Aiken and Statesboro) had only one designated women's health primary care provider and no plans for leave coverage, which could limit the system's ability to provide comprehensive healthcare services to women veterans. The acting Assistant Chief of Primary Care acknowledged the lack of two women's health designated providers and reported

[135] VHA Directive 1330.01(3).

[136] The OIG reviewed evidence sufficient to demonstrate that the medical center had completed improvement actions and therefore closed the recommendation before publication of the report.

[137] VHA Directive 1330.01(3).

that a second provider, who will have women's health designation at the Statesboro CBOC, started about one month prior to the OIG visit. As for the Aiken CBOC, providers identified for women's health designation were unable to attend training when it was offered.

Recommendation 13

13. The Chief of Staff determines the reasons for noncompliance and makes certain that each community-based outpatient clinic has at least two designated women's health primary care providers or arrangements for leave coverage when only one designated provider is available.[138]

Medical center concurred.

Target date for completion: Completed

Medical center response: Each CBOC has at least two designated women's health primary care providers. The Statesboro and Aiken CBOCs each have a physician and nurse practitioner as designated women's health primary care providers. Two physicians and a nurse practitioner are assigned to the Athens CBOC as designated women's health primary care providers.

VHA requires the CBOC to have a designated women's health clinical liaison to coordinate healthcare services with the Women Veterans Program Manager.[139] The OIG was informed that the medical center did not have a designated liaison at the Athens and Statesboro CBOCs. This could result in the Women Veterans Program Manager being unaware of or not taking actions to address women's health-related concerns at the CBOC. The Women Veterans Program Manager reported that ongoing efforts to recruit women's health clinical liaisons for the Athens and Statesboro CBOCs have been unsuccessful due to the lack of volunteers; at the time of the site visit, the program manager had not sought support from leaders to address the issue.

Recommendation 14

14. The Chief of Staff evaluates and determines additional reasons for noncompliance and ensures the medical center has a designated women's health clinical liaison at each community-based outpatient clinic.[140]

[138] The OIG reviewed evidence sufficient to demonstrate that the medical center had completed improvement actions and therefore closed the recommendation before publication of the report.

[139] VHA Directive 1330.01(3).

[140] The OIG reviewed evidence sufficient to demonstrate that the medical center had completed improvement actions and therefore closed the recommendation before publication of the report.

Medical center concurred.

Target date for completion: Completed

Medical center response: Each of the medical center's community-based outpatient clinics has a designated women's health clinical liaison. Aiken and Athens CBOCs each have nurse practitioner's assigned as women's health clinical liaisons. A registered nurse is assigned as women's health clinical liaison at the Statesboro CBOC.

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 sterile processing services (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment."[141] The goal of SPS is to "provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[142] 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 instruments[143]
- 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 inspections[144]

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.[145] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[146]

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,

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

[142] 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.)

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

[144] VHA Directive 1116(2).

[145] 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.

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

personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[147]

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.[148]

To determine whether the medical center complied with OIG-selected requirements, the inspection team examined relevant documents and training records; conducted physical inspections of the SPS, Gastroenterology SPS, and sterile 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 inspection of reprocessing and storage areas
  - Traffic restricted
  - Airflow monitored
  - Personal protective equipment available

[147] VHA Directive 1116(2).
[148] VHA Directive 1116(2).

  - Area is clean
  - Eating or drinking in the area prohibited
  - Equipment properly stored
  - Required temperature and humidity maintained
- 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

The medical center met several of the requirements for the proper operations and management of reprocessing RME. However, the OIG identified deficiencies with SOPs; the annual risk analysis; equipment storage; and staff training, competencies, and ongoing education.

As previously mentioned, VHA requires that facilities "must have standard operating procedures (SOPs) based on manufacturer's guidelines that establishes a documented and systematic approach to critical and semi-critical RME processes."[149] VHA also requires that "all SOPs are kept up-to-date, reviewed at least every 3 years and updated when there is a change in process or a change in manufacturer's IFU [Instructions For Use]."[150] The OIG found that the colonoscope SOP did not contain all the required steps when compared to the IFU. In addition, the OIG noted discrepancies and missing guidance within the SOP related to processing steps. This may have resulted in confusion and inadequate disinfection of RME. The Chief of SPS stated lack of attention to detail as the reason for noncompliance.

