DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018

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

www.va.gov/oig/hotline

1-800-488-8244

Figure 1. *U.S. Department of Veterans Affairs Building, Washington, DC*
(Source: https://www.gsa.gov/, accessed on March 13, 2019)

Abbreviations

AES	all employee survey
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infection
EHR	electronic health record
FPPE	focused professional practice evaluation
FY	fiscal year
GE	geriatric evaluation
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
PSI	patient safety indicators
PTSD	posttraumatic stress disorder
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
SHEP	survey of healthcare experience of patients
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

The Comprehensive Healthcare Inspection Program (CHIP) provides cyclical focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected VHA facilities. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the overall efforts of the Office of Inspector General (OIG) to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG selects and evaluates specific areas of focus each year and performs these cyclical routine inspections approximately every three years for each VA facility.

OIG teams evaluated facility leadership and organizational risks as well as clinical areas that reflect quality patient care. At the time of the review, the clinical areas of focus were

1. Quality, safety, and value;

2. Credentialing and privileging;

3. Environment of care;

4. Medication management (specifically the controlled substances inspection program);

5. Mental health (focusing on posttraumatic stress disorder screening, diagnostic evaluation, and referral to specialty care);

6. Long-term care (spotlighting effective geriatric evaluation);

7. Women's health (particularly the reporting of mammography results); and

8. High-risk processes[1] (specifically the central line-associated bloodstream infection program and staff training).

The OIG conducted unannounced site visits to VA facilities from October 16, 2017, through September 14, 2018, that involved interviews with facility leaders and staff and reviews of clinical and administrative processes. Although the OIG reviewed a broad spectrum of processes related to the above areas of focus, the sheer complexities of VA facilities limit the inspection teams' abilities to assess all areas of clinical risk. The results presented in this report are a snapshot of VHA performance within the identified focus areas at the time of the OIG visits. Although it is difficult to quantify the risk of patient harm, the findings in this report may help the Veterans Health Administration (VHA) to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

---

[1] The OIG's review of central line-associated bloodstream infections focused on those that developed during care in intensive care units.

Results and Inspection Impact

Leadership and Organizational Risks

The OIG noted positive observations during the review of leadership and organizational risks at the representative sample of 51 VA facilities. First, the OIG found that 85 percent of leadership positions (director, deputy director, chief of staff, associate director for Patient Care Services (ADPCS), associate director, and assistant directors) were filled by permanent staff. These facility leaders generally appeared engaged in supporting quality, safety, and value (QSV) activities at their respective facilities. They mostly felt supported by VISN leaders and program managers and had access to public/private sector expert resources for guidance and assistance for QSV and improvement activities. Members of the executive leadership team were also generally knowledgeable with improvement activities involving employee and patient satisfaction. Further, most facility leaders were actively involved in maintaining various accreditations, addressing Joint Commission and OIG recommendations for improvement, and taking action in response to selected potential organizational risks.

The OIG also recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[2] The OIG noted opportunities for multiple facilities to improve their respective SAIL star ratings. Sixteen of the surveyed facilities received a "1-" or "2-star" rating as of June 30, 2017. There were no notable trends observed when comparing facilities' star ratings to facility complexity, patient safety indicators (PSI) data, number of sentinel events, or number of institutional disclosures. However, the OIG observed that facilities with higher SAIL star ratings had noticeably fewer OIG CHIP recommendations for improvement.

The OIG also noted limited trends when comparing facilities' complexities to PSI data, number of sentinel events, number of institutional disclosures, and number of OIG CHIP report recommendations; a higher occurrence rate was observed for each of these elements for facilities with the highest complexity. This observation is not surprising given these facilities' complex clinical programs, volume of high-risk patients, and affiliations with teaching programs.

---

[2] VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star" rating system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 6, 2019.)

The OIG noted findings nationally in five of the eight clinical areas reviewed and issued 16 recommendations during fiscal year (FY) 2018 comprehensive healthcare inspections. These are briefly described below.

Quality, Safety, and Value

The OIG found general compliance with many of the selected requirements for protected peer reviews, utilization management (UM), and patient safety. However, the OIG identified concerns with the implementation of improvement actions recommended by peer review committees, documentation of physician UM advisors' decisions in the National UM Integration database, interdisciplinary review of UM data, and provision of feedback about root cause analysis actions to reporting employees.

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing and privileging but identified concerns with the focused professional practice evaluations (FPPEs) and ongoing professional practice evaluations (OPPE) processes. More specifically, concerns were identified because the OIG did not find evidence that completed FPPEs were reported to an appropriate committee of the medical staff, FPPEs were time limited as required, OPPEs included service-specific data collection, and required specialty-specific elements were included in the OPPEs of specialty providers.

Environment of Care

Generally, facilities and community based outpatient clinics (CBOCs) met requirements associated with infection prevention, general safety, privacy, and availability of supplies. Construction and Nutrition and Food Services areas, locked mental health units, and emergency management programs met many of their respective requirements. However, the OIG identified concerns with environmental cleanliness, installation and testing of panic alarms in high-risk areas, seclusion rooms in locked mental health units, and emergency management processes.[3]

Medication Management

The OIG found general compliance with requirements for some of the performance indicators evaluated, including the controlled substances coordinator reports, requirements for controlled substances inspectors, and pharmacy inspections. The OIG noted deficiencies which included the failure to correct issues identified in the annual VA Police survey of the pharmacy, the reconciliation of the one day dispensing from the pharmacy to each dispensing area, and return

---

[3] Reported findings at the national level may not have risen to the level of a recommendation at the individual facility level, and many of the deficiencies may have been corrected while OIG inspection teams were on site.

of stock from each dispensing area back to the pharmacy. The OIG also found that controlled substances coordinators conducted routine monthly inspections (in the place of controlled substance inspectors who should have been performing those inspections) rather than conducting the inspections only when training inspectors or covering for their unplanned leave, illness, or other emergencies.

Long-Term Care

Generally, facilities met requirements for provision of or access to geriatric evaluation, provision of clinical care, and geriatric management. However, the OIG identified a concern with program oversight and evaluation that warranted a recommendation for improvement.

Summary

In reviewing key healthcare processes, the OIG noted national-level findings in five of the eight clinical areas reviewed and issued 16 recommendations for improvement directed to the Under Secretary for Health, in conjunction with Veterans Integrated Service Network Directors and facility senior leaders. The results in this report, which were noted from systems issues, should be used by VHA leaders to improve operations and clinical care at the facility level. Failure to improve and sustain that improvement will eventually interfere with the delivery of consistent quality health care.

Comments

The Executive in Charge, Office of the Under Secretary for Health, concurred with CHIP inspection findings and recommendations 1–5 and 7–16, concurred in principle with recommendation 6, and provided acceptable improvement plans. (See Appendix E, page 67, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

Purpose and Scope

The purpose of the Office of Inspector General's (OIG) comprehensive healthcare inspections during fiscal year (FY) 2018 was to provide oversight of healthcare services to veterans. The OIG accomplished this focused evaluation of the quality of care delivered in the inpatient and outpatient settings of 51 randomly selected facilities by examining a broad spectrum of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reported its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions could be made to improve care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.[4] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[5] Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

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

1. Leadership and organizational risks;

2. Quality, safety, and value (QSV);

3. Credentialing and privileging;

4. Environment of care (EOC);

5. Medication management (specifically controlled substance inspection program);

6. Mental health (focusing on posttraumatic stress disorder screening, diagnostic evaluation, and referral to specialty care);

7. Long-term care (spotlighting effective geriatric evaluation);

8. Women's health (particularly the reporting of mammography results); and

---

[4] 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 March 1, 2018.)

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

9. High-risk processes (specifically the central line-associated bloodstream infection program and staff training).[6]
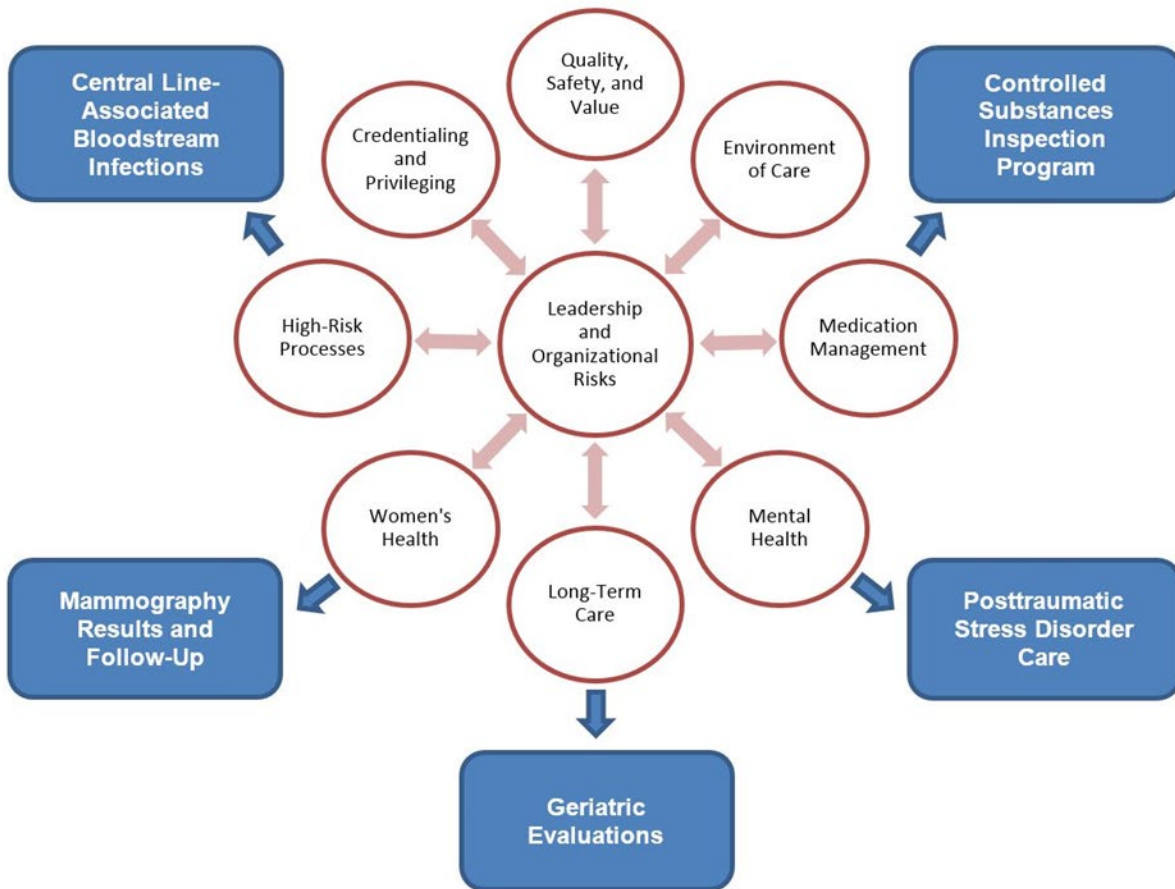
Figure 2. *FY 2018 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

---

[6] The OIG's review of central line-associated bloodstream infections focused on those that developed during care in intensive care units. See Figure 2. CHIP inspections address these processes during FY 2018 (October 1, 2017, through September 30, 2018); they may differ from prior years' focus areas.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection teams reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;[7] physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team at each facility.

The inspection period examined operations generally from each facility's last routine cyclical OIG inspection through September 2018. This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA completes corrective actions. The comments and action plans submitted by the Executive in Charge, Office of the Under Secretary for Health, in response to the report recommendations appear within each topic area.

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

---

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all the selected clinical areas of focus.[8] To assess facility risks, the OIG considered the following elements:

1. Executive leadership position stability and engagement

2. Employee satisfaction

3. Patient experience

4. Accreditation and/or for-cause surveys and oversight inspections

5. Factors related to possible lapses in care

6. VHA performance data.

Executive Leadership Position Stability and Engagement

The OIG performed this review at facilities representing all VISNs and complexity levels.[9] See Tables D.1 and D.2 (Appendix D). Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population served, the OIG observed variation in the composition of the executive leadership team at individual facilities inspected. The OIG noted the most common team composition (29 of 51 facilities) included a facility director, chief of staff, associate director for Patient Care Services (ADPCS), and associate director (primarily nonclinical). The OIG found that the next most common team composition observed (15 of 51 facilities) included an additional assistant director. The remaining seven facilities included deputy directors on their leadership teams. See Table D.3 (Appendix D).

