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VETERANS HEALTH ADMINISTRATION

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

CHIP REPORT | REPORT #19-00013-15 | NOVEMBER 21, 2019

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Figure 1. *Charlie Norwood VA Medical Center, Augusta, Georgia (Source: https://www.augusta.va.gov, accessed on July 23, 2019)*

Abbreviations

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

Report Overview

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

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

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

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

This unannounced visit was conducted during the week of February 11, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

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

The facility's leadership team had been working together since December 2018, although two had served in their position for several years. All of the leaders were permanently assigned except for the ADPCS, who had been serving in an interim capacity for about five months.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders had opportunities to improve employee satisfaction with leadership provided. The selected patient experience survey scores for facility leaders were lower than the VHA average, and facility leaders had implemented processes and plans to improve positive patient experiences.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[1] disclosures of adverse patient events, and patient safety indicator data and identified organizational risk factors, specifically with sentinel events related to surgical procedures and patient safety indicators. At the time of the OIG on-site visit, all Joint Commission survey recommendations from the January 2019 inspection remained open.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[2] Although the leadership team members were aware of selected SAIL metrics and community living center (CLC) measures, the leaders should continue to take actions to improve performance of the quality of

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

[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, but is not accessible by the public.)

care metrics and measures likely contributing to the facility's SAIL "2-star" and CLC "2-star" quality ratings.[3]

The OIG noted deficiencies in seven of the eight clinical areas reviewed and issued 24 recommendations that are attributable to the director, associate director, and chief of staff. These are briefly described below.

Quality, Safety, and Value

The OIG found there was general compliance with requirements for patient safety and resuscitation episode review. However, the OIG identified concerns with the protected peer review process and participation in interdisciplinary reviews of utilization management data.[4]

Medical Staff Privileging

The facility complied with the requirements for privileging. However, the OIG identified deficiencies with focused professional practice evaluation (FPPE), ongoing professional practice evaluation, and FPPE for cause processes.[5]

Environment of Care

The facility generally complied with requirements for privacy measures. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG noted deficiencies with environmental safety and cleanliness and emergency management.

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

[4] The definition of utilization management can be found within VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the "forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria." The January 2018 version of the directive was in effect at the time of the February 2019 review. Subsequently, the directive was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), which expired on July 31, 2019. The utilization management definition remained consistent in both versions of the directive.

[5] The definitions of ongoing professional practice evaluation and focused professional practice evaluations can be found within Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2). An ongoing professional practice evaluation is "the ongoing monitoring of privileged providers to confirm the quality of care delivered and ensures patient safety." A focused professional practice evaluation is "a time-limited process whereby the clinical leadership evaluates the privilege-specific competence of a provider who does not yet have documented evidence of competently performing the requested privilege(s) at the facility." A focused professional practice evaluation for cause is "a time-limited period during which the medical staff leadership assesses the provider's professional performance to determine if any action should be taken on the provider's privileges."

Medication Management

The facility complied with requirements for some of the performance indicators evaluated, including the staff restrictions for monthly review of balance adjustments, controlled substances inspectors having no conflicts of interest, and appointment not exceeding three years. However, the OIG identified deficiencies with controlled substances coordinator reports, program oversight, controlled substances inspector's completion of required annual competency assessment, and controlled substances area and pharmacy inspections.

Mental Health

Generally, the OIG found compliance with many of the performance indicators, including the designation of a military sexual trauma (MST) coordinator, tracking of MST-related data, and provision of clinical care. There was a concern noted, however, with providers completing MST mandatory training within the required time frame.

Women's Health

The OIG also noted the facility performed adequately on many of the performance indicators, including requirements for a designated women veterans program manager and women's health medical director and follow-up care when indicated. The OIG noted concerns with the Women Veterans Health Committee membership, tracking of data related to cervical cancer screenings, and communication of results to patients within the required time frame.

High-Risk Processes

The OIG inspection revealed that the facility generally complied with many of the performance indicators used to assess the operations and management of the emergency department. However, the emergency department lacked a backup call schedule for providers.

Summary

In reviewing key healthcare processes, the OIG issued 24 recommendations for improvement directed to the facility director, chief of staff, and associate director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The acting Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 82–83, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendations 3 and 11 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

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

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

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

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

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

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

9. High-risk processes (specifically the emergency department and urgent care center operations and management).[8]

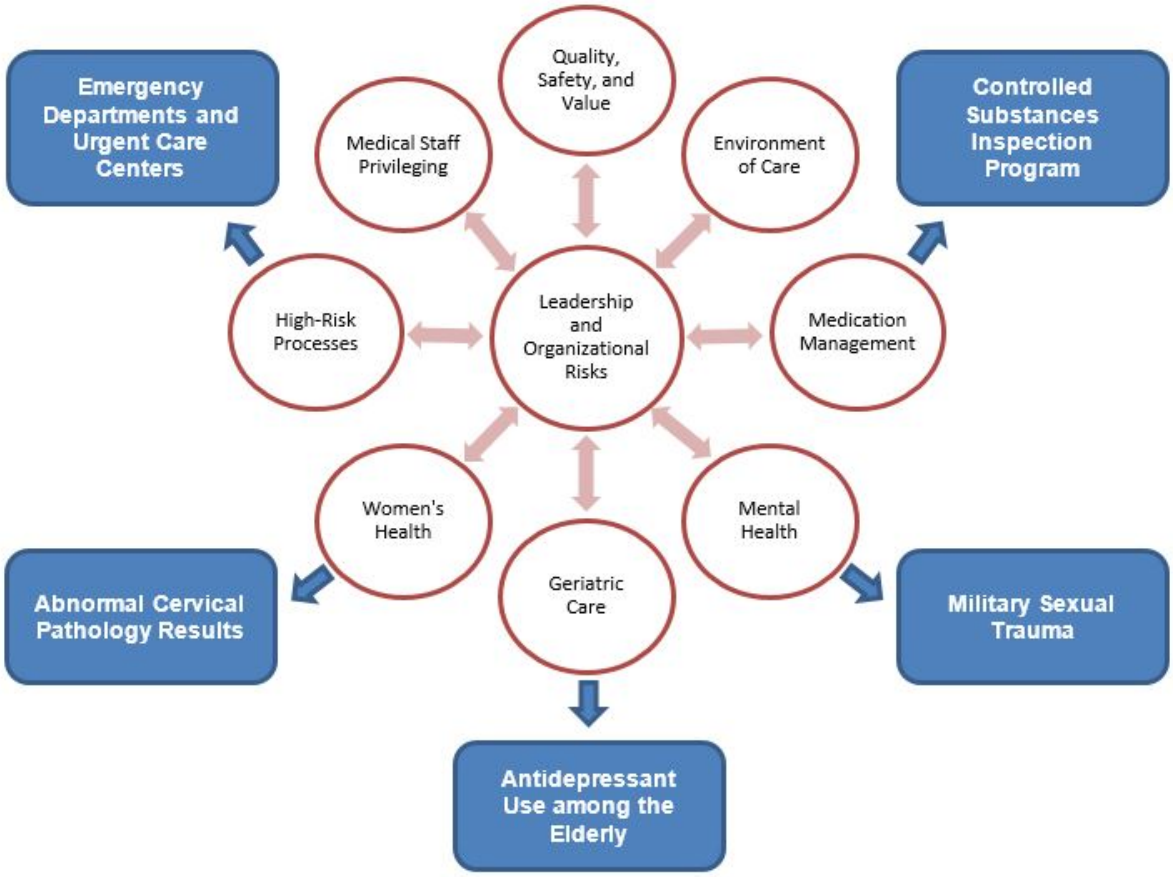

Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

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

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;[9] physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from January 30, 2016, through February 14, 2019, the last day of the unannounced week-long site visit.[10] While on site, the OIG referred issues and concerns beyond the scope of the CHIP review to our Hotline management team for further evaluation.

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

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

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

[10] The range represents the time period from the last Combined Assessment Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

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

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

Executive Leadership Position Stability and Engagement

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

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

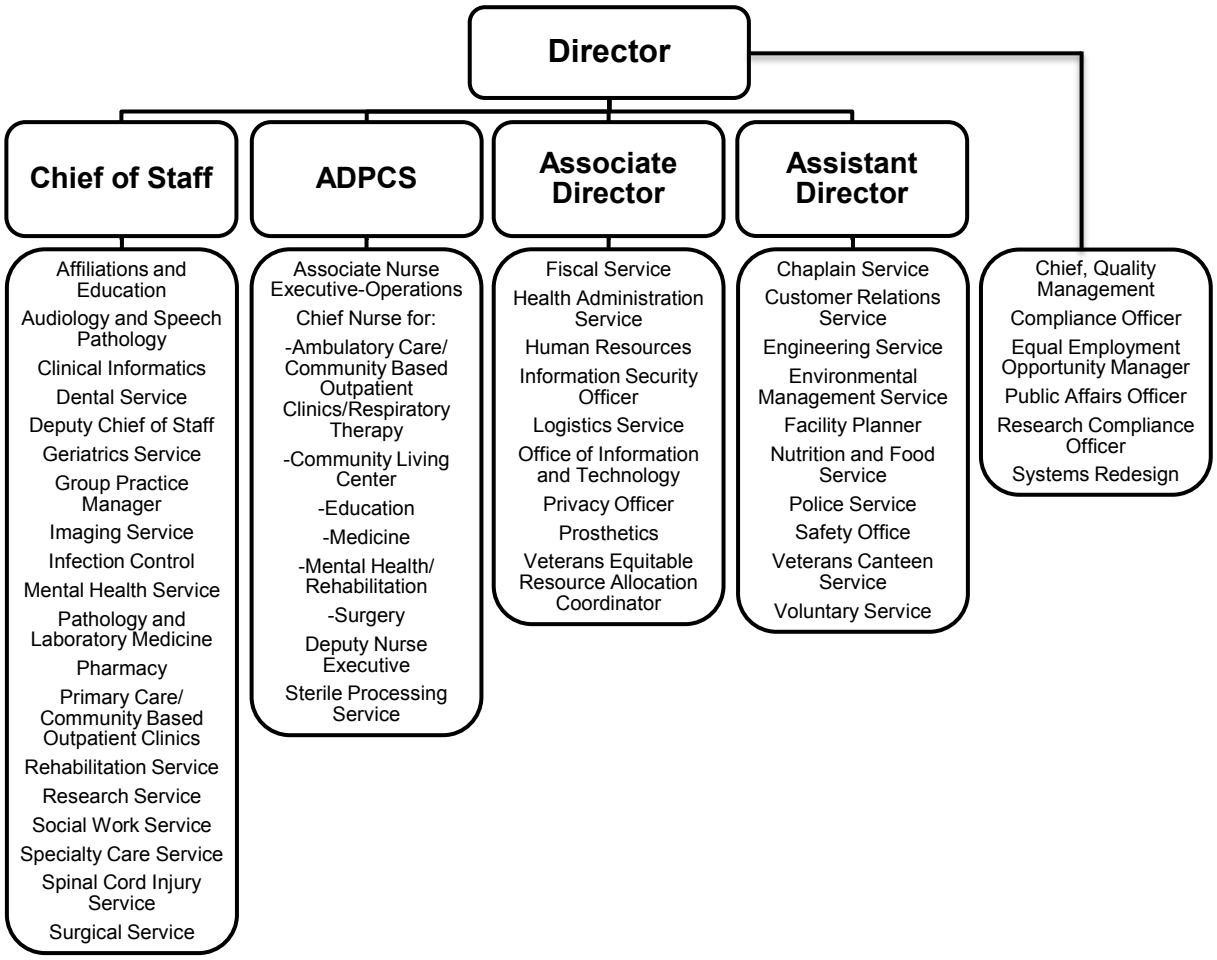

Figure 3. *Facility Organizational Chart*[12]
Source: Charlie Norwood VA Medical Center (received February 11, 2019)

At the time of the OIG site visit, the executive team had been working together since December 2018, although several team members have been in their position for many years (see Table 1). All of the leaders were permanently assigned except for the ADPCS, who had been serving in an interim capacity for about five months.