Recommendation 15

15. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that standard operating procedures align with manufacturers' instructions for use.

[149] VHA Directive 1116(2).
[150] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: December 31, 2021

Medical center response: Reasons for noncompliance of misaligned standard operating procedures and manufacturers' instructions for use, were considered when developing the action plan for sustained compliance and oversight. Actions taken by the Sterile Processing Service (SPS), include; a review and revision of the colonoscope standard operating procedure (SOP) by the SPS Reusable Medical Equipment (RME) coordinator, to ensure that its instructions aligned directly with the manufacturers' instruction for use (IFU). The updated colonoscope SOP was reviewed and signed per protocol on March 23, 2020. After which, competency assessments were formulated directly from that SOP. SPS endoscopy processing staff, reviewed the updated competency and were competency checked for the equipment per established protocol by April 13, 2020. The Chief of SPS and the RME coordinator will continue to strictly review and monitor all revisions and newly written SOPs for two quarters to verify continued compliance with manufacturers' instructions for use, with a compliance standard of 90% or greater.

Additionally, VHA requires that the SPS Chief performs an annual risk analysis and reports the results to the VISN SPS Management Board.[151] The medical center provided a completed fiscal year 2019 risk analysis report but did not share results with the VISN SPS Management Board. Failure to report risk analysis results can delay or prevent the identification of problems or process failures and opportunities for mitigation. The Chief of Biomedical Engineering and Chief of SPS both stated unawareness of the requirement to report the risk analysis to the VISN SPS Management Board.

Recommendation 16

16. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that the Sterile Processing Services Chief reports the annual risk analysis results to the Veterans Integrated Service Network Sterile Processing Services Management Board.

[151] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: January 30, 2021

Medical center response: Reasons for noncompliance for SPS Chief performing an annual risk analysis and failing to properly report to VISN SPS Management Board, was considered when developing the action plan for sustained compliance and oversight. The chief of SPS will compile and submit an annual risk analysis to the VISN SPS Management board as required each year. A record of the risk analysis review and/or revisions will be documented to the Reusable Medical Equipment Committee minutes and reported to the VISN SPS management board annually as indicated. The SPS Chief will be responsible for the completion and submission of this risk analysis with a future compliance standard of 100%.

VHA requires that high-level disinfected endoscopes "are to be hung so that no part of the scope touches the bottom of the cabinet and in sufficient space for storage of multiple endoscopes without touching."[152] The OIG found that multiple high-level disinfected endoscopes were not hanging freely in cabinets in several areas (endoscopy, audiology, ear nose and throat, and the operating room). Correct storage of endoscopes reduces the risk of contamination or damage to the equipment. The Lead Medical Supply Technician stated that it is challenging to keep the scopes from touching the walls of the cabinets due to the number and types of scopes needing to be stored and the current available cabinet space.

Recommendation 17

17. The Associate Director for Patient Care Services evaluates and determines additional reasons for noncompliance and make certain that the Sterile Processing Services staff properly store high-level disinfected endoscopes.

Medical center concurred.

Target date for completion: February 28, 2021

Medical center response: End-user on the spot education occurred on March 3, 2020 for proper hanging and storage of flexible endoscopes. Two RME Champions have been identified. Monitoring of the endoscope cabinets for proper storage and handling continue to be observed monthly during SPS RME rounds. No less than six months of RME rounding for compliance will be conducted for both Uptown Division and Downtown Division campuses with a compliance goal of 90% or greater.

[152] VHA Directive 1116(2).

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."[153] Of the eight selected SPS employees hired after March 23, 2016, the OIG found that two employees had not completed the SPS Level 1 training within 90 days of hire. When staff training is not completed timely, employees are more likely to put patients at risk by failing to properly clean equipment.