During each facility's comprehensive healthcare inspection, the OIG collected human resource data pertaining to the leadership team, particularly whether the positions were occupied by permanent or interim staff and the duration of each leader's tenure. For the 231 leadership positions reviewed, 197 positions (85 percent) were permanently assigned while 34 positions (15 percent) were occupied by staff serving in an acting capacity. The 34 positions filled by non-

---

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

[9] According to VHA Office of Productivity, Efficiency, and Staffing (OPES), "the Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex." Facility groupings are used for various peer grouping purposes, such as operational reporting, performance measurement, and research studies.

permanent staff included nine facility directors, seven chiefs of staff, four associate directors for Patient Care Services, one deputy director, seven associate directors, and six assistant directors. See Table D.4 (Appendix D).

For the permanently assigned leaders, the OIG noted some variations in the leaders' tenure in their respective positions. The 42 facility directors had served in their positions an average of two years; tenure ranged from approximately one week to almost six years at the time of their comprehensive healthcare inspections. The OIG also noted that 44 chiefs of staff served in their roles an average of four years with the newest chief of staff on the job for approximately one week and the most experienced for over 17 years.

As with the directors and chiefs of staff, the OIG found a range of tenure time frames for the associate directors for Patient Care Services, deputy directors, associate directors, and assistant directors. The 47 associate directors for Patient Care Services appear to have been the most stable group, having served in their roles an average of 5.3 years; the newest ADPCS was on the job for approximately five weeks, and the most experienced, for over 23 years at the time of their comprehensive healthcare inspections. The OIG also found that six deputy directors, 45 associate directors, and 13 assistant directors had served in their positions an average of 1.2, 2.5, and 2.2 years, respectively. The deputy directors' tenure ranged from ten weeks to 3.4 years, the associate directors' tenure ranged from approximately one week to almost 12 years, and the assistant directors' tenure ranged from approximately two weeks to just over 12 years. See Tables D.4 and D.5 (Appendix D).
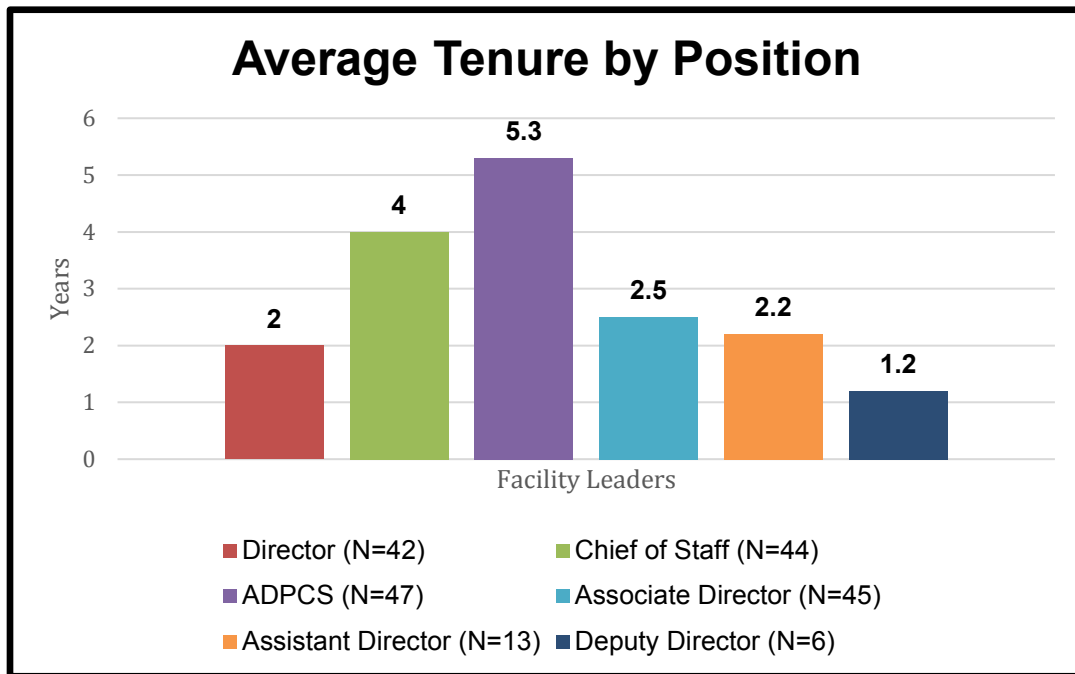

Figure 3. *Average Tenure by Leadership Position*
Source: OIG

During on-site interviews, the OIG assessed facility directors' participation and engagement with QSV activities; whether they felt supported by VISNs; and whether they had access to external/outside resources for QSV and performance improvement activities. During interviews, facility directors reported spending significant time supporting QSV and improvement activities.[10] When asked about the level of VISN support for QSV and improvement activities, 44 of 51 facility directors (86 percent) indicated that VISNs provide adequate support.[11] The OIG also noted that 48 of 51 facility directors (94 percent) reported access to public and/or private sector expert resources for guidance/assistance in QSV and performance improvement activities.

The OIG also assessed the level of engagement of all members of the leadership team with improvement activities involving Strategic Analytics for Improvement and Learning (SAIL), All Employee Survey (AES), and Survey of Healthcare Experience of Patients (SHEP) data.[12] Interviewed facility leaders were generally able to identify SAIL metrics that contribute to the facility's most recent star rating at the time of the OIG's inspection.[13] Further, when asked about two facility-specific, poorly-performing metrics, leaders were generally able to discuss the cause[14] as well as actions taken or currently underway to improve performance of the metrics.[15]

The OIG selected AES and SHEP survey results that relate to the period of October 1, 2015, through September 30, 2016, and assessed employee and patient attitudes toward facility leaders and leaders' knowledge of their results, factors affecting the results, and actions taken to improve or sustain performance. During interviews, facility leaders were generally able to discuss factors contributing to their AES results[16] and actions taken to improve or sustain employee satisfaction

---

[10] Responses included percentages of time, percentage ranges, and numbers of hours per week spent supporting QSV and improvement activities.

[11] Seven of the 51 facility director responses did not clearly address the question or indicated varying degrees of insufficient VISN support.

[12] The OIG assessed facility leaders' responses to specific questions using a scale of 1–5 where a score of 1 indicates the "Interviewee had no answer or could not provide a substantive response," and a score of 5 indicates the "Interviewee provided a thorough response that included in-depth understanding of the metric/question, several facility-based examples to support knowledge, and was able to speak knowledgeably about content/improvement actions/etc."

[13] The average of the scores assigned by the OIG to the interviewed leaders' responses was 4.0.

[14] The averages of the scores assigned by the OIG to the interviewed leaders' responses for factors affecting the two selected SAIL metrics were 3.7 and 3.6.

[15] The averages of the scores assigned by the OIG to the interviewed leaders' responses for actions taken to improve performance of the two selected SAIL metrics were 3.7 for both selected metrics.

[16] From October 1, 2017, through March 31, 2018, the OIG interviewed leaders and assessed their responses for factors affecting two selected AES questions related to satisfaction with executive leadership and servant leadership. The average of scores assigned by the OIG for the two questions were 3.7 and 3.6. From April 1, 2018, through September 30, 2018, the OIG also interviewed leaders and assessed their responses for factors affecting selected AES questions related to psychological safety and high accountability. The average of the score assigned by the OIG for the composite question was 3.6.

and psychological safety.[17] Interviewed facility leaders were also generally able to discuss factors contributing to the observed inpatient, Patient-Centered Medical Home, and Specialty Care (SC) SHEP survey results[18] and actions taken or currently underway to improve or sustain patient satisfaction.[19]

Accreditation Surveys and Oversight Inspections

The OIG noted that 50 of 51 inspected facilities had received accreditation from the College of American Pathologists.[20] Fifty facilities also received accreditation from Commission on Accreditation of Rehabilitation Facilities for at least one rehabilitation program.[21] Additionally, 46 of the 51 facilities had received Long Term Care Institute and 10 of the 51 facilities had received Paralyzed Veterans of America inspections.[22]

All recommendations made in previous OIG Clinical Assessment Program (CAP) and Community Based Outpatient Clinic (CBOC) inspections of the 51 selected facilities were closed

---

[17] From October 1, 2017, through March 31, 2018, the OIG interviewed leaders and assessed their responses for actions taken to improve performance of two selected AES questions related to satisfaction with executive leadership and servant leadership. The average of scores assigned by the OIG for the two questions were 3.8 and 3.7. From April 1, 2018, through September 30, 2018, the OIG also interviewed leaders and assessed their responses for actions taken to improve performance of selected AES questions related to psychological safety and high accountability. The average of the score assigned by the OIG for the composite question was 3.7.

[18] The averages of the scores assigned by the OIG to the interviewed leaders' responses for factors affecting the inpatient Willingness to Recommend Hospital question and the selected inpatient, patient-centered medical home, and specialty SHEP survey questions collectively were 3.6 and 3.5.

[19] The averages of the scores assigned by the OIG to the interviewed leaders' responses for actions taken to improve performance of the inpatient Willingness to Recommend Hospital question and the selected inpatient, patient-centered medical home, and specialty SHEP survey questions collectively were 3.7 and 3.6.

[20] 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. The facility liaison reported that the Erie VA Medical Center leaders opted to have The Joint Commission inspect the facility laboratory.

[21] 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. The quality management coordinator reported that the Beckley VA Medical Center does not have CARF-accredited programs.

[22] 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.). The Paralyzed Veterans of America performs these annual surveys to provide the VA Secretary with an assessment of each VA Spinal Cord Injury & Disease (SCI/D) Center's performance. This veteran service organization review does not result in accreditation status.

prior to each facility's respective CHIP site visit. From the time of their previous OIG CAP and CBOC reviews, the 51 facilities were subject to 71 OIG Hotline inspections that resulted in 210 recommendations. Although 72 of the 210 facility recommendations issued in the hotline reports remained open at the time of the OIG's on-site CHIP inspections, the OIG found that recommendations remained open because insufficient time had passed for the OIG to initiate follow-up or facility leaders were still actively engaged in addressing the recommendations or were monitoring to ensure sustained improvement.

The OIG also noted that all inspected facilities had received routine, unannounced Joint Commission inspections and that four of these facilities had been recently inspected or were actively addressing recommendations for improvement. The OIG also noted that 22 of the facilities had undergone for-cause Joint Commission inspections since their previous OIG CAP and CBOC reviews.[23] Recommendations for improvement remained open for one facility's recent for-cause inspection.

Factors Related to Possible Lapses in Care

The OIG also reviewed patient safety indicators (PSI) developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[24] The rates are applicable to specific facilities where lower rates indicate lower risks; however, not all PSI measures were applicable to all facilities. All 51 facilities inspected had applicable PSI data for review. See Table D.7 (Appendix D). Thirty-six facilities had at least two applicable PSI measures that exceeded the VHA average. See Table D.8 (Appendix D). Additionally, 148 of the 423 applicable PSI measures (35 percent) were greater than the VHA average.

The OIG also reviewed the number of facility-reported sentinel events, institutional disclosures, and large-scale disclosures since the facilities' previous CAP and/or CBOC inspections. The 51 facilities reported a total of 279 sentinel events (range of 0 to 20) with 35 of them reporting two or more events. See Table D.9 (Appendix D). The 51 facilities also reported a total of 488

---

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

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

institutional disclosures (range of 1 to 49). See Table D.10 (Appendix D). Additionally, three facilities reportedly conducted large-scale disclosures.[25]

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency" but has limitations for identifying all areas of clinical risk. Despite this, this VA model presents the data as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[26]

The OIG performed this review at facilities representing the spectrum of SAIL star ratings from "1-star" to "5-star" as of June 30, 2017. Four facilities received a "1-star" rating, 12 facilities received a "2-star" rating, 18 facilities received a "3-star" rating, 12 facilities received a "4-star" rating, and five facilities received an interim "5-star" rating.