[12] At this facility, the director is responsible for the Chief, Quality Management; Compliance Officer; Equal Employment Opportunity Manager; Public Affairs Office, Research Compliance Officer, and Systems Redesign.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	March 31, 2017 (interim) and March 1, 2018 (permanent)
Chief of staff	December 23, 2018
Associate director for Patient Care Services	September 1, 2018 (interim)
Associate director	July 12, 2015
Assistant director	July 29, 2012

Source: Charlie Norwood VA Medical Center human resources officer (received February 12, 2019)

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

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

The director serves as the chairperson of the Executive Leadership Board, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Board oversees various working groups, such as the Health Care Delivery, Operations, and Organizational Health Councils.

These leaders are also engaged in monitoring patient safety and care through the Quality, Safety, Value, & Innovation Council (formerly Quality, Safety, Value Board), which the director and the chief of Quality Management co-chair. The facility director had attended only 4 of 14 Quality, Safety, Value, & Innovation Council meetings from October 2017 to December 2018. The Quality, Safety, Value, & Innovation Council is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes, and it reports to the Executive Leadership Board (formerly Governance Board). See Figure 4. The OIG noted a lack of tracking, trending, and follow-through with the Quality, Safety, Value, & Innovation Council and that the facility was undergoing reorganization of their governance structure in order to strengthen their processes and reporting.

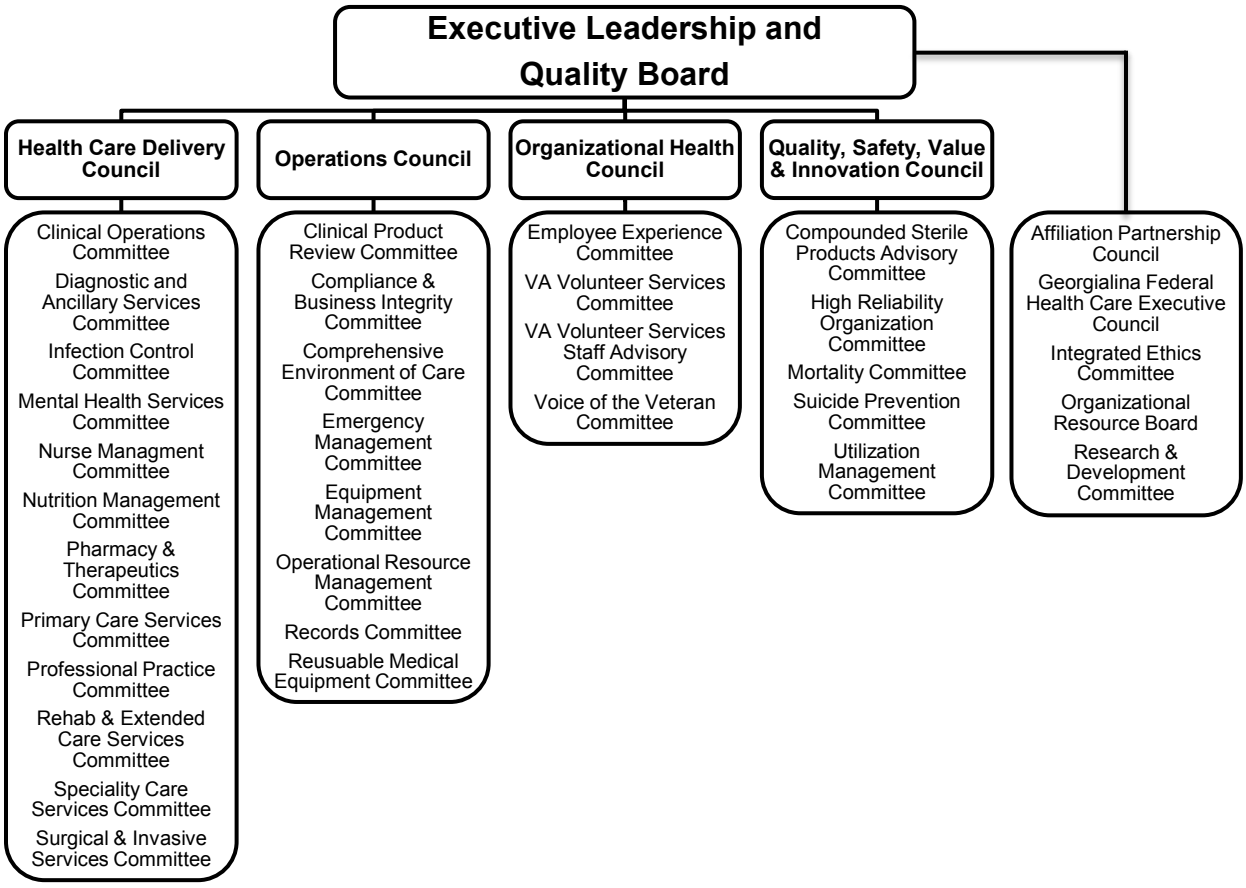

Figure 4. *Facility Committee Reporting Structure*[13]
Source: Charlie Norwood VA Medical Center (received February 12, 2019; May 29, 2019; and October 30, 2019)

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on facility leadership.

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2017,

[13] At the time of the OIG site visit, the facility was undergoing a governance committee restructuring. Figure 4 is the structure provided by the chief of Quality Management, effective February 1, 2019.

through September 30, 2018.[14] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for the selected survey leadership questions was lower than the VHA average.[15] The same trend was noted for the director in three of the selected measures and chief of staff for two of the selected measures. The ADPCS scores were similar to or better than the VHA averages, and the associate and assistant director scores were better than the VHA average for all selected measures.[16] In all, opportunities appear to exist for the director (director average) and all leaders (facility average) to improve employee satisfaction with leadership provided.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite*[17]	0–100 where HIGHER scores are more favorable	71.7	67.0	77.2	83.8	75.6	91.7	85.6
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	2.9	2.9	3.0	3.5	4.2	3.8

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

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

[16] It is important to note that the chief of staff and ADPCS scores are not reflective of the current leaders who assumed their roles after the survey was administered.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.1	3.2	3.6	3.4	4.4	3.8
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.2	3.3	3.4	3.5	4.5	3.8

Source: VA All Employee Survey (accessed January 11, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The facility average for each selected question was similar to or worse than the VHA average. Note that the executive leadership team averages for the selected survey questions were similar to or better than the VHA average, with the exception of one question regarding moral distress at work, where the director and chief of staff scores were worse.[18] In general, facility leaders appear to be maintaining an environment where employees feel safe bringing forth issues and concerns.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.5	3.9	4.0	4.2	4.7	4.5

[18] Again, it is important to note that the 2018 All Employee Survey results are not reflective of employee satisfaction with the current chief of staff.

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.5	3.8	4.3	4.0	4.2	4.3
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.5	1.6	1.8	1.7	0.8	1.0	1.1

Source: VA All Employee Survey (accessed January 11, 2019)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through September 30, 2018. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.[19]

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to four relevant survey questions that reflect

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

patients' attitudes toward facility leaders (see Table 4). For this facility, all four patient survey results reflected lower care ratings than the VHA average. Patients were less than satisfied with the leadership and care provided. Facility leaders had recently rolled out a new process to support front line to leadership communication and problem solving to improve patient care and satisfaction.

Table 4. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.9	56.3
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.2	77.3
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.3	74.2
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.5	72.8

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

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[20] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[21] The TJC inspected the facility in January 2019, and the facility staff was taking action toward addressing the recent findings.[22]

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[23] Additional results included the Long Term Care Institute's inspection of the facility's CLC[24] and the Paralyzed Veterans of America's inspection of the facility's spinal cord injury/disease unit and related services.[25]

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

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

[22] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

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

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

[25] The Paralyzed Veterans of America inspection took place August 14–15, 2018. This veteran service organization review does not result in accreditation status.

Table 5. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the Charlie Norwood VA Medical Center, Augusta, Georgia, Report No. 16-00106-211, March 28, 2016*)	January 2016	10	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of the Charlie Norwood VA Medical Center, Augusta, Georgia, Report No. 16-00012-251, April 19, 2016*)	January 2016	8	0
OIG (*Healthcare Inspection – Improper Consult and Appointment Management Practices, False, Documentation, and Document Scanning Errors, Charlie Norwood VA Medical Center Augusta, Georgia, Report No. 14-02890-168, March 10, 2017*)	June, July, and August 2014	6	0
OIG (*Healthcare Inspection Colorectal Cancer Screening Practices, Charlie Norwood VA Medical Center Augusta, Georgia, Report No. 15-05328-373, September 22, 2016*)	September 2015	2	0
TJC Hospital Accreditation	January 2019	48	48
TJC Behavioral Health Care Accreditation		6	6
TJC Home Care Accreditation		8	8

Sources: OIG and TJC (Inspection/survey results received from the chief of Quality Management on February 12, 2018)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. VHA requires submission of a Patient Safety Annual Report to provide an overview of the status of patient safety programs at the end of the fiscal year to facility leaders.[26] The FY 2017 report provided to facility leaders indicated no sentinel events occurred in the fiscal year, but the facility had one sentinel event related to a wrong-site surgery. The patient safety manager stated this was an oversight. The OIG also noted that three of the four sentinel events since January 30, 2016, were related to surgical procedures—one wrong site, one incorrect implant, and one retained foreign object. Table 6 lists the reported patient safety events from January 30, 2016 (the prior comprehensive OIG inspection), through February 14, 2019.[27]

[26] VHA Handbook 1050.01.