VHA also requires that SPS staff complete competency assessments for RME reprocessing.[154] The OIG found that 2 of 10 selected SPS staff had missing competency assessments for reprocessing one of two pieces of equipment selected for review, and one employee did not have a competency assessment for both pieces of equipment that were reviewed. This could result in improper cleaning of the RME and compromise patient safety.

In addition, VHA requires that SPS staff receive monthly continuing education.[155] The OIG did not find evidence of continuing education for all 10 selected SPS staff in August and September 2019. Lack of training can create a knowledge gap that results in improperly reprocessed equipment and compromised patient safety. The Chief of SPS stated lack of oversight as the reason for noncompliance.

Recommendation 18

18. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that all new employees complete Level 1 training within 90 days of hire.

Medical center concurred.

Target date for completion: February 28, 2021

Medical center response: All Sterile Processing Service staff (except for the Office Assistant) completed level 1 training within 90 days of hire. Reason for noncompliance were reviewed and considered in the development of this plan for sustained compliance and oversight. The SPS Chief conducts monthly audits of the new employee's orientation records to ensure that all TMS [Talent Management System] Level 1 training modules have been completed within 90 days of hire and prior to starting on-the-job training in restricted areas. Data outcomes are reported quarterly through the RME Committee. 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.

[153] VHA Directive 1116(2).
[154] VHA Directive 1116(2).
[155] VHA Directive 1116(2).

Recommendation 19

19. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that the Sterile Processing Services staff receive properly completed competency assessments prior to reprocessing reusable medical equipment.

Medical center concurred.

Target date for completion: January 30, 2021

Medical center response: All SPS staff who reprocess reusable medical equipment completed required competency training by April 13, 2020. Reasons for noncompliance were reviewed and considered in the development of the following plan for sustained compliance and oversight. The Sterile Processing Chief conducts monthly compliance audits. Data outcomes are reported quarterly through the RME Committee. 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 on time competency training; Denominator is the total number of SPS employees onboard during the designated review period.

Recommendation 20

20. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that Sterile Processing Services staff receive monthly continuing education.

Medical center concurred.

Target date for completion: January 1, 2021

Medical center response: Reasons for noncompliance of monthly continuing education were reviewed and considered in the development of this plan for sustained compliance and oversight. The sterile processing service chief completes annual reviews of the training calendar to ensure required continuing education sessions are offered monthly. An MST [Medical Supply Technician] lead ensures staff not present for training sessions are rescheduled. Supervisors ensure staff complete required monthly training and maintain supporting documentation. RME continuing education compliance outcomes are reported monthly to RME Committee. 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/Gastrointestinal (GI) scopes who completed continuing education for the month; denominator is the total number of SPS employees who reprocess RME/GI scopes each month. [Please note that the target completion date should include the time needed to monitor for sustained improvement.

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	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Factors related to possible lapses in care and medical center response • VHA performance data (facility) • VHA performance data for CLCs	Twenty OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director. See details below.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• Implemented improvement actions are monitored by the QSV and Innovation Council. • All applicable deaths that occur within 24 hours of admission are peer reviewed. • Root cause analyses include all required review elements and are properly documented in the VHA Patient Safety Information System.	• Feedback is provided to staff who submit patient safety incidents that result in a root cause analysis.
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• None	• Provider exit review forms are completed within seven calendar days of licensed healthcare professionals' departure from the medical center.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Medical center
	  ○ 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
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Privacy for women veterans
	  ○ Logistics
		• Occupational exposure to hazardous materials is minimized in decontamination areas.
		• Safe and clean environment is maintained throughout the Athens VA Clinic.
			• Chief of Police conducts a physical security evaluation of the Emergency Department.
			• Signage is in place for all areas where biohazards are present.
			• Medication room and housekeeping supply closet at the Athens VA Clinic are secured at all times.
			• Personally identifiable information is protected at the Athens VA Clinic.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• None	• None
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements	• None	• None
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• None	• None
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• Each CBOC has at least two designated women's health primary care providers or arrangements for leave coverage when CBOCs have only one designated provider.	• Policies and procedures are in place to ensure gynecological care is available 24 hours a day, 7 days per week. • Each CBOC has a designated women's health clinical liaison.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Quality assurance monitoring • Physical inspection • Staff training	• Standard operating procedures align with manufacturers' instructions for use. • High-level disinfected endoscopes are stored properly.	• The annual SPS risk analysis is reported to the VISN SPS Management Board. • All new employees complete Level 1 training within 90 days of hire. • SPS staff receive competency assessments for reprocessing reusable medical equipment. • SPS staff receive monthly continuing education.