There were no notable trends observed when comparing facilities' star ratings to facility complexity, PSI data, number of sentinel events, or number of institutional disclosures. See Tables D.11–D.14 (Appendix D). However, the OIG observed that facilities with higher SAIL star ratings had noticeably fewer OIG CHIP recommendations for improvement. See Table D.15 (Appendix D).

---

[25] Office of Inspector General, Comprehensive Healthcare Inspection Program Review of the William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin, Report No. 18-01147-47, December 20, 2018; Office of Inspector General, Comprehensive Healthcare Inspection Program Review of the Northport VA Medical Center, New York, Report No. 18-01018-281, September 18, 2018; Office of Inspector General, Comprehensive Healthcare Inspection Program Review of the Tomah VA Medical Center, Wisconsin, Report No. 17-05400-246, August 9, 2018.

[26] VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)
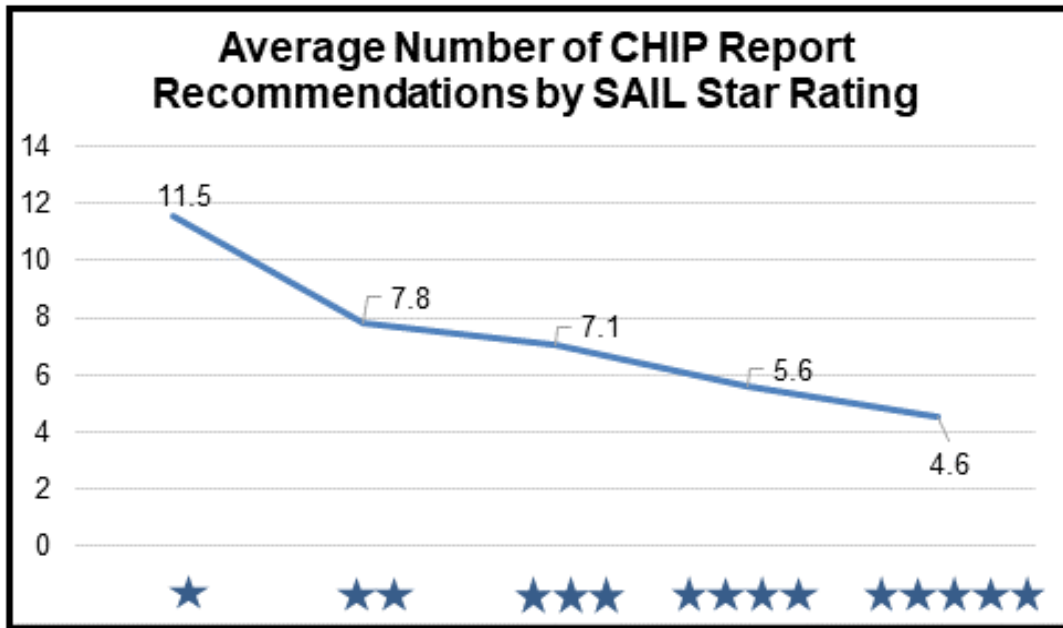
Figure 4. Average Number of CHIP Report Recommendations by SAIL Star Rating
Source: OIG

The OIG found limited trends when comparing facilities' complexities to PSI data, number of sentinel events, number of institutional disclosures, and number of OIG CHIP report recommendations. A higher occurrence rate was observed for each of these elements for facilities with the highest complexity. See Tables D.16–D.19 (Appendix D).

Leadership and Organizational Risks Conclusion

The OIG noted many positive observations during the review of leadership and organizational risks at the 51 VA facilities from October 1, 2017, through September 30, 2018. First, 85 percent of leadership positions were filled by permanent staff. Facility directors participated and appeared engaged in supporting QSV activities at their respective facilities. The facility directors also generally felt supported by VISN leaders and program managers and had access to public/private sector expert resources for guidance and assistance for QSV and improvement activities. All members of the executive leadership team were generally knowledgeable with improvement activities involving employee and patient satisfaction. Further, most facility leaders were actively involved in maintaining various accreditations, addressing Joint Commission and OIG recommendations for improvement, and taking action in response to selected potential organizational risks.

The OIG found opportunities for multiple facilities to improve their respective SAIL star ratings. Sixteen of the surveyed facilities received a "1-" or "2-star" rating as of June 30, 2017. However, there were no remarkable trends observed when comparing facilities' star ratings to facility complexity, PSI data, number of sentinel events, or number of institutional disclosures except for

the observation that facilities with higher SAIL star ratings had noticeably fewer OIG recommendations for improvement.

Lastly, the OIG also noted limited trends when comparing facilities' complexities to PSI data, number of sentinel events, number of institutional disclosures, and number of OIG CHIP report recommendations; a higher occurrence rate was observed for each of these elements for facilities with the highest complexity. This observation is not surprising given these facilities' complex clinical programs, high volume of high-risk patients, and affiliations with teaching programs.

This review of leadership and organizational risks was descriptive in nature, and the results should not be generalized across all VHA facilities.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.[27] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[28] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[29]

In determining whether facilities implemented and incorporated several OIG-selected key functions of VHA's Enterprise Framework for QSV into local activities, the OIG evaluated protected peer reviews of clinical care,[30] utilization management (UM) reviews,[31] and patient safety incident reporting with related root cause analyses.[32]

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the organization.[33]

The OIG interviewed senior managers and key QSV employees at selected facilities and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety

---

[27] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 and has not been recertified.)

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

[29] VHA Directive 1026.

[30] 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.

[31] According to VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria."

[32] The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

[33] VHA Handbook 1050.01.

report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[34]

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Entry of all reported patient incidents into VHA's patient safety reporting system[35]
  - Annual completion of a minimum of eight root cause analyses[36]
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report to facility leaders

Quality, Safety, and Value Conclusion

The OIG found general compliance with many of the selected requirements for protected peer reviews, UM, and patient safety. However, the OIG identified concerns with the implementation of improvement actions recommended by peer review committees, documentation of physician

---

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

[35] WebSPOT has been the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database. However, it is expected that by April 1, 2018, all facilities will have implemented the new Joint Patient Safety Reporting System (JPSR); and it is expected that all previous patient safety event reporting systems will have been discontinued by July 1, 2018.

[36] 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]."

UM advisors' decisions in the National UM Integration database, interdisciplinary review of UM data, and provision of feedback about root cause analysis actions to reporting employees.

Specifically, VHA requires that when peer review committees recommend individual improvement actions, clinical managers implement the actions.[37] The OIG inspected 386 peer reviews that identified the need for individual improvement actions and did not find evidence of action implementation in 48 of the peer reviews (12 percent). This likely prevented immediate and long-term improvements in patient care in the practice of involved healthcare providers. The facilities cited the lack of a tracking mechanism to ensure action implementation and noncompliance by previous staff as the reasons for noncompliance.

Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensure that clinical managers consistently implement improvement actions recommended from peer review activities and monitor clinical managers' compliance.

> Concur.
>
> Target date for completion: December 2020
>
> Response: Facilities will report data quarterly related to improvement action to the Veterans Integrated Service Networks who will upload data via the VHA Support Service Center regarding clinical manager's compliance. The metric is the total number of final level 2 & 3 cases completed in the preceding quarter compared to how many improvement actions were implemented. VHA will monitor the aggregate data for an enterprise-wide.

As to documentation of physician UM advisors' decisions, VHA requires that physician UM advisors document their decisions in the National UM Integration database regarding appropriateness of patient admissions and continued stays for 75 percent of all inpatient stays.[38] The OIG did not find evidence that physician UM advisors at eight facilities (16 percent) documented at least 75 percent of their reviews in the National UM Integration database. This prevented a comprehensive national-level review of UM data to set benchmarks, identify trends, actions, and opportunities to improve efficiency; and monitor outcomes. Reasons for noncompliance included staff vacancies and competing patient care priorities.

---

[37] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

[38] VHA Directive 1117.

Recommendation 2

2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, confirm that physician utilization management advisors document the minimum required percentage of all inpatient stay reviews in the National Utilization Management Integration database and monitor physician advisors' compliance.

Concur.

Target date for completion: October 2020

Response: For Fiscal Year 2018, 27 (21 percent) of VHA facilities were not in compliance with the 75 percent minimum Physician Utilization Management Advisor (PUMA) reviews. FY 2019 to date, 20 (15 percent) of VHA facilities are not meeting the 75 percent minimum PUMA reviews. Only Veterans Integrated Service Networks (VISN) 8, and 9 (9 percent [n=12] of all VHA facilities) sustained PUMA reviews of at least 75 percent over FY 2018 and 2019 to date; these two VISNs and facilities are exempt from reporting, as detailed below.

The Office of Quality, Safety, and Value will require attestation to Utilization Management (UM) VACO, Office of Quality, Safety, and Value through facility senior managers/VISNs on a quarterly basis the following:

1) VISNs (all but 8, 9) will attest facility PUMAs review decisions are entered into the VHA National Utilization Management Integration (NUMI) system with a minimum of 75 percent PUMA reviews completed.

2) UM VACO, Office of Quality, Safety, and Value, will additionally monitor all VISNs and provide quarterly audits on percent PUMA review decisions in NUMI.

Further, interdisciplinary facility groups that review UM data are to include representatives from UM, medicine, nursing, social work, case management, mental health, and chief Business Office revenue utilization review (CBO R-UR).[39] The OIG found that 36 of 51 facilities (71 percent) had an interdisciplinary group review UM data. For the remaining 15 facilities, two could not provide evidence of interdisciplinary group review of UM data, and 13 did not consistently include all required members in the interdisciplinary review process. This resulted in a lack of expertise in the interdisciplinary analysis of UM data and program oversight. Facility managers cited staffing vacancies, collateral duties, and lack of awareness of requirements as the reasons for noncompliance.

---

[39] VHA Directive 1117.

Recommendation 3

3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, make certain that an interdisciplinary group or committee, that includes all required representatives, consistently reviews utilization management data and monitor committees' compliance.

> Concur.
>
> Target date for completion: November 2019
>
> Response: The Office of Quality Safety Value will require each facility attest to the Veterans Integrated Service Networks that Utilization Management (UM) data is reviewed at least quarterly by an interdisciplinary group, that includes all required representatives.
>
> 1) All VISNs will attest facilities have a multidisciplinary committee that meets at least quarterly and reviews/acts upon UM data.
>
> 2) UM VACO, Office of Quality, Safety, and Value will additionally monitor and provide quarterly random reviews of facility committee minutes for compliance (committee members/attendance, and UM vulnerabilities addressed).

Finally, VHA requires patient safety managers or designees provide feedback about root cause analysis actions to the individuals or departments who reported the incidents.[40] The OIG did not find evidence that feedback was given to the reporting individuals or departments for 32 of 206 root cause analyses (16 percent). This resulted in missed opportunities to establish employee trust in the system and to positively reinforce a culture of safety. Reasons for noncompliance included staff turnover and new staff being unaware of requirements.

Recommendation 4

4. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensure that clinical managers provide feedback about root cause analysis actions to the individuals or departments who reported the incidents and monitor clinical managers' compliance.

> Concur.
>
> Target date for completion: March 2020
>
> Response: VHA National Center for Patient Safety is currently updating VHA Handbook 1050.01. The requirement for VISN Directors and Facility leadership will be included in the update. Anticipated publication is the second quarter of Fiscal Year 2020.

---

[40] VHA Handbook 1050.01.

Credentialing and Privileging

VHA has defined procedures for the credentialing and 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).[41]

Credentialing "refers to the systematic process of screening and evaluating qualifications." Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This systematic process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.[42]

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges need to be specific, based on the individual's clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to the expiration of the held privileges.[43]

To determine whether facilities complied with requirements for credentialing and privileging of selected medical staff members, the OIG teams interviewed key managers and reviewed the credentialing and privileging folders of LIPs who were hired within 18 months before on-site visits and LIPs who were re-privileged within 12 months before the visits. The OIG evaluated the following performance indicators:

- Credentialing
  - Current licensure
  - Primary source verification
- Privileging
  - Verification of clinical privileges
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific

---

[41] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012 (This VHA Handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

[42] VHA Handbook 1100.19.