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

Table 6. Summary of Selected Organizational Risk Factors (January 30, 2016, through February 14, 2019)

Factor	Number of Occurrences
Sentinel Events[28]	4
Institutional Disclosures[29]	15
Large-Scale Disclosures[30]	0

Source: Charlie Norwood VA Medical Center Chief of Quality Management (received February 12, 2019)

The OIG also reviewed patient safety indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[31] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 7 summarizes patient safety indicator data from October 1, 2016, through September 30, 2018.

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

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

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

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

Table 7. Patient Safety Indicator Data (October 1, 2016, through September 30, 2018)

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 7	Facility
Pressure ulcer	0.74	0.64	1.75
Death among surgical inpatients with serious treatable conditions	113.42	89.36	68.18
Iatrogenic pneumothorax[32]	0.17	0.13	0.40
Central venous catheter-related bloodstream infection	0.16	0.27	0.23
In-hospital fall with hip fracture	0.09	0.07	0.14
Perioperative hemorrhage or hematoma	2.61	2.58	1.70
Postoperative acute kidney injury requiring dialysis	0.89	0.64	1.57
Postoperative respiratory failure	4.54	5.43	4.49
Perioperative pulmonary embolism or deep vein thrombosis	2.97	2.46	2.45
Postoperative sepsis	3.55	2.85	6.54
Postoperative wound dehiscence (rupture along incision)	0.82	0.38	0.00
Unrecognized abdominopelvic accidental puncture or laceration	1.00	1.01	0.83

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

Six of the 12 applicable patient safety indicator measures show a reported rate per 1,000 hospital discharges in excess of the reported rates for VISN 7 and/or VHA. The patient safety indicator measures for central venous catheter-related bloodstream infection show a higher reported rate than VHA. The remaining five patient safety indicator measures (pressure ulcer, iatrogenic pneumothorax, in-hospital fall with hip fracture, postoperative acute kidney injury requiring dialysis, and postoperative sepsis) show a higher reported rate than VISN 7 and VHA.

The OIG also reviewed patient safety indicator data for FY 2018, quarter 4 (the most recent data) and the previous four quarters to identify any potential trends that may impact patient safety or increase the risk for patient harm. It is important to note that although the data are collected and reported by quarter, each set of quarterly data represents potential complications or patient safety

[32] According to Northwestern Memorial Hospital, "A Pneumothorax is a type of lung injury that allows air to leak into the area between the lungs and the chest wall, which causes mild to severe chest pain and shortness of breath. An Iatrogenic Pneumothorax is caused by medical treatment, often as an incidental event during a procedure such as a pacemaker insertion." Northwestern Medicine. http://www.nmh.org/nm/quality-lung-injury-due-to-medical-care. (The website was accessed on March 6, 2019.)

events over an eight-quarter or two-year period. Further, it is possible for a facility measure to exceed the VHA rate due to a single incident and for that measure to vary above or below the VHA rate over time due to differences in the number of patients treated. Figure 5 illustrates the time frames covered by the data reviewed.

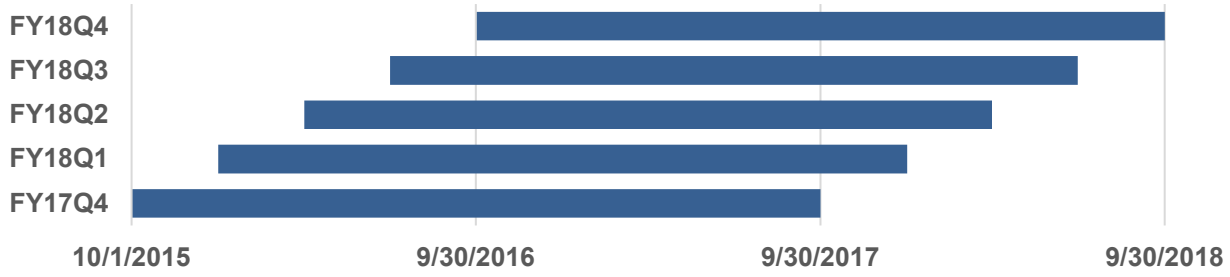

Figure 5. *Associated Time Frames for Quarterly Patient Safety Indicator Data*
Source: VA OIG
FY18Q4 = fiscal year 2018, quarter 4
FY18Q3 = fiscal year 2018, quarter 3
FY18Q2 = fiscal year 2018, quarter 2
FY18Q1 = fiscal year 2018, quarter 1
FY17Q4 = fiscal year 2017, quarter 4

Table 8 summarizes patient safety indicator data for FY 2017, quarter 4 (FY17Q4) through FY 2018, quarter 4 (FY18Q4), which includes potential complications from October 1, 2015, through September 30, 2018.

Table 8. Patient Safety Indicator Data Trending (October 1, 2015, through September 30, 2018)

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
Pressure ulcer	VHA	0.60	0.88	–[33]	0.76	0.74
	Facility	0.55	1.62	–	1.54	1.75
Death among surgical inpatients with serious treatable conditions	VHA	100.97	118.96	113.92	114.89	113.42
	Facility	105.26	69.77	73.17	66.67	68.18
Iatrogenic pneumothorax	VHA	0.19	0.19	0.17	0.15	0.17
	Facility	0.42	0.37	0.40	0.67	0.40
Central venous catheter-related bloodstream infection	VHA	0.15	0.14	0.15	0.16	0.16
	Facility	0.23	0.21	0.00	0.23	0.23

[33] According to VHA's Inpatient Evaluation Center, pressure ulcer data are not available for the time frame of April 1, 2016, through March 31, 2018.

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
In-hospital fall with hip fracture	VHA	0.08	0.09	0.08	0.09	0.09
	Facility	0.17	0.14	0.15	0.15	0.14
Perioperative hemorrhage or hematoma	VHA	1.94	2.58	2.62	2.59	2.61
	Facility	0.75	2.04	2.45	2.52	1.70
Postoperative acute kidney injury requiring dialysis	VHA	0.88	0.80	0.65	0.96	0.89
	Facility	1.26	1.17	1.42	1.55	1.57
Postoperative respiratory failure	VHA	5.55	5.34	5.11	4.88	4.54
	Facility	1.68	1.56	3.93	4.41	4.49
Perioperative pulmonary embolism or deep vein thrombosis	VHA	3.29	3.26	3.09	3.05	2.97
	Facility	3.62	3.29	3.15	3.22	2.45
Postoperative sepsis	VHA	4.00	3.96	3.72	3.70	3.55
	Facility	5.31	4.84	5.86	4.85	6.54
Postoperative wound dehiscence (rupture along incision)	VHA	0.52	1.04	1.00	0.93	0.82
	Facility	0.00	0.00	0.00	0.00	0.00
Unrecognized abdominopelvic accidental puncture or laceration	VHA	0.53	1.21	1.02	1.07	1.00
	Facility	0.00	0.00	0.00	0.85	0.83

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

Six measures (pressure ulcer, iatrogenic pneumothorax, central venous catheter-related bloodstream infection, in-hospital fall with hip fracture, postoperative acute kidney injury requiring dialysis, and postoperative sepsis) were above the VHA rates. Five have shown a general upward trend for all quarters except central venous catheter-related bloodstream infection, which had one quarter below VHA. The in-hospital fall with hip fracture rate has stayed consistent. Further, the remaining six measures are lower than VHA averages or have trended down over time. The OIG also noted that postoperative respiratory failure, though lower than the VHA averages, has had a consistent upward trend over the five quarters.

The OIG noted that the observed trend for pressure ulcers were largely due to five new cases reported during FY 2018—four in quarter 3 and one patient in quarter 4. There was no evidence of individual case review, but the facility had recently identified the need to re-establish their skin care committee, which was planned for March 2019. The facility recently completed an aggregate review and is piloting improvement actions.

Regarding the iatrogenic pneumothorax measure, facility leaders provided no evidence of completing individual reviews of the patient events. The measure included two new patients in quarter 1 and three new patients in quarter 3 of FY 2018. The facility staff reviewed the three

cases from quarter 3 while OIG was on site and stated the cases were not reviewed initially as they were not considered iatrogenic and should not have been in the measure; however, the facility had no active process to assess this measure or to correct potential coding errors.

As a result of an in-hospital fall, one patient experienced a hip fracture in the fourth quarter of FY 2017. The facility staff conducted a review of this case and identified an opportunity for improvement. There have been no new cases in FY 2018.

The central line venous catheter-related blood stream infection measure in quarter 4 of FY 2018 was the result of one patient identified as having developed an infection in November 2016; however, facility staff reported the patient did not have a central line, therefore, was not reviewed as a part of their infection prevention process.

For the surgical-related patient safety indicator measures (postoperative acute kidney injury requiring dialysis and postoperative sepsis), facility leaders provided no evidence of completing individual or aggregate reviews of the patients' care prior to the OIG's request for information during the on-site visit. Facility staff stated that all surgical complications meeting VA Surgical Quality Improvement Program criteria are reviewed through the facility's VA Surgical Quality Improvement Program; however, the OIG was not provided information regarding the reviews or actions taken, if necessary. Additional details regarding these measures are included below:

- Although an apparent trend was noted for patients requiring dialysis following postoperative kidney injury, the most recently reported rate was due to one injury sustained prior to FY 2018.
- Although four patients developed postoperative sepsis, there were no occurrences reported during the first quarter of FY 2018 and three recent occurrences during the second through fourth quarters of FY 2018.

The OIG noted that the facility did not have a consistent process to capture, track, and trend or identify opportunities for improvement for the patient safety indicators. There was, in general, a lack of awareness and evaluation of the patient safety indicators.

Veterans Health Administration Performance Data

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

"understand the similarities and differences between the top and bottom performers" within VHA.[34]

VA also uses a star-rating system where facilities with a "5-star" rating are performing within the top 10 percent of facilities and "1-star" facilities are performing within the bottom 10 percent of facilities. Figure 6 describes the distribution of facilities by star rating.[35] As of June 30, 2018, the facility was rated as "2-star" for overall quality.