Appendix B: Medical Center Profile

The table below provides general background information for this highest complexity (1a) affiliated[1] medical center reporting to VISN 7.[2]

**Table B.1. Profile of the Charlie Norwood VA Medical Center (509)
(October 1, 2016, through September 30, 2019)**

Profile Element	Medical Center Data FY 2017[3]	Medical Center Data FY 2018[4]	Medical Center Data FY 2019[5]
Total medical care budget in dollars	$467,246,111	$450,446,899	$478,620,944
Number of:			
• Unique patients	45,040	45,949	46,428
• Outpatient visits	554,682	592,919	594,125
• Unique employees[6]	2,124	2,076	2,068
Type and number of operating beds:			
• Blind Rehabilitation	15	15	15
• Community living center	132	132	132
• Domiciliary	60	60	60
• Medicine	58	58	58
• Mental health	68	68	57
• Rehabilitation medicine	10	10	10
• Spinal cord injury	71	71	71
• Surgery	27	27	27
Average daily census:			
• Blind Rehabilitation	9	11	9
• Community living center	87	86	81
• Domiciliary	49	52	50

[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	Medical Center Data FY 2017[3]	Medical Center Data FY 2018[4]	Medical Center Data FY 2019[5]
• Medicine	50	49	47
• Mental health	17	16	12
• Rehabilitation medicine	8	8	7
• Spinal cord injury	47	43	49
• Surgery	10	9	7

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 Profiles[1]

The VA outpatient clinics in communities within the catchment area of the medical center 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
Athens, GA	509GA	11,310	7,365	n/a	EKG	Nutrition Pharmacy Social work Weight management
Aiken, SC	509GB	10,126	3,647	n/a	EKG	Nutrition Pharmacy Social work Weight management

[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.

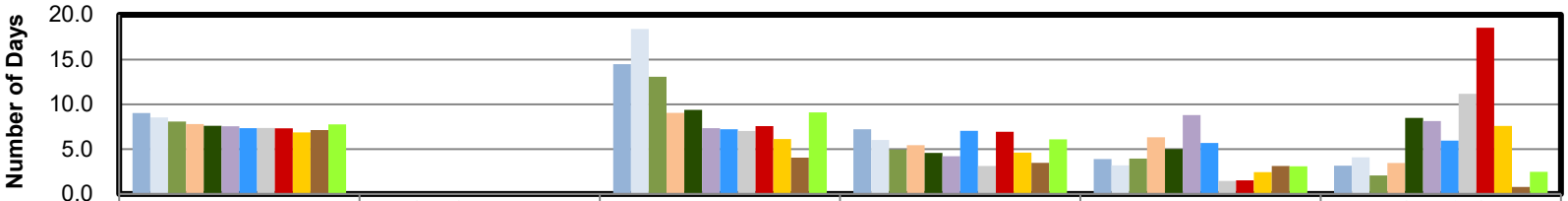
[4] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

[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
Statesboro, GA	509QA	4,706	1,131	n/a	n/a	Pharmacy Social work