[43] VHA Handbook 1100.19.

- Provider-specific[44]
  - o Service chief recommendation of approval for requested privileges
  - o Medical Staff Executive Committee decision to recommend requested privileges
  - o Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations (FPPEs)
  - o Evaluation initiated
    - Time frame clearly documented
    - Criteria developed
    - Evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee decision to recommend continuing initially granted privileges
- Ongoing professional practice evaluations (OPPEs)
  - o Determination to continue privileges
    - Criteria specific to the service or section
    - Evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee decision to recommend continuing privileges

Credentialing and Privileging Conclusion

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

VHA requires that all LIPs new to the facility have FPPEs completed, documented in the provider's profile, and reported to an appropriate committee of the medical staff.[45] The process involves the evaluation of privilege-specific competence of the provider who has no documented evidence of competently performing the requested privileges. This may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.[46] The OIG did not find evidence that 49 of 414

---

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

[45] VHA Handbook 1100.19.

[46] VHA Handbook 1100.19.

completed FPPEs (12 percent) were reported to an appropriate committee of the medical staff. This resulted in LIPs delivering care without a thorough evaluation of their practice. Facility managers cited the lack of a tracking mechanism, oversight, and awareness of requirements as reasons for noncompliance.

Recommendation 5

5. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, verify that clinical managers report completed focused professional practice evaluations to an appropriate committee of the medical staff and monitor clinical managers' compliance.

Concur.

Target date for completion: June 2020

Response: Medical Center Directors will be required to submit an attestation statement to the Veterans Integrated Service Networks (VISN) Network Director that they have a process in place to ensure that all new privileged providers undergo a focused Professional practice evaluations (FPPE) period and that results of the FPPE are reported to the appropriate medical staff committee upon completion with a recommendation of appropriate action, i.e., move to ongoing professional practice evaluation (OPPE), privileging action, or extension for unique circumstance. Ongoing assessment will be through the standardized assessment tool utilized by VISN Chief Medical Officers as directed in VHA Handbook 1100.19, Credentialing and Privileging. The assessment tool being deployed in late summer 2019 is an automated tool which includes FPPE tracking and monitoring questions and validation. VISN level and national level reports may be generated from the assessment tool for auditing and monitoring purposes.

At completion of these actions the VHA Office of Integrity/Medical Staff Affairs will provide the following documentation to demonstrate compliance:

- Attestation statement from facilities

- Audit results related to FPPE completion

VHA also requires that FPPEs be time limited.[47] The OIG found that 46 of the 431 initiated FPPEs (11 percent) were not time limited. Time limitations help to ensure an efficient process by preventing undefined or indefinite evaluation of providers. Reasons for noncompliance included omittance of time frames on FPPE forms and staff's belief that general time frames met the intent of the requirement.

---

[47] VHA Handbook 1100.19

Recommendation 6

6. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, verify that clinical managers clearly delineate time frames in focused professional practice evaluations and monitor clinical managers' compliance.

Concur in Principle.

Target date for completion: June 2020

Response: Joint Commission requires that, "A period of focused professional practice evaluation is implemented for all initially requested privileges. The "period" of focused professional practice evaluation can be either of the following: (1) Time (volume may be excessive or insufficient) or (2) Procedure/admission/activity oriented (allows for flexibility and dealing with infrequently performed privileges). Source: *Joint Commission Booster Pack*, for example, if a facility establishes that a focused professional practice evaluations (FPPE) must be concluded in 90 days for a low volume, high risk surgical procedure, it is unlikely enough procedures would be completed to confidently assess a surgeon's clinical competency for that procedure. Therefore, procedure (volume) oriented FPPE is most appropriate.

VHA concurs that FPPE criteria must be defined to include the period of monitoring but it is not appropriate to only require and consider time-limited periods vs. consideration for volume-oriented periods.

Medical Center Directors will be required to submit an attestation statement to the Veterans Integrated Service Networks (VISN) Network Director that FPPE criteria in place at their facility includes a defined period of evaluation. Ongoing assessment will be through the standardized assessment tool utilized by VISN Chief Medical Officers as directed in VHA Handbook 1100.19, Credentialing and Privileging. The assessment tool being deployed in late summer 2019 is an automated tool which includes FPPE tracking and monitoring questions and validation. VISN level and national level reports may be generated from the assessment tool for auditing and monitoring purposes.

At completion of these actions the VHA Office of Integrity/ Medical Staff Affairs will provide the following documentation to demonstrate compliance:

- Attestation statement from facilities

- Audit results related to defining FPPE assessment period on FPPE reviews for privileged providers

VHA requires that at the time of reprivileging, service chiefs consider relevant service- and practitioner-specific data that utilize defined criteria when recommending the continuation of LIPs' privileges to the Executive Committee of the Medical Staff. Such data are maintained as part of the practitioner's provider profile and may include direct observations, clinical discussions, and clinical record reviews.[48] The OPPE process is "essential to confirm the quality of care delivered" and "allows the facility to identify professional practice trends that impact the quality of care and patient safety." For 165 of 1,007 provider profiles (16 percent) used to support the renewal of practitioners' privileges, there was no evidence of service-specific data collection, resulting in providers continuing to deliver care without a thorough evaluation of their practice. Facility managers stated lack of oversight, inadequate systematic processes to track OPPE completion, and leadership changes as the reasons for noncompliance.

Recommendation 7

7. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, verify that clinical managers include service-specific data in ongoing professional practice evaluations and monitor clinical managers' compliance.

Concur.

Target date for completion: June 2020

Response: Ongoing assessment will be through the standardized assessment tool utilized by Veterans Integrated Service Networks Chief Medical Officers as directed in VHA Handbook 1100.19, Credentialing and Privileging. The assessment tool being deployed in late summer 2019 is an automated tool which includes use of specialty specific ongoing professional practice evaluation (OPPE) indicators, specifically in the Competency area of Patient Care and Procedural Skills.

At completion of these actions the VHA Office of Integrity/ Medical Staff Affairs will provide the following documentation to demonstrate compliance:

• Audit results related to specialty specific OPPE indicators in the Competency area of Patient Care and Procedural Skills

In addition, VHA has defined specialty-specific elements to be utilized, where appropriate, for gastroenterology, pathology, nuclear medicine, and radiation oncology OPPEs.[49] For 17 of 123 applicable OPPEs (14 percent) for providers in clinical areas with a requirement for defined

---

[48] VHA Handbook 1100.19.

[49] Acting Deputy Under Secretary for Health for Operation and Management (10N) memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

specialty-specific elements, the OIG found no evidence of the required specialty-specific elements.[50] As a result, providers continued delivering care without a thorough evaluation of their practice. Reasons for noncompliance included lack of oversight and service chiefs being unaware of requirements.

Recommendation 8

8. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, verify that clinical managers include specialty-specific elements in gastroenterology, pathology, nuclear medicine, and radiation oncology providers' ongoing professional practice evaluations and monitor clinical managers' compliance.

Concur.

Target date for completion: June 2020

Response: Ongoing assessment will be through the standardized assessment tool utilized by Veterans Integrated Service Networks Chief Medical Officers as directed in VHA Handbook 1100.19, Credentialing and Privileging. The assessment tool being deployed in late summer 2019 is an automated tool which includes use of specialty specific OPPE indicators, specifically in the Competency area of Patient Care and Procedural Skills. The assessment tool will contain a specific question related to specialty-specific indicators in gastroenterology, pathology, nuclear medicine, and radiation oncology.

At completion of these actions the VHA Office of Integrity/Medical Staff Affairs will provide the following documentation to demonstrate compliance:

• Audit results related to specialty specific OPPE indicators in the Competency area of Patient Care and Procedural Skills in gastroenterology, pathology, nuclear medicine, and radiation oncology.

---

[50] The 17 OPPEs were for five gastroenterology, seven pathology, two nuclear medicine, and three radiation oncology providers.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional, but should also promote healing.[51]

The purpose of this facet of the OIG inspection was to determine whether facilities maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG also determined whether facilities met requirements in selected areas that are often associated with higher risks of harm to patients, such as construction safety[52] and in the locked mental health unit.[53] The inspection team also looked at facility compliance with Nutrition and Food Services[54] and emergency management processes.[55]

VHA requires a safe and healthy worksite for staff, patients, and the general public during construction and renovation-related activities. The implementation of a proactive and comprehensive construction safety program reduces the potential for injury, illness, accidents, or exposures.[56]

VHA requires its facilities to have the "capacity for [providing] mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting;" however, for facilities that do not have inpatient mental health services, that "capacity" could mean facilitating care at a nearby VA or non-VA facility. "Inpatient mental health settings must also provide a healing, recovery-oriented environment."[57]

---

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

[52] VHA Directive 7715, *Safety and Health during Construction*, April 6, 2017.

[53] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA Handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

[54] VHA Handbook 1109.04, *Food Service Management Program*, October 11, 2013. (This VHA Handbook was scheduled for recertification on or before the last working date of October 2018 and has not been recertified.)

[55] Applicable requirements for high-risk areas and emergency management include those detailed in or by various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

[56] VHA Directive 7715.

[57] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA Handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

The Nutrition and Food Services Program must provide quality meals that meet the regulatory requirements for food safety in accordance with the U.S. Food and Drug Administration's Food Code and VHA's food safety program. Facilities must have annual hazard analysis critical control point food safety plan, food services inspections, food service emergency operations plan, and safe food transportation and storage practices.[58]

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a disaster or emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities' efforts to identify and minimize harm and allow the identification and minimization of impacts from potential hazards, threats, incidents, and events on health care and other essential services.[59] Managers also must develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with The Joint Commission (TJC),[60] Occupational Safety and Health Administration,[61] and National Fire Protection Association standards.[62] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[63]

In all, the OIG team inspected 474 patient care areas, 42 construction site perimeters, 28 Nutrition and Food Services storage and preparation areas, five food storage and preparation areas within community living centers, and 27 locked mental health units. The team also inspected 51 CBOCs. The OIG reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility

  o Environment of care rounds

  o Environment of care deficiency tracking

  o Infection prevention

  o General safety

---

[58] VHA Handbook 1109.04.

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

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

[61] The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA's mission is to assure safe and healthful working conditions "by setting and enforcing standards and by providing training, outreach, education, and assistance." https://www.osha.gov/about.html (This website was accessed on June 28, 2018.)

[62] The National Fire Protection Association (NFPA) is a global nonprofit organization devoted to eliminating death, injury, and economic and property loss due to fire, electrical, and related hazards.

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

- o Environmental cleanliness

- o General privacy

- o Women veterans' exam room privacy

- o Availability of medical equipment and supplies

- Community based outpatient clinic

  - o General safety

  - o Medication safety and security

  - o Infection prevention

  - o Environmental cleanliness

  - o General privacy

  - o Exam room privacy

  - o Availability of medical equipment and supplies

- Construction safety

  - o Completion of infection control risk assessment for all sites

  - o Infection Prevention/Infection Control Committee discussions on construction activities

  - o Dust control

  - o Safety and security

  - o Selected requirements based on project type and class[64]

- Locked mental health unit

  - o Biannual mental health environment of care rounds

  - o Nursing station security

  - o Public area and general unit safety

  - o Patient room safety

---

[64] VA Master Construction Specifications, Section 01-35-26, Sub-Section 1.12. The Type assigned to construction work ranges from Type A (non-invasive activities) to Type D (major demolition and construction). Type C construction involves work that generates a moderate to high level of dust or requires demolition or removal of any fixed building components or assemblies. The Class assigned to construction work ranges from Class I (low-risk groups affected) to Class IV (highest risk groups affected). Class III construction projects affect patients in high-risk areas such as the emergency department, inpatient medical and surgical units, and the pharmacy.