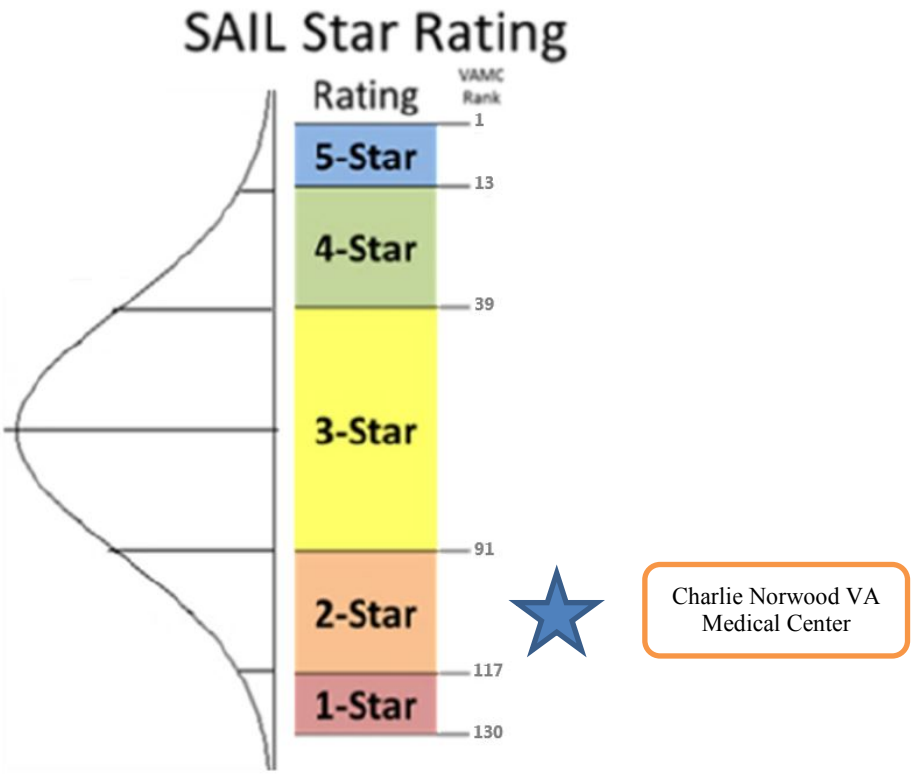

Figure 6. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed January 11, 2019)

Figure 7 illustrates the facility's quality of care and efficiency metric rankings and performance compared with other VA facilities as of September 30, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of stress discussed,

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

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

complications, rating (of) specialty care (SC) provider, and rating (of) primary care (PC) provider). Metrics that need improvement are denoted in orange and red (for example, Acute care in-hospital standardized mortality ratio (SMR), rating (of) hospital, registered nurse (RN) turnover, ambulatory care sensitive conditions (ACSC) hospitalizations, and best place to work).[36]

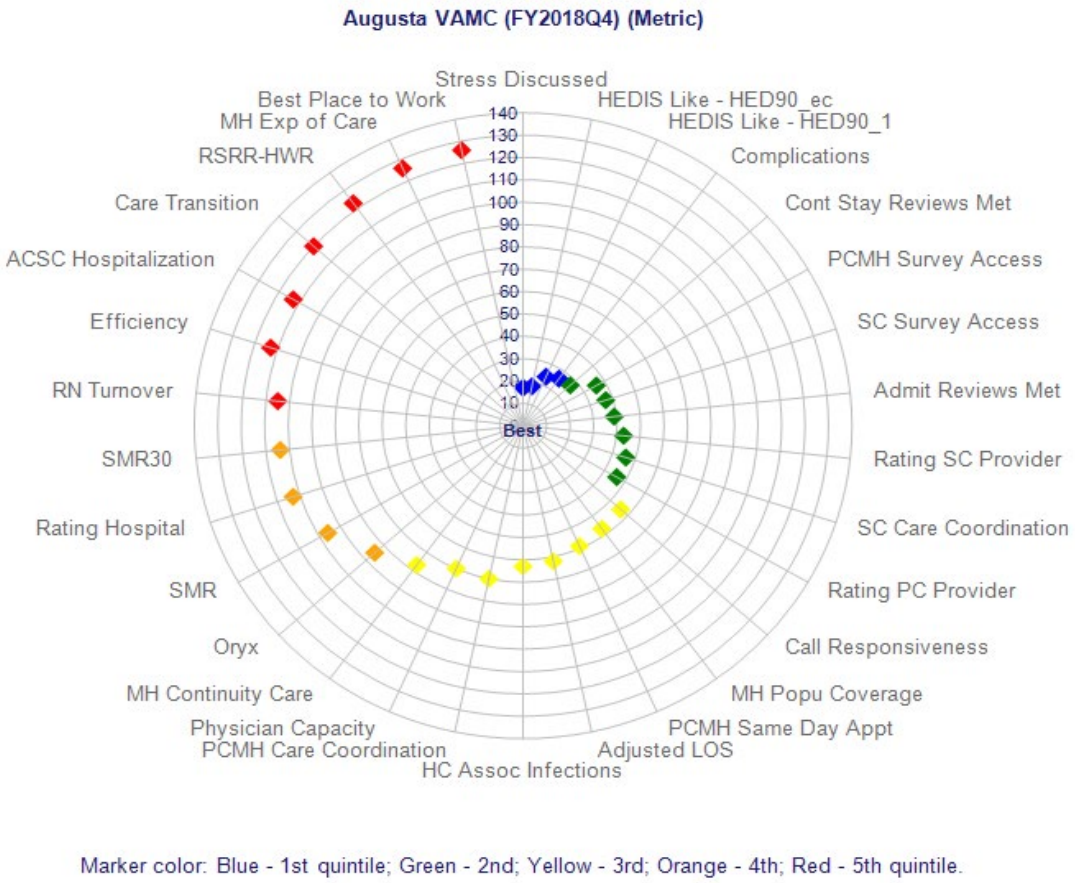

Figure 7. *Facility Quality of Care and Efficiency Metric Rankings (as of September 30, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

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

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

The Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare*.[37] The SAIL CLC provides a single resource to review quality measures and health inspection results. It includes star ratings for an unannounced survey, staffing, quality, and overall results.[38] Table 9 summarizes the rating results for the facility's CLC as of September 30, 2018. The facility has an overall "2-star" rating, and its rating for quality is also a "2-star.

Table 9. Facility CLC Star Ratings (as of September 30, 2018)

Domain	Star Rating
Unannounced Survey	1
Staffing	5
Quality	2
Overall	2

Source: VHA Support Service Center

In exploring the reasons for the "2-star" quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 8 illustrates the facility's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of improvement in function–short stay (SS), physical restraints–long stay (LS), and ability to move independently worsened (LS)). Metrics that need improvement and were likely the reasons why the facility had a "2-star" for quality are denoted in orange and red (for example, moderate-severe pain (SS) and catheter in bladder (LS)).[39]

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

[38] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on March 6, 2019 but is not accessible by the public.)

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

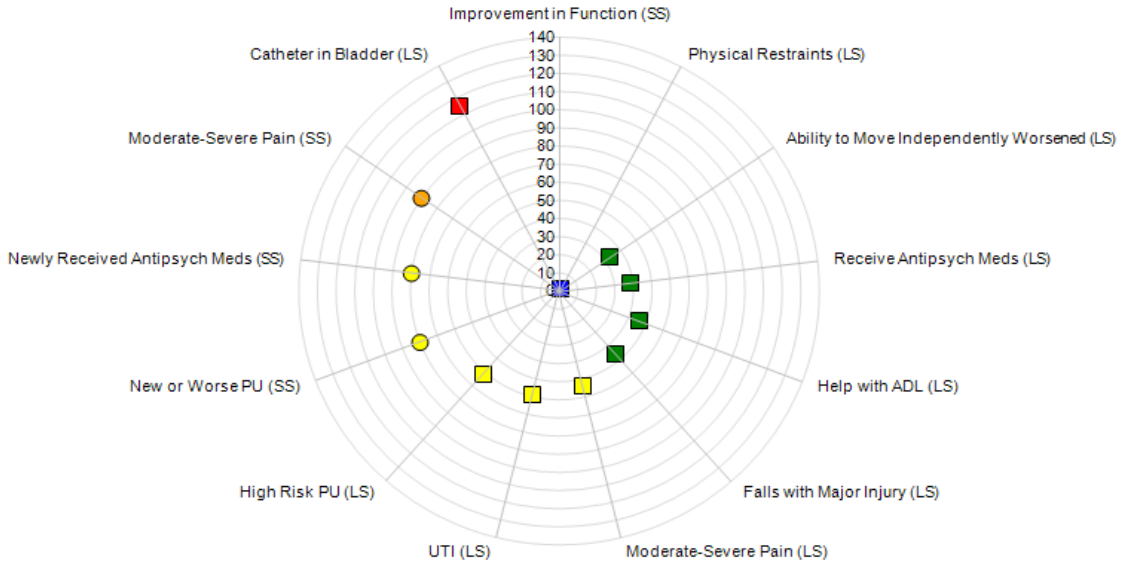

Figure 8. *Facility CLC Quality Measure Rankings (as of September 30, 2018)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team was relatively stable and had been working together since December 2018, although some leaders had been in their position for many years. All of the leaders were permanently assigned except for the ADPCS, who had been serving in an interim capacity for about five months. Selected survey scores related to employees' satisfaction with the facility executive leaders appear to highlight opportunities for all leaders to improve employee satisfaction. Patient experience survey data revealed that scores related to satisfaction with the facility were also below VHA averages. The facility leaders were working to improve employee and patient engagement and satisfaction. Additionally, the OIG reviewed accreditation agency findings, sentinel events,[40] disclosures of adverse patient events, and patient safety indicator data and identified organizational risks, which included sentinel events related to surgical procedures. The OIG had concerns about sentinel events as three of the four events since the last OIG Combined Assessment Program review were related to surgical procedures. Additionally, the facility did not have a consistent process to capture, track, and trend or identify opportunities for improvement in response to patient safety indicator data. The leadership team

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

was aware of selected SAIL and CLC metrics but should continue to take actions to improve performance of measures contributing to the SAIL "2-star" and CLC "2-star" quality ratings.

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.[41] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[42] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[43]

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's Enterprise Framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,[44] utilization management (UM) reviews,[45] patient safety incident reporting with related root cause analyses,[46] and cardiopulmonary resuscitation (CPR) episode reviews.[47]

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and

[41] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 but was rescinded on October 24, 2019.)

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

[43] VHA Directive 1026.

[44] 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.