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

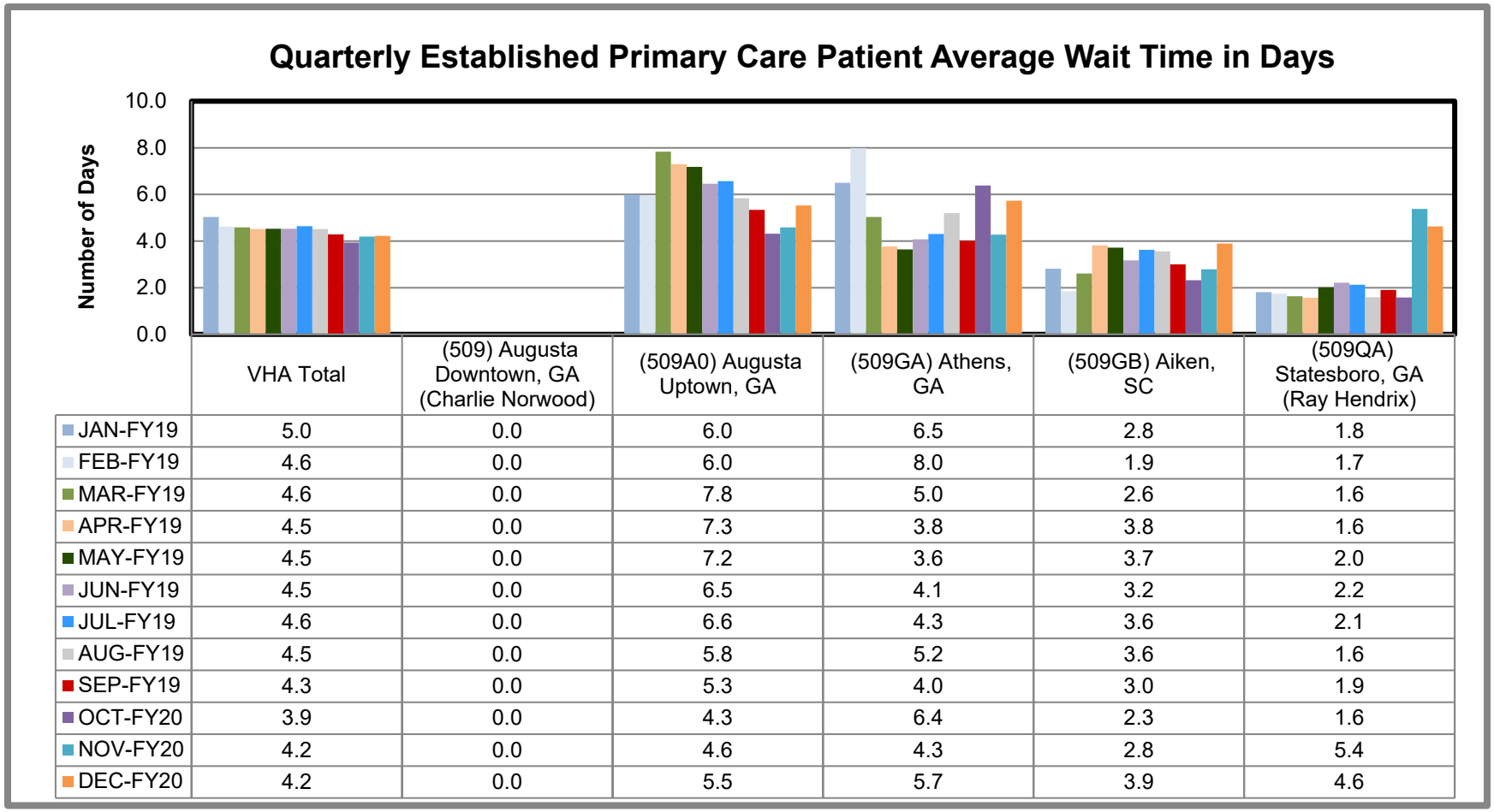
Appendix D: Patient Aligned Care Team Compass Metrics[1]