- o Infection prevention

- o Availability of medical equipment and supplies

- Nutrition and Food Services

  - o Hazard analysis critical control point food safety system plan

  - o Food Services inspections

  - o Emergency operations plan for food service

  - o Safe transportation of prepared food

  - o Environmental safety

  - o Infection prevention

  - o Storage areas

- Emergency management

  - o Hazard vulnerability analysis (HVA)

  - o Emergency operations plan (EOP)

  - o Emergency power testing and availability

Environment of Care Conclusion

Generally, facilities and CBOCs met requirements associated with infection prevention, general safety, privacy, and availability of supplies. Construction and Nutrition and Food Services areas, locked mental health units, and emergency management programs met many of their respective requirements. However, the OIG identified concerns with environmental cleanliness, installation and testing of panic alarms in high-risk areas, seclusion rooms in locked mental health units, and emergency management processes.[65]

Regarding environmental cleanliness, TJC requires hospitals to maintain and continually monitor the environment and remediate conditions to ensure a clean and safe environment.[66] The OIG noted various issues with cleanliness during main facility, CBOC, Nutrition and Food Services, and locked mental health unit inspections. Dirty ventilation grills were found in 83 of the 474 main facility patient care areas (18 percent) inspected. Dirty floors were also found in 62 of the 474 main facility patient care areas (13 percent) inspected. Four of 27 locked mental health units (15 percent) had both dirty ventilations grills and/or floors. Four of 28 Nutrition and Food Services areas (14 percent) had dirty exhaust air ducts. Further, the OIG noted dirty furnishings

---

[65] Reported findings at the national level may not have risen to the level of a recommendation at the individual facility level, and many of the deficiencies may have been corrected while OIG inspection teams were on site.

[66] TJC. Environment of Care standard EC.02.06.01, EP20, July 2017.

and/or furnishings in disrepair in 63 of 474 facility areas (13 percent) and in 6 of 51 CBOCs (12 percent) inspected. Reasons for noncompliance included lack of oversight and staffing challenges.

Recommendation 9

9. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensure that managers maintain a clean and safe environment throughout the facilities and monitor managers' compliance.

Concur.

Target date for completion: June 2020

Response: The Environment of Care Committee (EOC) Program is an important part of VHA efforts to ensure accordance with accreditation requirements and compliance with VHA Directives. While the EOC Program has established metrics in place, the metrics were not designed to measure success but to measure compliance.

The VHA Comprehensive Environment of Care Committee has developed outcome-oriented program goals and objectives in addition to reevaluating existing performance measures. The following proposed metrics should be monitored by the facility EOC Committee on a quarterly basis:

a) Attendance of 90 percent or greater by a member of the Executive Team during EOC Rounds conducted at VA medical centers and leased spaces. Executive Team defined as a Quadrad or Pentad Official.

b) Each medical center will select one EOC trend and create a performance improvement plan. Actions should be tracked through the Environment of Care Committee and presented to the facility leadership committee annually (Metric is included in the Network Director SES Performance Plan Fiscal Year 2019).

c) 100 percent of identified EOC team members participate in EOC rounds over the fiscal year (95 percent primary, and or 90 percent secondary). Alternates may be used when a primary and secondary member is unavailable and must be approved by the EOC Committee Chair.

d) The designated facility EOC coordinator will review and provide quarterly updates to EOC team members (primary, secondary and alternates) using EOC software, through the facility EOC Committee.

e) Facility EOC Committee will ensure that deficiencies are tracked monthly to monitor for compliance until closed or a Plan for Action is implemented within 14 business days to ensure compliance (85 percent >=FS; 90 percent >=Exceeds; 95 percent >=Outstanding) (Metric is included in the Network Director SES Performance Plan fiscal year 2019).

f) Scheduled EOC inspections are 100 percent closed within 5 business days.

The EOC committee will track all metrics through an effective tracking system. Ensuring the adoption and compliance of these measures helps to ensure a clean, safe, and functional environment across VHA. On June 26, 2019 the Deputy Under Secretary for Health and Operations Management released a memorandum to all Veterans Integrated Service Network directors stating the new proposed performance metrics. Closure on this recommendation will be requested when 90 percent of facilities have met all proposed performance metrics for two consecutive quarters.

Panic alarms monitored by the VA Police are needed in locked mental health units to provide immediate assistance in the event of a disruptive patient event. VHA requires VA Police to periodically test and document response time to panic alarms to ensure functional status and processes for patient, visitor, and staff safety in locked mental health units.[67] VHA also requires VA Police to regularly test panic alarms that are installed in high-risk outpatient areas which may include CBOCs.[68] The OIG did not find evidence of monthly alarm system testing in four of 27 units (15 percent) inspected, and for four of the 23 units (17 percent) that documented alarm testing, the OIG did not find documented evidence of VA Police response times. Additionally, although 46 of 47 high-risk areas in CBOCs had panic alarms installed, the OIG did not find evidence that 5 of 46 area alarms (11 percent) were tested. This resulted in a lack of assurance of a safe environment for patients, visitors, and staff since timely police responses greatly impact the overall success of police intervention and reduces organizational risks. Facility leaders and/or VA Police were generally unaware of testing requirements.

Recommendation 10

10. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, confirm that VA Police test panic alarms and document response times to alarm testing in locked mental health units and high-risk outpatient clinic areas and monitor VA Police compliance.

---

[67] VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, December 8, 2016.

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

Concur.

Target date for completion: June 2020

Response: The Deputy Under Secretary for Health for Operations and Management (DUSHOM) will establish guidelines through the Veterans Integrated Service Network Directors and facility senior leaders, requiring VA Police to test panic alarms and document response times to alarm testing in locked mental health units and high-risk outpatient clinic areas.

The means for rapidly contacting VA police from all areas of the facility during emergencies by telephone, radio, or duress alarms will be ensured.

The network offices will be responsible for the tracking of the panic alarm testing with documented response times to alarm testing in locked mental health units and high-risk outpatient clinic areas. The Office of the VHA Senior Security Officer will review the action plans at the end of each fiscal year. Bi-annual follow ups will be conducted tracking the action plans concerning the testing. Outstanding deficiencies that are identified will be elevated to the DUSHOM for additional action.

VHA requires that inpatient rooms designated for seclusion be structured to prevent patient injury; this includes floors which must be made of material that provides cushioning.[69] The OIG found that 5 of the 19 applicable locked mental health units (26 percent) with seclusion rooms did not have flooring made of a material that provides cushioning. These deficiencies could result in harm to patients. Facility managers reported a lack of awareness of the requirements for floor cushioning and the belief that installed flooring met requirements while awaiting pending renovation.

Recommendation 11

11. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, make certain that facility managers install floor cushioning in locked mental health unit seclusion rooms and monitor facility managers' compliance.

---

[69] VA National Center for Patient Safety, Mental Health Environment of Care Checklist (MHEOCC).

Concur.

Target date for completion: November 2019

Response: The Office of Mental Health and Suicide Prevention (MHSP) will assess all VA medical facilities with inpatient mental health units to review current flooring configurations. Specifically, MHSP will issue a memorandum from the Office of the Deputy Under Secretary for Health for Operations and Management to all Veterans Integrated Service Network (VISN) Directors and Chief Mental Health Officers requesting all facilities with an Inpatient Mental Health Unit review their current flooring configuration.

Facilities are to confirm via an attestation memorandum that either, (1) the cushioning is installed in each seclusion room in all Inpatient Mental Health Unit(s), or (2), if the cushioning is not yet installed, develop a Corrective Action Plan which is to include anticipated completion dates and identified responsible individuals.

Network Directors are responsible for validating facility reviews and to forward facility attestations or Corrective Action Plans no later than 30 days following the date of this memorandum.

VHA requires facilities to develop and annually review an emergency operations plan and a documented inventory of resources and assets (on site) that may be needed during an emergency.[70] The OIG did not find evidence of the annual review of 3 of 26 facility emergency operations plans (12 percent) and 5 of 26 resource and asset inventories (19 percent). This resulted in a lack of assurance that the facilities are prepared for contingency operations during emergencies. Reasons for noncompliance included emergency management staff's lack of attention to detail and insufficient staffing.

Recommendation 12

12. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, verify that facility managers annually review emergency operations plans and resource and asset inventories and monitor facility managers' compliance.

---

[70] VHA Directive 0320.01.

Concur.

Target date for completion: September 2020

Response: The following plan of action will be employed:

1) The Veterans Health Administration Office of Emergency Management (VHA OEM) will issue a memo directing all VA medical centers/Healthcare Systems to review and upload all the following products into the Performance Improvement Management System (PIMS) no later than November 1, 2019:

       a. Facility emergency operations plans

       b. Hazard Vulnerability Assessments

       c. Resources and assets inventory

       d. Exercise schedules and After-Action Reviews

2) VHA OEM will ensure all VA medical centers have identified all appropriate personnel requiring access to PIMS by September 1, 2019.

3) VHA OEM will identify personnel requiring PIMS training and complete all training and refresher courses as needed by October 1, 2019.

4) VHA OEM will complete the review of all PIMS documentation (items a, b, c, d above) for the VHA enterprise by April 1, 2020.

5) VHA OEM will issue certifications of completion and compliance to all medical centers that have successfully conducted, developed, maintained, exercised and promoted the facility emergency operations plans, hazard vulnerability assessments and updated all resources/assets inventories by May 1, 2020.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.[71] Diversion of controlled substances by healthcare workers—the transfer of a legally-prescribed controlled substances from the prescribed individual to another person for illicit use—remains a serious problem that can increase serious patient safety issues and elevates the liability risk to healthcare facilities.[72]

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and the inspections of the pharmacy and clinical areas with controlled substances.[73]

To determine whether the facility complied with requirements related to controlled substances security and inspections and to follow up on recommendations from the 2014 report,[74] the OIG teams interviewed key managers and reviewed controlled substances inspection reports for the prior two completed quarters. The OIG teams also inspected monthly summaries of deficiencies reported to the director for the prior 12 months; controlled substances inspection trend reports for the prior four quarters; and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
  - o Monthly summary of findings to the director
  - o Quarterly trend report to the director
  - o Actions taken to resolve identified problems
- Pharmacy operations
  - o Annual physical security survey of the pharmacy/pharmacies by VA Police
  - o Controlled substances ordering processes

---

[71] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (The website was accessed on August 21, 2017.)

[72] American Society of Health-System Pharmacists, "ASHP Guidelines on Preventing Diversion of Controlled Substances," *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

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

[74] VA Office of Inspector General, Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities, Report No. 14-01785-184, June 10, 2014.

- o Inventory completion during chief of Pharmacy transition

- o Staff restrictions for monthly review of balance adjustments[75]

- Requirements for controlled substances coordinators

  - o No conflicts of interest

  - o Controlled substances coordinator duties included in position description or functional statement

  - o Completion of required controlled substances coordinator orientation training course

- Requirements for controlled substances inspectors

  - o Free from conflicts of interest

  - o Appointed in writing by the director for a term not to exceed three years

  - o Hiatus of one year between any reappointment

  - o Completion of required annual certification course

  - o Completion of required annual updates and/or refresher training

- Controlled substances area inspections

  - o Completion of monthly inspections

  - o Rotations of controlled substances inspectors

  - o Patterns of inspections

  - o Completion of inspections on day initiated

  - o Reconciliation of dispensing between pharmacy and each dispensing area

  - o Verification of controlled substances orders

  - o Performance of controlled substances inspections

- Pharmacy inspections

  - o Monthly physical counts of the controlled substances in the pharmacy

  - o Completion of inspections on day initiated

---

[75] Controlled substance balance adjustment reports list transactions in which the pharmacy vault inventory balance was manually adjusted.