[45] The definition of utilization management can be found within VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the "forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria." The January 2018 version of the directive was in effect at the time of the February 2019 review. Subsequently, the directive was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), which expired on July 31, 2019. The utilization management definition remained consistent in both versions of the directive.

[46] 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."

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

nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[48]

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[49]

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.[50]

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.[51]

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[52]

- Protected peer reviews
  - Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
  - Completion of final reviews within 120 calendar days

[48] VHA Directive 1190.

[49] VHA Directive 1117(1).

[50] VHA Handbook 1050.01.

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

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

  - Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee
  - Peer review of all applicable deaths within 24 hours of admission to the hospital
  - Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[53]
- 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
  - Annual completion of a minimum of eight root cause analyses[54]
  - Inclusion of required content in root cause analyses (generally)
  - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report to facility leaders
- Resuscitation episode review
  - Evidence of a committee responsible for reviewing resuscitation episodes
  - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
  - Evidence of basic or advanced cardiac life support certification for code team responders
  - Evaluation of each resuscitation episode by the CPR Committee or equivalent

[53] VHA Directive 1190.

[54] 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 analysis per fiscal year must be individual [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses]."

Quality, Safety, Value Conclusion

The OIG found there was general compliance with requirements for patient safety and resuscitation episode review. However, the OIG identified concerns with the protected peer review process and participation in interdisciplinary reviews of UM data that warranted recommendations for improvement.

Specifically, VHA requires that when the Peer Review Committee recommends individual improvement actions, clinical managers implement the actions.[55] In two of nine peer reviews conducted that documented a need for improvement actions, there was a lack of evidence that clinical managers implemented the individual improvement actions. The failure to implement the peer review recommendations likely prevented immediate and long-term improvements in patient care in the practice of one or more healthcare providers. The deputy chief of staff stated staff transitioning in multiple areas as well as restructuring of the committees contributed to lack of compliance.

Recommendation 1

1. The chief of staff ensures that managers consistently implement improvement actions recommended from peer review activities and monitors manager compliance.

Facility concurred.

Target date for completion: 4/30/2020

Facility response: The chief of staff, and chief of quality management, ensure improvement actions are implemented by the clinical managers and compliance with implementation monitored. Tracking mechanism established by the clinical risk manager, March 2019, and actions reviewed in Peer Review Committee (PRC), which reports to Healthcare Delivery Council. For increased awareness and tracking, past due action plans are placed on the PRC agenda. Compliance is closed improvement actions within 30-days monitored until 90% maintained for six consecutive months.

Timeliness is important when performing peer reviews, therefore, VHA requires that final peer reviews are completed within 120 calendar days from the determination that a peer review is needed.[56] From January 1, 2018, through December 31, 2018, the OIG found that 3 of 20 reviews were not completed in the expected time frame with no written extension approved by the director. This likely prevented timely implementation of corrective actions to improve the quality of health care provided at the facility. The deputy chief of staff stated staff transitioning

[55] VHA Directive 1190.

[56] VHA Directive 2010-025, *Peer Review for Quality Management,* June 3, 2010.

in multiple areas as well as restructuring of facility committees as reasons for lack of timely review.

Recommendation 2

2. The chief of staff ensures that final peer reviews are completed within 120 calendar days from the determination of the need for the review, or there is an extension approved in writing by the director, and monitors compliance.

Facility concurred.

Target date for completion: 1/31/2020

Facility response: The chief of staff, and clinical risk manager, ensure final peer reviews are completed within 120 calendar days or an extension is approved in writing by the director. Clinical risk manager tracks compliance with a peer review committee monitoring tool. Leadership overview is established through Peer Review Committee, which reports to Executive Council of the Medical Staff (ECMS). Compliance monitored for complete peer reviews within 120 calendar days for six consecutive months for 100% compliance.

VHA requires that a summary of the Peer Review Committee's work be reviewed quarterly by an executive level medical committee.[57] The OIG found that from January 1, 2018, through December 31, 2018, the Peer Review Committee (a subcommittee of the Professional Practice Committee) did not provide a summary report for review by the Executive Council of the Medical Staff[58] for two of four quarters. The lack of peer review aggregate data available to leadership for analysis could impact improvements in patient care. The deputy chief of staff stated staff transitioning in multiple areas as well as restructuring facility meetings as reasons for noncompliance.

Recommendation 3

3. The facility director makes certain that a summary of the Peer Review Committee's work is reviewed quarterly by the executive level medical committee and monitors compliance.[59]

[57] VHA Directive 2010-025.

[58] The facility was undergoing a governance structure change at the time of the OIG on-site visit. The Executive Council of the Medical Staff was transitioning to the Health Care Delivery Council.

[59] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

Facility concurred.

Target date for completion: 9/30/2019 (closed)

Facility response: The director, and clinical risk manager, verify the Executive Council of the Medical Staff (ECMS) minutes include a summary of Peer Review Committee (PRC) that is reported quarterly now to the Health Care Delivery Council (HCDC), August 2019. Compliance monitored through ECMS/ HCDC committee minutes (standing agenda item) to ensure PRC report is documented (March and June) for 100% compliance for two consecutive quarters.

VHA requires that an interdisciplinary group review the UM data. This group must include, but not be limited to, "representatives from UM, medicine, nursing, social work, case management, mental health, and chief business office revenue-utilization review (CBO R-UR)."[60] The OIG found, from January 2018 through July 2018, the UM Committee (a subcommittee of the High Reliability Systems Committee) lacked representation from mental health and business office revenue utilization review. As a result, the UM Subcommittee performed reviews and analyses of UM data without the perspectives of key mental health and utilization review colleagues. The chief of Quality Management reported that the mental health representative did not attend due to a vacancy, and UM staff were not aware of the requirement for business office revenue review attendance. The UM staff reported that information was shared through informal weekly meetings/morning reports, which lacked attendance and minutes.

Recommendation 4

4. The facility director makes certain that all required representatives consistently participate in interdisciplinary reviews of utilization management data and monitors representatives' compliance.

Facility concurred.

Target date for completion: 4/30/2020

Facility response: The director, and utilization management (UM) lead, ensure the Utilization Management Committee (UMC) had representatives from mental health and CBO R-UR to meet the requirement in VHA Directive 1117 Utilization Management Program. Committee meeting schedules are quarterly and report to Quality, Safety, Value, and Innovation (QSVI) Council. Compliance will be monitored for both participation of mental health and CBO R-UR at scheduled UMC meetings for 90% of required representatives for two consecutive quarters.

[60] VHA Directive 1117(1).

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[61]

Clinical privileges need to be specific, based on the individual's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to their expiration.[62]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges." "The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation[s] (OPPE), [are] essential to confirm the quality of care delivered."[63]

According to TJC, the "FPPE for Cause" should be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care. The "FPPE for Cause" is limited to a particular time frame and customized to the specific provider and related clinical concerns.[64] Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.[65]

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

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[61] 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.)

[62] VHA Handbook 1100.19.

[63] VHA Handbook 1100.19.

[64] Office of Safety and Risk Awareness, Office of Quality and Performance, Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance, July 2016 (Revision 2).

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

- Four solo or few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months[66]
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs re-privileged within 12 months before the visit
- Six providers who underwent a FPPE for cause within 12 months prior to the visit.

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[67]
  - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
  - Criteria defined in advance
  - Use of required criteria in FPPEs for selected specialty LIPs
  - Results and time frames clearly documented
  - Evaluation by another provider with similar training and privileges
  - Executive Committee of the Medical Staff consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
  - Criteria specific to the service or section
  - Use of required criteria in OPPEs for selected specialty LIPs

[66] The 18-month period was from August 11, 2017, through February 11, 2019. The 12-month review period covered February 11, 2018, through February 11, 2019; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being fewer than three providers in the facility that are privileged in a particular specialty.

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

  - Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities
  - Evaluation by another provider with similar training and privileges
  - Executive Committee of the Medical Staff's decision to recommend continuing privileges based on OPPE results
- Focused professional practice evaluations for cause
  - Clearly defined expectations/outcomes
  - Time-limited
  - Provider's ability to practice independently not limited for more than 30 days
  - Shared with the provider in advance
- Reporting of privileging actions to National Practitioner Data Bank

Medical Staff Privileging Conclusion

The OIG found general compliance with requirements for privileging. However, the OIG identified deficiencies with FPPE, OPPE, and FPPE for cause processes that warranted recommendations.

Specifically, VHA requires that the FPPE (new or for cause) is completed with criteria defined in advance, is objective, and is accepted by the practitioner.[68] The OIG found that 12 of the 16 profiles, which included two FPPEs for cause, lacked documentation that providers were aware of the criteria for evaluation before initiation of the FPPE. This resulted in providers not knowing the criteria being used to evaluate their practice. Deputy chief of staff stated they provided a copy of the medical center bylaws and the service chiefs discussed the evaluation criteria with the providers.

Recommendation 5

5. The chief of staff makes certain that service chiefs define and communicate expectations for focused professional practice evaluation criteria in advance and maintain appropriate documentation of the processes and monitors service chiefs' compliance.

[68] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: 4/30/2020

Facility response: The chief of staff ensures FPPEs are discussed with the providers prior to the initiation of the FPPE. This process is included in medical center policy, and medical staff bylaws provided upon hire and included in the on-boarding process with service chiefs. To verify documentation of discussions, FPPEs include an initial signature and date line to document the discussion. The amended form, reviewed in Credentials Committee, pending final approval. For leadership overview, the Credentials Committee reports to the Executive Council of the Medical Staff (ECMS), now the Health Care Delivery Council, August 2019. Compliance will be monitored for appropriate FPPE documentation of evaluation criteria for six months for 90% compliance.

Additionally, VHA requires providers with "similar training and privileges evaluate the privilege-specific competence of the practitioner and document evidence of competently performing the requested privileges of the facility."[69] The OIG found that for 8 of 33 practitioner's profiles, three of which were solo providers, the professional practice evaluations were conducted by a provider who did not have similar training and privileges. This resulted in providers practicing without a comprehensive evaluation of their practice. Service chiefs for surgery and specialty care reported they typically completed the evaluations for the providers who reported directly to them.

Recommendation 6

6. The chief of staff ensures that professional practice evaluations are completed by a provider with similar training and privileges and monitors compliance.

Facility concurred.

Target date for completion: 6/30/2020

Facility response: The chief of staff (COS) ensures evaluations are conducted by providers with similar training and privileges. For solo providers, or providers without similar training and privileges internally, the COS collaborates with VISN regional providers for additional professional practice evaluation support. The process is currently in review with VISN workgroup. Compliance monitored of professional practice evaluations by a provider with similar training/privileges for six consecutive months for 90% compliance.