	VHA Total	(509) Augusta Downtown, GA (Charlie Norwood)	(509A0) Augusta Uptown, GA	(509GA) Athens, GA	(509GB) Aiken, SC	(509QA) Statesboro, GA (Ray Hendrix)
JAN-FY19	9.0	0.0	14.5	7.2	3.9	3.2
FEB-FY19	8.5	0.0	18.4	6.0	3.2	4.1
MAR-FY19	8.1	0.0	13.1	5.0	4.0	2.1
APR-FY19	7.8	0.0	9.1	5.4	6.3	3.5
MAY-FY19	7.6	0.0	9.4	4.6	5.0	8.5
JUN-FY19	7.6	0.0	7.4	4.2	8.8	8.1
JUL-FY19	7.3	0.0	7.2	7.0	5.7	6.0
AUG-FY19	7.4	0.0	7.0	3.1	1.5	11.2
SEP-FY19	7.3	0.0	7.6	6.9	1.5	18.6
OCT-FY20	6.9	0.0	6.1	4.6	2.4	7.6
NOV-FY20	7.1	0.0	4.1	3.5	3.1	0.8
DEC-FY20	7.8	0.0	9.1	6.1	3.1	2.5

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 a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Note that prior to FY15, this metric was calculated using the earliest possible create date. The absence of reported data would be indicated by "n/a."

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



	VHA Total	(509) Augusta Downtown, GA (Charlie Norwood)	(509A0) Augusta Uptown, GA	(509GA) Athens, GA	(509GB) Aiken, SC	(509QA) Statesboro, GA (Ray Hendrix)
JAN-FY19	5.0	0.0	6.0	6.5	2.8	1.8
FEB-FY19	4.6	0.0	6.0	8.0	1.9	1.7
MAR-FY19	4.6	0.0	7.8	5.0	2.6	1.6
APR-FY19	4.5	0.0	7.3	3.8	3.8	1.6
MAY-FY19	4.5	0.0	7.2	3.6	3.7	2.0
JUN-FY19	4.5	0.0	6.5	4.1	3.2	2.2
JUL-FY19	4.6	0.0	6.6	4.3	3.6	2.1
AUG-FY19	4.5	0.0	5.8	5.2	3.6	1.6
SEP-FY19	4.3	0.0	5.3	4.0	3.0	1.9
OCT-FY20	3.9	0.0	4.3	6.4	2.3	1.6
NOV-FY20	4.2	0.0	4.6	4.3	2.8	5.4
DEC-FY20	4.2	0.0	5.5	5.7	3.9	4.6

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 Definitions[1]

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
Capacity	Acute care risk adjusted complication ratio (observed to expected ratio)	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

[1] VHA Support Service Center, *Strategic Analytics for Improvement and Learning (SAIL)* (last updated September 30, 2019). http://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 continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	ORYX	A higher value is better than a lower value
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 Definitions[1]

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 meds (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: November 17, 2020

From: Interim Director, VA Southeast Network (VISN 7) (10N7)

Subj: Draft Report - Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center Augusta, Georgia

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

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 Charlie Norwood VA Medical Center Augusta, Georgia.

2. VISN 7 and Charlie Norwood VA Medical Center submits the attached status update providing justification and documentation to recommendations 1-20. I concur with the recommendations 1-20.

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.

(Original signed by:)

Joe D. Battle

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: November 2, 2020

From: Director, Charlie Norwood VA Medical Center (509/00)

Subj: Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center Augusta, Georgia

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

1. In response to the VA Office of Inspector General (OIG) Comprehensive Inspection of the Charlie Norwood VA Medical Center Augusta, Georgia, we concur with recommendations: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20.

2. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

3. If you have any questions or require further information, please contact Acting Chief, Quality Management.

(Original signed by:)

Robin E. Jackson PhD

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Melinda Alegria, AUD, CCC-A, Team Leader Patricia Calvin, RN, MBA Tasha Felton Williams, DNP, ACNP Donna Murray, MSN, RN Michelle (Shelly) Wilt, MBA, BSN
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Alicia Castillo-Flores, MBA, MPH Limin Clegg, PhD Ashley Fahle Gonzalez, MPH, BS 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

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