- Security and documentation of drugs held for destruction[76]

- Accountability for all prescription pads in pharmacy

- Verification of hard copy controlled substances prescriptions

- Verification of 72-hour inventories of the main vault

- Quarterly inspections of emergency drugs

- Monthly checks of locks and verification of lock numbers

Medication Management Conclusion

The OIG found general compliance with requirements for some of the performance indicators evaluated, including the controlled substances coordinator reports, requirements for controlled substances inspectors, and pharmacy inspections. The OIG identified deficiencies from the annual VA Police survey of the pharmacy, one-day reconciliation from the pharmacy to each dispensing area, and return of stock to pharmacy from each dispensing area. The OIG also found that controlled substances coordinators or alternate coordinators conducted monthly inspections that were not performed while training inspectors or covering for unplanned leave, illness, or other emergencies.

Specifically, VHA requires the chief, VA Police and Security, follow up with the pharmacy to ensure that identified deficiencies from the annual physical security survey have been corrected.[77] The OIG found that 13 of 27 areas (48 percent) with identified deficiencies from the security survey had not been corrected by the time of the facilities' comprehensive healthcare inspections. Failure to correct security deficiencies places the pharmacy at risk for potential loss or theft of medications. Reasons for noncompliance included lack of oversight, poor communication between VA Police and pharmacy managers, unresolved work orders due to competing priorities with patient care area renovations, and financial constraints delaying the completion of submitted orders.

Recommendation 13

13. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, confirm that facility managers correct identified deficiencies from annual physical security surveys and monitor facility managers' compliance.

---

[76] According to VHA Directive 1108.02(1), The Destructions File Holding Report "lists all drugs awaiting local destruction or turn-over to a reverse distributor." Controlled substances inspectors "must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report."

[77] VHA Handbook 0730, *Security and Law Enforcement*, August 11, 2000; VA Handbook 0730/4, *Security and Law Enforcement*, March 29, 2013.

Concur.

Target date for completion: June 2020

Response: The Deputy Under Secretary for Health for Operations and Management (DUSHOM) will ensure that physical security surveys will be conducted annually to ensure the effective planning and utilization of security resources.

These surveys will be conducted in accordance with guidance provided by the Office of Security & Law Enforcement.

Monitoring of compliance to confirming that facility managers correct identified deficiencies from annual physical security surveys will be conducted by the VHA Senior Security Officer. Action plans will be reviewed bi-annually. Any outstanding deficiencies not timely and appropriately addressed will be elevated to the DUSHOM for additional action.

VHA requires that the controlled substances inspector, controlled substances coordinator, or alternate controlled substances coordinator reconcile one-day's dispensing from the pharmacy to every automated dispensing cabinet and returned stock to pharmacy from each dispensing area.[78] The OIG found that the one-day reconciliation from pharmacy to every automated dispensing cabinet was not completed in 66 of 481 areas (14 percent) reviewed. Also, the one-day reconciliation of returned stock to pharmacy from each dispensing area was not completed in 142 of 481 areas (30 percent) reviewed. Failure to complete required reconciliation of controlled substances dispensed from pharmacy to automated dispensing cabinet and returns to pharmacy may cause delays in identifying any potential diversion activities. Facility managers cited controlled substances coordinators' lack of oversight, awareness of requirements, and efficient processes as reasons for noncompliance.

Recommendation 14

14. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, verify that controlled substances coordinators reconcile one-day's dispensing from the pharmacy to every automated dispensing cabinet and returns to pharmacy stock from each dispensing area during controlled substances inspections and monitor controlled substances coordinators' compliance.

---

[78] VHA Directive 1108.02(1).

Concur.

Target date for completion: September 2019

Response: VHA Directive 1108.02 requires that Controlled Substance Inspectors, Controlled Substance Coordinators or Alternate Controlled Substance conduct the reconciliation activities as referenced in Recommendation 14. The office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) in collaboration with the Veterans Integrated Service Network Quality Managers and the Pharmacy Benefits Management Office, will verify that Directive 1108.02 is followed in regard to the required reconciliation activities. VISN Directors will require Facility Directors to certify compliance in writing to the DUSHOM office thru the VISN office.

VHA requires that the "[controlled substances coordinator] should not routinely be scheduled to conduct inspections but may participate in cases of [training new inspectors], unplanned leave, illness, or other emergency to ensure the completion of all monthly inspections."[79] The OIG found that the controlled substances coordinator conducted monthly inspections in 131 out of 481 non-pharmacy area inspections (27 percent). The OIG did not find evidence that the coordinator participated due to training inspectors, unplanned leave, illness, or other emergencies in 33 out of 131 cases (25 percent). When the coordinators conduct frequent monthly inspections, program oversight may be compromised. The coordinators generally reported an insufficient number of controlled substances inspectors and/or being unaware of the requirement.

Recommendation 15

15. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, make certain that controlled substances coordinators refrain from routinely conducting monthly controlled substances inspections and monitor controlled substances coordinators' compliance.

Concur.

Target date for completion: Completed

Response: It is VA policy that Controlled Substance Coordinators (CSC) not routinely conduct monthly inspection activities unless it is required in cases of unplanned leave, illness or validating competency. VHA will continue to follow the policy, accordingly.

---

[79] VHA Directive 1108.02(1).

Mental Health: Posttraumatic Stress Disorder Care

Posttraumatic Stress Disorder (PTSD) may occur "following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; or other threat to one's physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate."[80] For veterans, a common factor contributing to PTSD is combat-related stress. Other experiences, such as prolonged time away from home and military sexual trauma, may also contribute to the development of PTSD.[81]

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed.[82] VHA requires that

1. PTSD screening is performed for every new patient and then is repeated annually for the first five years post-separation and every five years thereafter;

2. If the patient's PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and

3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.[83]

To determine whether the facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG inspection team reviewed relevant documents and interviewed key employees and managers. The team also reviewed the electronic health records of 2,073 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Completion of suicide risk assessment by acceptable provider within required time frame

---

[80] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (This handbook was rescinded and replaced with VHA Directive 1160.03(1), Programs for Veterans with Post-Traumatic Stress Disorder (PTSD), November 16, 2017 (amended April 24, 2019.)

[81] Department of Veterans Affairs, *PTSD: National Center for PTSD. Combat Exposure.* https://www.ptsd.va.gov/understand/types/combat_exposure.asp. (The website was updated December 17, 2018.)

[82] According to the Department of Veterans Affairs, *Information Bulletin: Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 6, 2015, a PTSD screen is not required if the patient received "a PTSD diagnosis in an outpatient setting within the past year; [has a] life expectancy of six months or less; [has] severe cognitive impairment; [is] enrolled in a VHA or community-based hospice program; or [has a] diagnosis of cancer of the liver, pancreas, or esophagus."

[83] VHA Directive 1160.03(1), *Programs for Veterans with Posttraumatic Stress Disorder (PTSD)*, November 16, 2017 (amended April 24, 2019.)

- Offer to patient of further diagnostic evaluation

- Referral for diagnostic evaluation

- Completion of diagnostic evaluation within required time frame

Mental Health Conclusion

Generally, VHA facilities met requirements statistically with the above performance indicators. The OIG made no recommendations.

Long-Term Care: Geriatric Evaluations

More than "nine million veterans of all ages are enrolled with [VA], and 46 percent of these veterans are age 65 and over."[84] "As a group, veterans experience more chronic disease and disability" than their non-veteran peers. VA must "plan for [the] growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner."[85] Participants in geriatric evaluation programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.[86]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to geriatric evaluation.[87] This includes a "comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care." The healthcare team would then manage the patient with "treatment, rehabilitation, health promotion, and psychosocial interventions necessary for fulfillment of the plan of care provided by key personnel."[88] Facility leaders must also evaluate the geriatric evaluation program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.[89]

In determining whether the facility provided an effective geriatric evaluation, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the electronic health records of 2,110 randomly selected patients who received a geriatric evaluation from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Provision of or access to geriatric evaluation

- Program oversight and evaluation

  - Evidence of program evaluation

  - Evidence of performance improvement activities through leadership board

- Provision of clinical care

---

[84] VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

[85] VHA Directive 1140.04.

[86] Chad Boult, Lisa B. Boult, Lynne Morishita, Bryan Dowd, Robert L. Kane, and Cristina F. Urdangarin, "A randomized clinical trial of outpatient geriatric evaluation and management," *Journal of the American Geriatrics Society* 49, no. 4 (April 2001): 351–359.

[87] Public Law 106-117.

[88] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

[89] VHA Directive 1140.04.

- o Medical evaluation by geriatric evaluation provider

- o Assessment by geriatric evaluation nurse

- o Comprehensive psychosocial assessment by geriatric evaluation social worker

- o Patient or family education

- o Plan of care based on geriatric evaluation

- Geriatric management

- o Implementation of interventions noted in plan of care

Long-Term Care Conclusion

Generally, VHA facilities met requirements for provision of or access to geriatric evaluation, clinical care, and geriatric management. However, the OIG identified a concern with program oversight and evaluation that warranted a recommendation for improvement.

Specifically, VHA requires that geriatric evaluation performance improvement activities be coordinated with quality management and reviewed by the leadership board responsible for oversight of all performance improvement activities at the facility.[90] The OIG noted that of the 51 facilities inspected, 45 (88 percent) conducted geriatric evaluation performance improvement activities. However, of those 45 facilities, only 37 (82 percent) reported the performance improvement activities to the leadership board responsible for oversight. When healthcare facilities do not have a consistent process to conduct and report performance improvement activities to the leadership board, executive oversight is impacted and delays in identifying process improvements, implementing appropriate action plans, and measuring program outcomes could occur. Facility managers reported lack of oversight and staffing as reasons for noncompliance.

Recommendation 16

16. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network Directors and facility senior leaders, ensure that facility managers conduct and report geriatric evaluation program performance improvement activities to an appropriate leadership board and monitor facility managers' compliance.

---

[90] VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

Concur.

Target date for completion: September 2022

Response: In collaboration with the Office of Reporting, Analytics, Performance, Improvement and Deployment (RAPID), the Office of Geriatrics and Extended Care (GEC) initiated a Quality Indicator Pilot Measure to monitor monthly, the number of Veterans who received an Interdisciplinary Comprehensive Geriatric Evaluation, as identified by the Healthcare Common Procedure Coding System Code 'S0250'. The Pilot will focus on what is presumed to be the more "at-risk" Veteran population, identified as "Veterans aged 65 years and over with functional decline treated in the past 24 months with inpatient or outpatient VA care. Functional decline is defined as a Jenn Frailty Index Score between 3-5 AND a Care Assessment Need Score greater or equal to 75".

GEC will continue to communicate the initiation of this Pilot Indicator on VA National calls including those with Geriatric Patient Aligned Care Teams and GEC Veterans Integrated Service Network Leads throughout the remainder of fiscal year (FY) 2019. Additionally, in collaboration with several national VHA Program Offices including the Managerial Cost Accounting Office and Health Informatics, GEC will develop workload capture guidance for dissemination to the field. GEC will implement the measure in FY 2020 while later assessing recommending the measure in subsequent Senior Executive Performance Plans.

As FY 2020 is approaching, no additional changes can be made to the upcoming Network Director's Performance Plan. At the earliest, revisions to the upcoming Network Director's plan will be incorporated in FY 2021 which concludes September 2022.

Women's Health: Mammography Results and Follow-Up

In 2019, an estimated 268,600 new cases of invasive breast cancer and 41,760 breast cancer deaths were expected to occur among U.S. women.[91] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veteran's Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.[92] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services including mammography services to eligible women veterans.[93]

VHA has established time frames for clinicians to notify ordering providers and patients of mammography results. Mammography results must be communicated to the ordering provider and patient within 30 days of the procedure. "Suspicious" and "highly suggestive of malignancy" results, along with the recommended course of action, must be communicated as soon as possible. Communication with patients must be documented.[94]

The OIG team examined whether the facility complied with selected VHA requirements for the reporting of mammography results by reviewing relevant documents and interviewing selected employees and managers. The team also reviewed the electronic health records of 2,383 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Electronic linking of mammogram results to radiology order

- Scanning of hard copy mammography reports, if outsourced

- Inclusion of required components in mammography reports

- Communication of results and any recommended course of action to ordering provider

- Communication of results and any recommended course of action to patient

- Performance of follow-up mammogram if indicated

- Performance of follow-up study

---

[91] U.S. Breast Cancer Statistics. http://www.BreastCancer.org. (The website was accessed on June 21, 2019.)