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

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.[70]

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.[71]

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.[72]

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities' efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.[73] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[74]

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

[71] 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).

[72] 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.)

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

[74] VHA Directive 1028, *Electrical Power Distribution Systems*, July 25, 2014. (This VHA Directive was scheduled for recertification on or before the last working date of July 2019 and has not been recertified.)

Occupational Safety and Health Administration,[75] and National Fire Protection Association standards.[76] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[77]

In all, the OIG team inspected nine inpatient and outpatient areas located at the facility's downtown and uptown divisions. At the downtown division the OIG inspected the critical care unit (intensive care unit 3B), emergency department (unit 1D), medical (unit 6D), outpatient clinic (unit 4C), post anesthesia care unit (unit 3D), and surgical (unit 4A). At the uptown division the OIG inspected the CLC (unit 1C), inpatient mental health (unit 2G), and outpatient clinic (unit 3E). The team also inspected the Statesboro VA Clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Community based outpatient clinic
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Locked inpatient mental health unit
  - Mental health environment of care rounds

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

[76] The National Fire Protection Association (NFPA) is a global nonprofit organization "devoted to eliminating death, injury, property, and economic loss due to fire, electrical, and related hazards." https://www.nfpa.org/About-NFPA. (This website was accessed on June 28, 2018.)

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

  - Nursing station security
  - Public area and general unit safety
  - Patient room safety
  - Infection prevention
  - Availability of medical equipment and supplies
- Emergency management
  - Hazard vulnerability analysis (HVA)
  - Emergency operations plan (EOP)
  - Emergency power testing and availability

Environment of Care Conclusion

The OIG noted privacy measures were in place at the parent facility and the representative community based outpatient clinic. The OIG did not identify any issues with availability of medical equipment and supplies. However, the OIG noted deficiencies with environmental safety and cleanliness and emergency management that warranted recommendations for improvement.

Specifically, TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices and keep furnishings and equipment safe.[78] Of the nine patient care areas inspected at the facility, the OIG noted eight areas with dusty, damaged, or stained ceiling tiles or dirty/dusty heating, ventilation, and air condition grills;[79] seven areas with damaged, dusty or stained light fixtures;[80] six areas with dirty, damaged, stained floor tiles or stained/damaged walls;[81] and two areas with dusty fire sprinkler heads.[82] Additionally, at the Statesboro VA Clinic, the OIG noted a stained ceiling tile, dirty/dusty floor tiles, and dirty light fixtures. These conditions resulted in a lack of assurance of a clean and safe patient care environment. The Environmental Management

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

[79] Dirty, dusty, stained ceiling tiles were found in: critical care unit (intensive care unit 3B), CLC (1C), medical unit (6D), inpatient mental health (2G), post anesthesia care unit (3D), surgical unit (4A), emergency department (1D), and outpatient clinic (3E). Dirty/dusty heating, ventilation, and air conditioning (HVAC) grills were found in: critical care unit (intensive care unit 3B), CLC (1C), medical unit (6D), inpatient mental health (2G), post anesthesia care unit (3D), surgical unit (4A), and outpatient clinics (3E and 4C).

[80] Damaged, dusty, stained light fixtures were found in: critical care unit (intensive care unit 3B), CLC(1C), inpatient mental health (2G), post anesthesia care unit (3D), surgical unit (4A), emergency department (1D), and outpatient clinic (4C).

[81] Dirty, damaged, stained floor tiles were found at: critical care unit (intensive care unit 3B), community living center (1C), medical unit (6D), inpatient mental health (2G), surgical unit (4A), and emergency department (1D). Damaged/stained walls were found in: critical care unit (intensive care unit 3B), CLC (1C), medical unit (6D), inpatient mental health (2G), surgical unit (4A), and emergency department (1D).

[82] CLC (1C) and emergency department (1D).

Services chief reported the rounds team inspects a small number of rooms and may not be fully evaluating each area and that inspectors had not followed environment of care standards when evaluating the areas.

Recommendation 7

7. The associate director ensures a clean and safe environment is maintained throughout the facility and monitors team's compliance.

Facility concurred.

Target date for completion: 4/30/2020

Facility response: The associate director, and chief of environmental management services (EMS), ensure a clean and safe environment through environment of care (EOC) rounds. Chief of EMS increased supervisory inspections to monitor and validate cleanings including the CBOCs. The EOC rounds team members re-educated to utilize environment of care inspection checklist to better identify and report issues during rounds. Deficiency findings and trending patterns from EOC rounds presented at monthly Comprehensive Environment of Care Committee (CEOCC). Compliance of EOC deficiency findings and trending report for six consecutive months for 90% compliance.

VHA requires facilities to develop and annually review their emergency operations plan.[83] In addition, TJC requires the facility maintain an inventory of assets and resources available in the event of a disaster. This emergency operations plan must describe how the facility manages "a potential increase in demand for clinical services for vulnerable populations served by the hospital," such as geriatric or disabled patients, mental health services, and building evacuations during emergencies. Further, TJC requires the plan contain descriptions on how the facility manages activities for patient scheduling, assessments, treatment, admissions, transfers and discharges during emergencies.[84]

The OIG noted the facility lacked an inventory of on-site assets and resources that would need to be available in the event of an emergency. In addition, the emergency operations plan had not been reviewed annually and did not include how the facility manages a potential increase in demand for clinical services for vulnerable patients, mental health services, and building evacuations during emergencies. The plan also lacked how the facility manages activities for patient scheduling, assessments, treatment, admissions, transfers, and discharges during emergencies. This resulted in a lack of assurance that the facility is prepared for contingency operations during emergencies. The safety manager reported that staffing vacancies, including

[83] VHA Directive 0320.01.

[84] TJC. Emergency Management standards EM.01.01.01, EM.02.02.11, and EM.02.02.01.

the emergency manager position that was vacant for seven months until filled in August 2018, were a factor.

Recommendation 8

8. The associate director ensures the facility maintains an inventory of assets and resources available in the event of a disaster and that it is reviewed annually and monitors compliance.

Facility concurred.

Target date for completion: 12/31/2019

Facility response: The associate director, and emergency manager (EM), ensures availability of facility inventory in the event of a disaster. Inventory completed by EM, and approved at Emergency Management Committee, May 2019. Additionally, review of inventory will be conducted and documented in the annual Emergency Management Program review in December 2019. Completion of annual inventory tracked as one of the performance measures for evaluating the effectiveness of the emergency management program. Compliance of approved EM inventory validated through Emergency Management Committee minutes, leadership overview is Operations Council.

Recommendation 9

9. The associate director validates that the facility's emergency operations plan includes all required elements and is reviewed annually and monitors compliance.

Facility concurred.

Target date for completion: 12/31/2019

Facility response: The associate director will ensure emergency manager updates the emergency operations plan (EOP), to include all required elements, and reviewed annually in the Operations Council for leadership overview. The EOP is tracked as one of the performance measures for evaluating the effectiveness of the emergency management program. Compliance monitoring will be the review and approval of the completed annual EOP at the Operations Council, December 2019.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.[85] Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.[86]

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.[87]

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the prior two completed quarters;[88] and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
  - Monthly summary of findings to the director
  - Quarterly trend reports to the director
  - Quality Management Committee's review of monthly and quarterly trend reports
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Staff restrictions for monthly review of balance adjustments[89]
- Requirements for controlled substances inspectors

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

[86] 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.

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

[88] The two quarters were from July 1, 2018, through December 31, 2018.

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

  - No conflicts of interest
  - Appointed in writing by the director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required annual competency assessment
- Controlled substances area inspections
  - Completion of monthly inspections
  - Rotations of controlled substances inspectors
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of controlled substances orders
  - Performance of routine controlled substances inspections
- Pharmacy inspections
  - Monthly physical counts of the controlled substances in the pharmacy
  - Completion of inspections on day initiated
  - Security and verification of drugs held for destruction[90]
  - 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
- Facility review of override reports[91]

Medication Management Conclusion

The OIG found general compliance with requirements for some of the performance indicators evaluated, including the staff restrictions for monthly review of balance adjustments, controlled

[90] 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."

[91] When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists' review of medications ordered by the providers.

substances inspectors having no conflicts of interest, and appointment not exceeding three years. However, the OIG identified deficiencies in controlled substances coordinator reports, program oversight, controlled substances inspector's completion of required annual competency assessment, and controlled substances area and pharmacy inspections that warranted recommendations for improvement.

Specifically, VHA requires the controlled substances coordinator to provide the director as well as a quality management committee with a monthly and quarterly summary of findings and trends that include discrepancies and vulnerabilities identified during monthly controlled substances inspections.[92] The OIG found no monthly summary reports had been submitted to the director until February 2019. In addition, there had not been any quarterly findings reports or evidence of review by the Quality, Safety, Value, & Innovation Council since June 2018. The interim controlled substances coordinator did not submit the monthly summary reports of findings and trends to the director for July–September 2018 and October–December 2018 until February 10 and February 3, 2019, respectively. Failure to report controlled substance issues may cause a delay in responding to critical issues and puts the facility at risk for diversion. The chief of Quality Management reported that the interim controlled substances coordinator was given one day of training with the outgoing coordinator, and all other training was independently acquired. A lack of time for training also contributed to the identified deficiencies in the program.

Recommendation 10

10. The facility director makes certain that the controlled substances coordinator submits monthly summary of findings and quarterly trends, that include discrepancies and vulnerabilities, to the director and monitors controlled substances coordinator's compliance.

[92] VHA Directive 1108.2(1).

Facility concurred.

Target date for completion: 11/1/2019

Facility response: The director, and new full-time pharmacist controlled substance coordinator (CSC), ensured monthly and quarterly reports were signed by the director and reported to Quality, Safety, Value, and Innovation (QSVI) Council quarterly. These signed reports by the director included discrepancies, trends, and problematic areas for improvement. Submission of monthly and quarterly reports for discrepancies were monitored for compliance for eight consecutive months. Monthly summary reports, including discrepancies, to the director were 8/8 months (February-September) at 100% compliance. Quarterly trend reports to the QSVI Council 2/2 months (August and October) at 100% compliance.

Recommendation 11

11. The facility director makes certain that the appropriate quality management committee reviews the controlled substances monthly and quarterly reports at least on a quarterly basis and monitors compliance.[93]

Facility concurred.