[92] VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011. (This handbook was rescinded and replaced with VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018.)

[93] Veterans Health Care Act of 1992, Title I, Publ L. 102-585 (1992).

[94] VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018.

Women's Health Conclusion

Generally, VHA facilities met requirements statistically with the above performance indicators. The OIG made no recommendations.

High-Risk Processes: Central Line-Associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[95] Central lines "refer to a broad category of [intravascular (within blood vessels)] devices used to administer fluids, medications, blood and blood products, and parenteral nutrition. Unlike the short, temporary catheters inserted into the peripheral vasculature,"[96] central lines are threaded through a vein in the arm, chest, neck, or groin and advanced so that the furthest tip terminates at or close to the heart or in one of the great vessels.[97]

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a central line-associated bloodstream infection (CLABSI) as a primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site.[98]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[99] The patient's age, underlying conditions, and gender are basic risk factors, but external risk factors such as prolonged hospitalization, multi-lumen central lines, and central line duration far outnumber the basic ones. External factors are associated with a 2.27-fold increased risk for mortality and increased healthcare costs.[100]

The OIG's review of these issues examined whether the facility established and maintained programs to reduce the incidence of healthcare-associated bloodstream infections in intensive care unit patients with indwelling central lines. In addition to conducting manager and staff interviews, the OIG team reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents. The team also reviewed the training records of 892 registered nurses involved in inserting and/or managing central lines.

---

[95] TJC. Infection Prevention and Control standard IC.02.01.01.

[96] Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

[97] These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, aorta.

[98] The Centers for Disease Control and Prevention, Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011.

[99] The Centers for Disease Control and Prevention National Healthcare Safety Network, Bloodstream Infection Event: Central Line-Associated Bloodstream Infection and Non-Central Line-Associated Bloodstream Infection, January 2017.

[100] Association for Professionals in Infection Control and Epidemiology, 2015.

The OIG evaluated the following performance indicators:

- Presence of facility policy on the use and care of central lines

- Performance of annual infection prevention risk assessment

- Evidence of routine discussion of CLABSI data and prevention outcome measures in committee minutes

- Provision of infection incidence data on CLABSI

- Education on reducing the risk of CLABSI for staff involved in inserting and/or managing central lines

- Educational materials about CLABSI prevention for patients and families

- Use of a checklist for central line insertion and maintenance

High-Risk Processes Conclusion

Generally, the facility met requirements with the above performance indicators. The OIG made no recommendations.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Program Review Findings

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

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	- Executive leadership position stability and engagement - Employee satisfaction - Patient experience - Accreditation and/or for-cause surveys and oversight inspections - Factors related to possible lapses in care - VHA performance data	Sixteen OIG recommendations in the areas of quality, safety, and value; medical staff privileging; environment of care; management of controlled substances inspections; and geriatric evaluation are attributable to VHA facility leaders. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	- Protected peer reviews - Utilization management reviews - Patient safety incident reporting and root cause analyses	- Improvement actions recommended from peer review activities are consistently implemented. - Feedback about root cause analysis actions is provided to the individuals or departments who reported the incidents.	- Physician utilization management advisors document the minimum required percentage of all inpatient stay reviews in the National Utilization Management Integration database. - An interdisciplinary group or committee, that includes all required representatives, consistently reviews utilization management data.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• Service-specific data are included in OPPEs. • Specialty-specific elements for gastroenterology, pathology, nuclear medicine, and/or radiation oncology are included in the providers' OPPEs.	• Completed FPPEs are reported to an appropriate committee of the medical staff. • Time frames are clearly delineated in FPPEs.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent facility
	  o Environment of care rounds and deficiency tracking
	  o Infection prevention
	  o General safety
	  o Environmental cleanliness
	  o General and exam room privacy
	  o Availability of medical equipment and supplies
	• Community based outpatient clinic
	  o General safety
	  o Medication safety and security
	  o Infection prevention
	  o Environmental cleanliness
	  o General and exam room privacy
	  o Availability of medical equipment and supplies
	• Locked Mental Health Unit
	  o Biannual mental health environment of care rounds
	  o Nursing station security
	  o Public area and general unit safety
	  o Patient room safety
	  o Infection prevention
	  o Availability of medical equipment and supplies
	• Emergency management
	  o Hazard vulnerability analysis (HVA)
	  o Emergency operations plan (EOP)
	  o Emergency power testing and availability
		• A clean and safe environment is maintained throughout the facilities.
		• VA Police test panic alarms and document response times to alarm testing in locked mental health units and high-risk outpatient clinic areas.
		• Floor cushioning is installed in locked mental health unit seclusion rooms.
			• Emergency operations plans and resource and asset inventories are annually reviewed.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	• Controlled substances coordinator reports • Pharmacy operations • Annual physical security survey • Controlled substances ordering processes • Inventory completion during chief of Pharmacy transition • Review of balance adjustments • Controlled substances coordinator requirements • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections	• Identified deficiencies from annual physical security surveys are corrected. • One-day's dispensing from the pharmacy to every automated dispensing cabinet and returns to pharmacy stock from each dispensing area are reconciled during controlled substance inspections.	• Controlled substance coordinators refrain from routinely conducting monthly controlled substance inspections.
Mental Health: Posttraumatic Stress Disorder Care	• Completion of suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• None	• None
Long-Term Care: Geriatric Evaluations	• Provision of or access to geriatric evaluation • Program oversight and evaluation requirements • Provision of clinical care • Geriatric management	• None	• Geriatric evaluation program performance improvement activities are conducted and reported to an appropriate leadership board.
Women's Health: Mammography Results and Follow-Up	• Electronic linking of results • Scanning of hard copy reports • Inclusion of required components in reports • Communication of results and recommended course of action • Follow-up mammograms and studies	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Central Line-Associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data • Education and educational materials • Policy, procedure, and checklist for insertion and maintenance of central venous catheters	• None	• None

Appendix B: Parent Facilities Inspected

**Table B. Parent Facilities Inspected
(October 1, 2017, through September 30, 2018)**

Names	Locations
Samuel S. Stratton VA Medical Center	Albany, NY
VA Ann Arbor Healthcare System	Ann Arbor, MI
Charles George VA Medical Center	Asheville, NC
VA Maine Healthcare System	Augusta, ME
Battle Creek VA Medical Center	Battle Creek, MI
Bay Pines VA Healthcare System	Bay Pines, FL
Beckley VA Medical Center	Beckley, WV
Gulf Coast Veterans Health Care System	Biloxi, MS
VA Boston Healthcare System	Boston, MA
Ralph H. Johnson VA Medical Center	Charleston, SC
Chillicothe VA Medical Center	Chillicothe, OH
Cincinnati VA Medical Center	Cincinnati, OH
Louis A. Johnson VA Medical Center	Clarksburg, WV
William Jennings Bryan Dorn VA Medical Center	Columbia, SC
VA North Texas Health Care System	Dallas, TX
VA Illiana Health Care System	Danville, IL
Dayton VA Medical Center	Dayton, OH
Durham VA Medical Center	Durham, NC
VA New Jersey Health Care System	East Orange, NJ
Erie VA Medical Center	Erie, PA
Veterans Health Care System of the Ozarks	Fayetteville, AR
Iowa City VA Health Care System	Iowa City, IA
G.V. (Sonny) Montgomery VA Medical Center	Jackson, MS
VA Southern Nevada Healthcare System	North Las Vegas, NV
Central Arkansas Veterans Healthcare System	Little Rock, AR
Robley Rex VA Medical Center	Louisville, KY
William S. Middleton Memorial Veterans Hospital	Madison, WI
Marion VA Medical Center	Marion, IL
Martinsburg VA Medical Center	Martinsburg, WV

Names	Locations
Memphis VA Medical Center	Memphis, TN
VA Hudson Valley Health Care System	Montrose, NY
Captain James A. Lovell Federal Health Care Center	North Chicago, IL
Northport VA Medical Center	Northport, NY
Oklahoma City VA Health Care System	Oklahoma City, OK
VA Nebraska-Western Iowa Health Care System	Omaha, NE
VA Palo Alto Health Care System	Palo Alto, CA
Phoenix VA Health Care System	Phoenix, AZ
VA Pittsburgh Healthcare System	Pittsburgh, PA
John J. Pershing VA Medical Center	Poplar Bluff, MO
VA Sierra Nevada Health Care System	Reno, NV
Roseburg VA Health Care System	Roseburg, OR
Salem VA Medical Center	Salem, VA
VA San Diego Healthcare System	San Diego, CA
San Francisco VA Health Care System	San Francisco, CA
VA Puget Sound Health Care System	Seattle, WA
Mann-Grandstaff VA Medical Center	Spokane, WA
VA St. Louis Health Care System	St. Louis, MO
Central Texas Veterans Health Care System	Temple, TX
Tomah VA Medical Center	Tomah, WI
Washington DC VA Medical Center	Washington DC
West Palm Beach VA Medical Center	West Palm Beach, FL

Source: OIG

Appendix C: VA Outpatient Clinics Inspected

**Table C. VA Outpatient Clinics Inspected
(October 1, 2017, through September 30, 2018)**

Outpatient Clinic Name and Location	Parent Facility Location
Troy VA Clinic, Troy, NY	Albany, NY
Jackson VA Clinic, Michigan Center, MI	Ann Arbor, MI
Hickory VA Clinic, Hickory, NC	Asheville, NC
Lewiston VA Clinic, Lewiston, ME	Augusta, ME
Lansing North VA Clinic, Lansing, MI	Battle Creek, MI
St. Petersburg VA Clinic, St. Petersburg, FL	Bay Pines, FL
Princeton VA Clinic, Princeton, WV	Beckley, WV
Panama City Beach VA Clinic, Panama City Beach, FL	Biloxi, MS
Lowell VA Clinic, Lowell, MA	Boston, MA
Trident 1 VA Clinic, North Charleston, SC	Charleston, SC
Lancaster VA Clinic, Lancaster, OH	Chillicothe, OH
Clermont County VA Clinic, Cincinnati, OH	Cincinnati, OH
Wood County VA Clinic, Parkersburg, WV	Clarksburg, WV
Orangeburg VA Clinic, Orangeburg, SC	Columbia, SC
Granbury VA Clinic, Granbury, TX	Dallas, TX
Decatur VA Clinic, Decatur, IL	Danville, IL
Springfield VA Clinic, Springfield, OH	Dayton, OH
Durham County VA Clinic, Durham, NC	Durham, NC
Hamilton VA Clinic, Hamilton, NJ	East Orange, NJ
Ashtabula County VA Clinic, Ashtabula, OH	Erie, PA
Ozark VA Clinic, Ozark, AR	Fayetteville, AR
Dubuque VA Clinic, Dubuque, IA	Iowa City, IA
McComb VA Clinic, McComb, MS	Jackson, MS
Northwest Las Vegas VA Clinic, Las Vegas, NV	North Las Vegas, NV
Hot Springs VA Clinic, Hot Springs, AR	Little Rock, AR
Fort Knox VA Clinic, Fort Knox, KY	Louisville, KY
Madison West VA Clinic, Madison, WI	Madison, WI
Harrisburg VA Clinic, Harrisburg, IL	Marion, IL
Franklin VA Clinic, Franklin, WV	Martinsburg, WV