Target date for completion: 10/1/2019 (closed)

Facility response: The director, and new full-time pharmacist controlled substance coordinator (CSC), ensured monthly and quarterly reports were signed by the director and reported to Quality, Safety, Value, and Innovation (QSVI) Council quarterly. These signed reports by the director included discrepancies, trends and problematic areas for improvement. Submission of monthly and quarterly reports were monitored for compliance for eight consecutive months. Monthly summary reports, including discrepancies, to the director were 8/8 months (February-September) at 100% compliance. Quarterly trend reports to the QSVI Council, 2 reports/2 quarters, (April, July) at 100% compliance.

The VHA requires every controlled substances inspector to have evidence of completion of required annual competency assessment.[94] The OIG found 4 of 10 controlled substances inspectors did not have an annual competency assessment. Failure to assess the competency of controlled substances inspectors has the potential for an inadequate evaluation of the program and may miss identifying required elements which lead to drug diversion activities. The chief of Quality Management reported that the interim controlled substances coordinator was given one

[93] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

[94] VHA Directive 1108.02(1).

day of training with the outgoing coordinator, and all other training was independently acquired. A lack of time for training also contributed to the identified deficiencies in the program.

Recommendation 12

12. The facility director makes certain the controlled substances coordinator conducts required annual competency assessments of the controlled substances inspectors and monitors the coordinator's compliance.

Facility concurred.

Target date for completion: 11/1/2019

Facility response: The director, and new full-time pharmacist controlled substance coordinator (CSC), ensure initial and annual competencies of inspectors are complete. The CSC pharmacist was hired on 6/9/2019. A competency tracker is used to monitor controlled substance inspector (CSI) competency (annual and new hire) compliance. Compliance monitored for annual and new hire competency completion. Annual competencies for 9/9 inspectors, with more than 1-year experience are 100%, (completed 6/2019) and initial competencies, 4/4 inspectors, are 100% (completed 10/2019). Discrepancies reported quarterly at the Quality, Safety, Value and Innovation (QSVI) council for leadership overview.

Additionally, the VHA requires that controlled substances inspectors conduct monthly physical inventories of the controlled substances storage areas and complete these inventories on the day they are initiated.[95] The OIG found that all 10 non-pharmacy areas selected for review lacked evidence that the inventory count was conducted and completed on the day it was initiated. This resulted in missed opportunities to identify potential drug diversion activities and any discrepancies related to controlled substances. The interim controlled substances coordinator did not maintain inventory worksheets for non-pharmacy areas and thought the cover sheet was sufficient.

Recommendation 13

13. The facility director makes certain that controlled substances inspectors complete monthly physical inventories of controlled substances in storage areas on the day initiated and monitors inspectors' compliance.

[95] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: 1/31/2020

Facility response: The director, and controlled substance coordinator (CSC), ensure the controlled substance inspectors complete monthly physical inventories in storage areas. A pharmacist was hired full-time on 6/9/2019 as the CSC. Completed inventory inspections of non-pharmacy areas are printed from CareFusion (Pyxis software) reports by the CSC. Documentation in accordance with VHA Directive 1108.02 Inspection of Controlled Substances. Compliance is monthly physical inventories completed on day of inspection for six consecutive months for 90% compliance. Discrepancies reported quarterly at the Quality, Safety, Value and Innovation (QSVI) council for leadership overview.

Further, VHA requires controlled substances inspection program staff to reconcile one random day's stocking/refilling from the pharmacy to every automated dispensing unit and one random day's return of stock to pharmacy from every automated dispensing unit during controlled substances area inspections.[96] The OIG found that for April to September 2018, all 10 areas lacked reconciliation of one-day dispensing from the pharmacy to the automated dispensing cabinet and one-day's return of stock to the pharmacy from every automated dispensing cabinet. Failure to reconcile dispensing and returns in all controlled substances areas may cause delays in identifying potential drug diversion activities. The chief of Quality Management reported that the interim controlled substances coordinator was given one day of training with the outgoing coordinator, and all other training was independently acquired. A lack of time for training and awareness of the requirement also contributed to the identified deficiencies in the program.

Recommendation 14

14. The facility director makes certain that reconciliation of one day dispensing from pharmacy to every automated dispensing cabinet and one day return of stock to pharmacy from every automated dispensing cabinet is performed during monthly controlled substances area inspections and monitors compliance.

[96] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: 11/1/2019

Facility response: The director, and new full-time pharmacist controlled substance coordinator (CSC), ensure reconciliation of every automated dispensing cabinet and one day return of stock to pharmacy. Enhanced monitoring by comparing CareFusion reports showing Pyxis activity with Vista reports from the pharmacy. The CSC reports to the Quality, Safety, Value, and Innovation (QSVI) Council quarterly for leadership oversight. Reconciliation compliance monitored for 8/8 months (February-September) for 100% reconciliation of audits conducted.

VHA requires that during controlled substances area inspections, inspectors verify hard copy controlled substances order (electronic or written) for a specified number of all randomly selected dispensing activities during monthly controlled substances area inspections.[97] The OIG found that from July to December 2018, 4 of 10 areas lacked verification of the controlled substances order for five randomly selected dispensing activities. When program oversight and process validation are not completed, opportunities to maintain an accurate count of controlled substances and minimize drug diversion activities may be missed, leading to organizational and patient risk. The chief, Quality Management reported that the interim controlled substances coordinator was given one day of training with the outgoing coordinator, and all other training was independently acquired. A lack of time for training and awareness of the requirement also contributed to the identified deficiencies in the program.

Recommendation 15

15. The facility director makes certain the controlled substances inspectors and coordinator carry out all required responsibilities for the verification of controlled substances orders during monthly area inspections and monitors compliance.

Facility concurred.

Target date for completion: 1/31/2020

Facility response: The director, and new full-time pharmacist controlled substance coordinator (CSC), ensure that required verification of controlled substance orders are completed during monthly inspections. Verification of orders are compliant with requirements through enhanced oversight with the new CSC position. Revision to the CSI inspection tool, August 2019, is included with the verification of the controlled substance order documentation. Compliance is monitored for documentation of the controlled substance order for six consecutive months for 90% compliance. Discrepancies reported quarterly to Quality, Safety Value, and Innovation (QSVI) Council for leadership oversight.

[97] VHA Directive 1108.02(1).

VHA requires that during controlled substances inspections, controlled substances inspectors verify that there is a corresponding sealed evidence bag containing drug(s) for each medication held for destruction as listed on the "Destructions File Holding Report."[98] For three pharmacy areas where medications are held for destruction, the OIG did not find evidence that controlled substances inspectors verified the security of the drugs held for destruction and that there is a corresponding sealed evidence bag containing drugs for destruction for each destruction holding number on the report. Failure to verify drugs held for destruction against the holding number on the report may leave the facility vulnerable to loss and theft. The chief of Quality Management reported that the interim controlled substances coordinator was given one day of training with the outgoing coordinator, and all other training was independently acquired. A lack of time for training and awareness of the requirement also contributed to the identified deficiencies in the program.

Recommendation 16

16. The facility director makes certain that controlled substances inspectors verify, during monthly inspections, there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number listed on the "Destructions File Holding Report" and monitors inspector's compliance.

Facility concurred.

Target date for completion: 11/1/2019

Facility response: The director, and new full-time pharmacist controlled substance coordinator (CSC), ensure a corresponding sealed evidence bag containing drug(s) for each destruction holding number listed on the "Destructions File Holding Report" is available upon each pharmacy inspection. The report is now printed monthly by the CSC and given to the controlled substance inspector (CSI) to conduct the inspection. This has been added to the inspection sheet for monthly inspections. Compliance audits of CSI pharmacy inspections, for six consecutive months, by the CSC (April-September) for 100%. Discrepancies reported quarterly at Quality, Safety, Value, and Innovation (QSVI) Council for leadership oversight.

Also, VHA requires that controlled substances inspectors verify the inventory count of prescription pads on the day of the monthly pharmacy inspection.[99] The OIG found that two pharmacy areas, where prescription pads are stored, lacked evidence that the controlled substances inspectors verified prescription pad counts each month. This could result in missed opportunities to identify potential drug diversion activities and any discrepancies related to controlled substances. The chief of Quality Management reported that the interim controlled

[98] VHA Directive 1108.02(1).
[99] VHA Directive 1108.02(1).

substances coordinator was given one day of training with the outgoing coordinator, and all other training was independently acquired. A lack of time for training and awareness of the requirement also contributed to the identified deficiencies in the program.

Recommendation 17

17. The facility director ensures that controlled substances inspectors complete verification of prescription pad inventories count during monthly pharmacy inspections and monitors inspectors' compliance.

Facility concurred.

Target date for completion: 11/1/2019

Facility response: The director, and new full-time pharmacist controlled substance coordinator (CSC), ensured the pharmacy inspection form was amended, April 2019, to include the prescription pad inventory. Compliance was verification of the prescription pad inventories count for six consecutive months (April-September), for 100% compliance. Discrepancies are reported quarterly in Quality, Safety, Value, and Innovation (QSVI) Council for leadership oversight.

VHA requires that controlled substances inspectors verify for evidence of a written signature (non-electronically prescribed) for controlled substances prescriptions for the previous month.[100] The OIG found that two pharmacy areas, where controlled substances prescriptions are filled, lacked evidence of verification of hard copy prescriptions for 50 controlled substances orders. When program oversight and lack of process validation is not completed, opportunities to maintain an accurate count of controlled substances and minimize drug diversion activities may be missed, leading to organizational and patient risk. The chief of Quality Management reported that the interim controlled substances coordinator was given one day of training with the outgoing coordinator, and all other training was independently acquired. A lack of time for training and awareness of the requirement also contributed to the identified deficiencies in the program.

Recommendation 18

18. The facility director ensures that the controlled substances inspectors verify evidence of written signature for non-electronic controlled substances prescriptions during monthly area inspections and monitors inspectors' compliance.

[100] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: 11/1/2019

Facility response: The director, and new full-time pharmacist controlled substance coordinator (CSC), ensure inspectors verify evidence of written signature for the "non-digitally signed controlled prescriptions" report. Enhanced monitoring through verifying the hard copy of prescriptions with the report. Compliance monitored for verified evidence of written signature for six consecutive months (April-September), for 100% compliance. Quarterly reports to Quality, Safety, Value, and Innovation (QSVI) Council for leadership oversight.

Further, VHA requires that controlled substances inspectors verify and document that 72-hour pharmacy inventory checks have been completed.[101] The OIG found that all five pharmacy areas inspected lacked evidence of verification of the 72-hour inventory count. Failure to verify 72-hour physical inventories could potentially delay identification of discrepancies and potential drug diversions. The chief of Quality Management reported that the interim controlled substances coordinator was given one day of training with the outgoing coordinator, and all other training was independently acquired. A lack of time for training and awareness of the requirement also contributed to the identified deficiencies in the program.