Outpatient Clinic Name and Location	Parent Facility Location
Covington VA Clinic, Memphis, TN	Memphis, TN
Poughkeepsie VA Clinic, Poughkeepsie, NY	Montrose, NY
Kenosha VA Clinic, Kenosha, WI	North Chicago, IL
Riverhead VA Clinic, Riverhead, NY	Northport, NY
Blackwell VA Clinic, Blackwell, OK	Oklahoma City, OK
Shenandoah VA Clinic, Shenandoah, IA	Omaha, NE
San Jose VA Clinic, San Jose, CA	Palo Alto, CA
Thunderbird VA Clinic, Phoenix, AZ	Phoenix, AZ
Westmoreland County VA Clinic, Greensburg, PA	Pittsburgh, PA
Sikeston VA Clinic, Sikeston, MO	Poplar Bluff, MO
Diamond View VA Clinic, Susanville, CA	Reno, NV
Eugene VA Clinic, Eugene, OR	Roseburg, OR
Tazewell VA Clinic, Tazewell, VA	Salem, VA
Chula Vista VA Clinic, Chula Vista, CA	San Diego, CA
Santa Rosa VA Clinic, Santa Rosa, CA	San Francisco, CA
South Sound VA Clinic, Chehalis, WA	Seattle, WA
Wenatchee VA Clinic, Wenatchee, WA	Spokane, WA
St. Louis County VA Clinic, Florissant, MO	St. Louis, MO
Austin VA Clinic, Austin, TX	Temple, TX
Wisconsin Rapids VA Clinic, Wisconsin Rapids, WI	Tomah, WI
Charlotte Hall VA Clinic, Charlotte Hall, MD	Washington DC
Port Saint Lucie VA Clinic, Port Saint Lucie, FL	West Palm Beach, FL

Source: OIG

Appendix D: Leadership and Organizational Risk Summary Results

Table D.1. Inspected Facilities by VISN

VISN	Number of Facilities Inspected
VISN 1: VA New England Healthcare System	2
VISN 2: New York/New Jersey VA Health Care Network	4
VISN 4: VA Healthcare – VISN 4	2
VISN 5: VA Capitol Health Care Network	4
VISN 6: VA Mid-Atlantic Health Care Network	3
VISN 7: VA Southeast Network	2
VISN 8: VA Sunshine Healthcare Network	2
VISN 9: VA MidSouth Healthcare Network	2
VISN 10: VA Healthcare System	5
VISN 12: VA Great Lakes Health Care System	4
VISN 15: VA Heartland Network	3
VISN 16: South Central VA Health Care Network	4
VISN 17: VA Heart of Texas Health Care Network	2
VISN 19: Rocky Mountain Network	1
VISN 20: Northwest Network	3
VISN 21: Sierra Pacific Network	4
VISN 22: Desert Pacific Healthcare Network	2
VISN 23: VA Midwest Health Care Network	2

Source: OIG

Table D.2. Inspected Facilities by Complexity[101]

Facility Complexity	Number of Facilities Inspected
1a-Highest Complexity[102]	15
1b-High Complexity[103]	9
1c-Mid-High Complexity[104]	17
2-Medium Complexity[105]	2
3-Low Complexity[106]	8

Source: OIG

Table D.3. Composition of Leadership Teams[107]

Composition	Number of Leadership Teams
Facility Director, Chief of Staff, ADPCS, and Associate Director(s)	29
Facility Director, Chief of Staff, ADPCS, Associate Director(s), and Assistant Director	15
Facility Director, Chief of Staff, ADPCS, Deputy Director, and Associate Director(s)	5
Facility Director, Chief of Staff, ADPCS, Deputy Director, and Assistant Director	1
Facility Director, Chief of Staff, ADPCS, Deputy Director, Associate Director(s), and Assistant Director	1

Source: OIG

---

[101] Results as of the CHIP inspection.

[102] Facilities with high volume, high risk patients, most complex clinical programs, and large research and teaching programs.

[103] Facilities with medium-high volume, high risk patients, many complex clinical programs, and medium-large research and teaching programs.

[104] Facilities with medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs.

[105] Facilities with medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs.

[106] Facilities with low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs.

[107] Results as of the CHIP inspection.

Table D.4. Permanence of Facility Leaders[108]

Position	Yes	Percent Yes	No	Percent No	Total
Facility Director	42	82	9	18	51
Chief of Staff	44	86	7	14	51
ADPCS	47	92	4	8	51
Deputy Director	6	86	1	14	7
Associate Director	45	87	7	13	52
Assistant Director	13	68	6	32	19
Overall	**197**	**85**	**34**	**15**	**231**

Source: OIG

Table D.5. Average Tenure of Permanent Leaders[109]

Position	Number of Staff	Average Tenure (Years)	Minimum Tenure Observed (Weeks)	Maximum Tenure Observed (Years)
Facility Director	42	2.0	1.0	5.8
Chief of Staff	44	4.0	1.0	17.2
ADPCS	47	5.3	5.1	29.3
Deputy Director	6	1.2	10.0	3.4
Associate Director	45	2.5	1.1	11.8
Assistant Director	13	2.2	2.0	12.1
Overall	**197**	**3.3**	**n/a**	**n/a**

Source: OIG

n/a = not applicable

---

[108] Results as of the CHIP inspection.

[109] Results as of the CHIP inspection.

Table D.6. Distribution of Permanent Leaders' Tenure[110]

Position	<6 Months	6 months–1 year	1–2 years	2–5 years	>5 years	Total
Director	4	8	14	13	3	42
Chief of Staff	5	7	11	9	12	44
ADPCS	3	6	13	11	14	47
Deputy Director	3	1	1	1	0	6
Associate Director	7	14	11	6	7	45
Assistant Director	4	1	6	0	2	13
Overall	**26**	**37**	**56**	**40**	**38**	**197**

Source: OIG

n/a = not applicable

Table D.7. Number of Patient Safety Indicators

Number of PSI Measures	Number of Facilities
5	2
6	3
7	1
8	1
10	2
11	12
12	30
Overall	**51**

Source: OIG

---

[110] Results as of the CHIP inspection.

Table D.8. Number of Patient Safety Indicator Measures Greater than the VHA Average

PSI Measures Above VHA Average	Number of Facilities
0	11
1	4
2	11
3	5
4	7
5	2
6	6
7	4
9	1
Overall	**51**

Source: OIG

Table D.9. Occurrence of Sentinel Events across Facilities

Number of Reported Sentinel Events	Number of Facilities	Total Sentinel Events
0	7	0
1	9	9
2	5	10
3	3	9
4	2	8
5	2	10
6	5	30
7	4	28
8	1	8
9	3	27
10	1	10
11	1	11
12	2	24
13	2	26
14	1	14
15	1	15
20	2	40
Overall	**51**	**279**

Source: OIG

Table D.10. Occurrence of Institutional Disclosures across Facilities

Number of Reported Institutional Disclosures	Number of Facilities	Total Institutional Disclosures
1	3	3
2	7	14
3	1	3
4	3	12
5	6	30
6	3	18
7	3	21
8	3	24
9	4	36
10	1	10
11	3	33
12	2	24
15	1	15
16	2	32
18	2	36
19	2	38
20	2	40
25	2	50
49	1	49
Overall	**51**	**489**

Source: OIG

Table D.11. Facility Complexity by VHA SAIL Star Rating

SAIL Star Rating	Facility Complexity	Number of Facilities
1	1a-Highest	1
	1b-High	1
	1c-Mid-High	1
	2-Medium	0
	3-Low	1
2	1a-Highest	5
	1b-High	2
	1c-Mid-High	3
	2-Medium	1
	3-Low	1
3	1a-Highest	6
	1b-High	2
	1c-Mid-High	6
	2-Medium	1
	3-Low	3
4	1a-Highest	1
	1b-High	3
	1c-Mid-High	6
	2-Medium	0
	3-Low	2
5	1a-Highest	2
	1b-High	1
	1c-Mid-High	1
	2-Medium	0
	3-Low	1
Overall	**n/a**	**51**

Source: OIG

n/a = not applicable

Table D.12. Facility PSI Results by VHA SAIL Star Rating

SAIL Star Rating	Number of Facility PSIs Greater than VHA Average	Number of Facilities
1	0	1
	4	1
	7	1
	9	1
2	0	1
	1	2
	2	3
	3	1
	5	1
	6	2
	7	2
3	0	5
	1	2
	2	6
	3	1
	4	3
	6	1
4	0	2
	2	2
	3	2
	4	2
	5	1
	6	2
	7	1
5	0	2
	3	1
	4	1
	6	1
Overall	**n/a**	**51**

Source: OIG

n/a = not applicable

Table D.13. Sentinel Events by VHA SAIL Star Rating

SAIL Star Rating	Number of Sentinel Events	Number of Facilities	Average Number of Sentinel Events
1	13	4	3.3
2	38	12	3.2
3	132	18	7.3
4	64	12	5.3
5	32	5	6.4
Overall	**279**	**51**	**5.5**

Source: OIG

Table D.14. Institutional Disclosures by VHA SAIL Star Rating

SAIL Star Rating	Number of Institutional Disclosures	Number of Facilities	Average Number of Institutional Disclosures
1	35	4	8.8
2	122	12	10.2
3	205	18	11.4
4	85	12	7.1
5	41	5	8.2
Overall	**488**	**51**	**9.6**

Source: OIG

Table D.15. OIG CHIP Report Recommendations by VHA SAIL Star Rating

SAIL Star Rating	Number of CHIP Report Recommendations	Number of Facilities	Average Number of CHIP Report Recommendations
1	46	4	11.5
2	94	12	7.8
3	127	18	7.1
4	67	12	5.6
5	23	5	4.6
Overall	**357**	**51**	**7.0**

Source: OIG

Table D.16. Facility PSI Results by Facility Complexity[111]

Facility Complexity	Number of Facility PSIs Greater than VHA Average	Number of Applicable Facility PSIs	Average Number of Applicable PSIs Greater than VHA Average
1a-Highest Complexity	65	177	0.37
1b-High Complexity	37	105	0.35
1c-Mid-High Complexity	48	194	0.25
2-Medium Complexity	1	21	0.05
3-Low Complexity	1	58	0.02
Overall	**152**	**555**	**0.27**

Source: OIG

Table D.17. Sentinel Events by Facility Complexity[112]

Facility Complexity	Number of Sentinel Events	Number of Facilities	Average Number of Sentinel Events
1a-Highest Complexity	127	15	8.5
1b-High Complexity	57	9	6.3
1c-Mid-High Complexity	83	17	4.9
2-Medium Complexity	1	2	0.5
3-Low Complexity	11	8	1.4
Overall	**279**	**51**	**5.5**

Source: OIG

---

[111] Results as of the CHIP inspection.

[112] Results as of the CHIP inspection.

Table D.18. Institutional Disclosures by Facility Complexity[113]

Facility Complexity	Number of Institutional Disclosures	Number of Facilities	Average Number of Institutional Disclosures
1a-Highest Complexity	186	15	12.4
1b-High Complexity	90	9	10.0
1c-Mid-High Complexity	157	17	9.2
2-Medium Complexity	10	2	5.0
3-Low Complexity	45	8	5.6
Overall	**488**	**51**	**9.6**

Source: OIG

Table D.19. OIG CHIP Report Recommendations by Facility Complexity[114]

Facility Complexity	Number of CHIP Report Recommendations	Number of Facilities	Average Number of CHIP Report Recommendations
1a-Highest Complexity	122	15	8.1
1b-High Complexity	64	9	7.1
1c-Mid-High Complexity	120	17	7.1
2-Medium Complexity	14	2	7.0
3-Low Complexity	37	8	4.6
Overall	**357**	**51**	**7.0**

Source: OIG

---

[113] Results as of the CHIP inspection.

[114] Results as of the CHIP inspection.

Appendix E: Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: August 14, 2019

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: Comprehensive Healthcare Inspection Summary Report, FY 2018

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the OIG draft report, Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018.

2. I concur with recommendations 1-5 and 7-16. I concur in principle with recommendation 6. The applicable information is provided in the attached action plan.

3. If you have any questions, please email Karen Rasmussen, M.D., Director for GAO OIG Accountability Liaison Office at VHA10EGGOALAction@va.gov.

(Original signed by:)

Richard A. Stone, M.D.

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

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Contributors	Mary Toy, MSN, RN, CHIP Director Limin Clegg, PhD Justin Hanlon, BS Henry Harvey, MS LaFonda Henry, MSN, RN-BC Yoonhee Kim, PharmD Scott McGrath, BS Paul Rogers, PhD, MS Larry Ross, Jr., MS Patrick Smith, MS Marilyn Stones, BS Robert Wallace, ScD, MPH Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Veterans Integrated Service Network Directors (1–23)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and
    Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and
    Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

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