Recommendation 19

19. The facility director makes certain that controlled substances inspectors complete the verification of the 72-hour inventory and monitors inspectors' compliance.

Facility concurred.

Target date for completion: 11/1/2019

Facility response: The director, and new full-time pharmacist controlled substance coordinator (CSC), ensure the pharmacy inspection form was amended, April 2019, to include the verification of the (72-hour inventory) now twice per week per updated regulation. Compliance was verification of the (72-hour inventory) now twice per week for six consecutive months (April-September), for 100% compliance. Quarterly reports to Quality Safety Value and Innovation (QSVI) Council for leadership oversight.

[101] VHA Directive 1108.02(1).

Mental Health: Military Sexual Trauma Follow-Up and Staff Training

The Department of Veterans Affairs uses the term "military sexual trauma" (MST) to refer to a "psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty, active duty for training, or inactive duty training."[102] MST is an experience, not a diagnosis or a mental health condition. Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.[103]

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.[104] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[105]

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system.[106] Those who screen positive must have access to appropriate MST-related care.[107] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.[108]

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.[109] All mental health and primary care providers must complete MST mandatory

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

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

[104] VHA Directive 1115.

[105] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008 (amended November 16, 2015). (This VHA Handbook was scheduled for recertification on or before the last working date of September 2013 and has not been recertified.)

[106] VHA Directive 1115 states that "MST-related care is not subject to the minimum active duty service requirement set forth in 38 U.S.C. 5303A; Veterans may therefore be able to receive MST-related care even if they are not eligible for VA health care under other treatment authorities."

[107] VHA Directive 1115.

[108] VHA Handbook 1160.01.

[109] VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[110]

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 50 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Designated facility MST coordinator
  - Establishes and monitors MST-related staff training
  - Establishes and monitors informational outreach
  - Communicates MST-related issues, services, and initiatives with local leaders
- Evidence of tracking MST-related data
- Provision of clinical care
  - Referral for MST-related care to patients with positive MST screens
  - Initial evaluation within 24 hours of referral for mental health services
  - Comprehensive diagnostic and treatment planning evaluation within 30 days of referral for mental health services
- Completion of MST mandatory training requirement for mental health and primary care providers

Mental Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including the designation of an MST coordinator, tracking of MST-related data, and provision of clinical care. There was a concern noted, however, with providers completing MST mandatory training within the required time frame that warranted a recommendation for improvement.

Specifically, VHA requires that all primary care and mental health providers complete the MST mandatory training; for those hired after July 1, 2012, this training must be completed no later than 90 days after entering their position.[111] The OIG found for those hired after July 1, 2012,

[110] VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017; Acting Deputy Under Secretary for Health for Operations and Management Memorandum, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

[111] VHA Directive 1115.01; Acting Deputy Under Secretary for Health for Operations and Management Memorandum, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

four of eight providers did not complete training within 90 days of their hire date. This could potentially prevent clinicians from providing a consistent level of counseling, care, and service to veterans who experienced MST. The MST coordinator reported staff were not assigned mandatory training in a timely manner due to education staff turnover and communication barriers between education staff and the MST coordinator.

Recommendation 20

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

Facility concurred.

Target date for completion: 12/31/2019

Facility response: The chief of staff, and military sexual trauma (MST) coordinator, ensure mandatory training occurs within the required time frame. The MST coordinator provides training requirements to the talent management system (TMS) manager for new hires training assignment. Monthly compliance reports generated by TMS manager and provided to the MST coordinator, supervisor, and staff as an additional back-up. Supervisors reminded of pending mandatory MST training assignments not completed 30 days out. Compliance will be 96% or greater compliance for MST mandatory training within 90 days after hire for six consecutive months.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."[112] The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.[113]

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepression drugs, psychotherapy, or a combination of both."[114]

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.[115] The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."[116] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[117] Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.[118] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[112] Hans Peterson, "Late Life Depression," *U.S. Department of Veterans Affairs*, Mental Health Featured Article, March 1, 2011. https://www.mentalhealth.va.gov/featureArticle_Mar11LateLife.asp. (The website was accessed on March 8, 2019.)

[113] *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf. (The website was accessed November 20, 2018.)

[114] Centers for Disease Control and Prevention, "Depression is Not a Normal Part of Growing Older," January 31, 2017. https://www.cdc.gov/aging/mentalhealth/depression.htm. (The website was accessed on March 8, 2019.)

[115] American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." http://www.sigot.org/allegato_docs/1057_Beers-Criteria.pdf. (The website was accessed on March 22, 2018.)

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

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

[118] TJC. National Patient Safety Goal standard NPSG.03.06.01.

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.[119]

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 45 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[120] The OIG evaluated the following performance indicators:

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

Geriatric Care Conclusion

Generally, the facility achieved the performance indicators listed above. The OIG made no recommendations.

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

[120] The seven selected antidepressant medications are Amitriptyline, Clomipramine, Desipramine, Doxepin (>6mg/day), Imipramine, Nortriptyline, and Paroxetine.

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

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.[121] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[122] In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.[123] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[124]

VA is authorized to provide "gender-specific services, such as Papanicolaou tests (Pap smears)," to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.[125]

VHA requires that each facility have a "full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health care." VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women's health program. Each facility must also have a "Women Veterans Health Committee (WVHC) comprised of appropriate facility leadership and program directors, which develops and implements a Women's Health Program strategic plan." The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.[126]

VHA has established time frames for notifying patients of abnormal cervical pathology results. Abnormal cervical pathology results must be communicated to patients within seven calendar days from the date the results are available to the ordering provider. Communication of the

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[121] Centers for Disease Control and Prevention. "Cervical Cancer" *Inside Knowledge* fact sheet, December 2016. https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf. (The website was accessed on February 28, 2018.)

[122] Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

[123] Centers for Disease Control and Prevention. *What Are the Risk Factors for Cervical Cancer?* February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm. (The website was accessed on March 8, 2019.)

[124] Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

[125] VHA Directive 1330.01(2), *Health Care Services for Women Veterans,* February 15, 2017 (amended July 24, 2018).

[126] VHA Directive 1330.01(2).

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.[127]

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of 43 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Appointment of a women veterans program manager
- Appointment of a women's health medical director or clinical champion
- Facility Women Veterans Health Committee
  - Core membership
  - Quarterly meetings
  - Reports to clinical executive leaders
- Collection and tracking of cervical cancer screening data
  - Notification of patients due for screening
  - Completed screenings
  - Results reporting
  - Follow-up care
- Communication of abnormal results to patients within required time frame
- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women's Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including requirements for a designated women veterans program manager and women's health medical director and follow-up care when indicated. The OIG noted concerns with the Women Veterans Health Committee membership, tracking of data related to cervical cancer screenings, and communication of results to patients within the required time frame that warranted recommendations for improvement.

Specifically, VHA requires that each facility has a Women Veterans Health Committee that meets at least quarterly and that the core membership includes a women veterans program

[127] VHA Directive 1330.01(2).

manager; a women's health medical director; "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care; and a member from executive leadership."[128] From March 2018 through January 2019, the Women Veterans Subcommittee (a subcommittee of the Patient Services Committee) did not meet quarterly and OIG was unable to assess representation for required core members. This resulted in a lack of oversight and expertise in the review and analysis of data to ensure appropriate clinical services are available to women veterans.[129] The interim women veterans program manager stated ineffective hand-off for the position reporting being only provided a two-hour orientation and a box of folders for self-training and was not made aware of the core committee membership requirements until the VISN women veterans program manager call in November 2018.

Recommendation 21

21. The facility director confirms that the committee responsible for Women Veterans Subcommittee meets quarterly and includes required core members and monitors committee's compliance.

Facility concurred.

Target date for completion: 1/31/2019

Facility response: The director, and women veterans program manager (WVPM), ensure the charter for Women Veterans Health Subcommittee updated to include the required representation. Memo sent to all committee members regarding the importance of attending all meetings or sending a representative if excused. Compliance monitored by review of required core member representation at quarterly committee meetings for two quarters (May, July, October) for 90% compliance. Women Veterans Health Subcommittee reports to the Primary Care Services Committee for leadership overview.

According to VHA, each facility must have a process to track and follow-up on findings from "cervical cancer screenings, including notification of patients who are due for screening, tracking completion of screenings, results reporting, and follow-up care" related to cervical cancer screenings.[130] The OIG found that the facility did not have a systematic process for tracking this data. Lack of a systematic tracking process may not ensure the highest quality in care for women veterans. The interim women veterans program manager confirmed that there was not a process for tracking the data and only learned of this requirement during the OIG's site visit.

[128] VHA Directive 1330.01(2).
[129] VHA Directive 1330.01(2).
[130] VHA Directive 1330.01(2).

Recommendation 22

22. The facility director ensures that assigned staff implement a process to track and follow-up on findings from cervical cancer screenings and monitors staff's compliance.

Facility concurred.

Target date for completion: 1/31/2020

Facility response: The director, and women veterans program manager (WVPM), ensure systematic tracking process to track and follow-up on cervical cancer screenings within required timeframes. The PAP tracker tool revised, April 2019, to include date of patient notification, and pending notification greater than seven days. Data monitored by the PAP coordinator, reported to Women Veterans Health Subcommittee which reports to Primary Care Services Committee for leadership oversight. Staff trained on new process, April 2019, regarding cervical cancer screenings and follow-up. Compliance will be tracking and follow-up on PAP findings for six consecutive months at 90% compliance.

VHA also requires that the ordering provider notify patients of abnormal cervical cancer screening results within seven calendar days from the date the results are available.[131] The OIG determined that providers communicated results to patients within the required time frame in 81 percent of the electronic health records reviewed.[132] This may result in delays in follow-up care. The acting associate chief of Primary Care reported the reasons for noncompliance was the volume of alerts providers receive and a vacancy that caused two providers to care for an increased number of patients.

Recommendation 23

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

[131] VHA Directive 1330.01(2).

[132] Confidence intervals are not included because the data represented a census (every patient is in the dataset).

Facility concurred.

Target date for completion: 1/31/2020

Facility response: The chief of staff and women veterans program manager (WVPM), ensure compliance with communication of abnormal results to the patient. A weekly 'pap due report' is communicated with each team by the PAP coordinator. Additionally, staff use the patient aligned care team (PACT) huddle tool and clinical reminder to identify patients due/overdue for PAP screenings. To reduce the volume of clinical alerts, nurses now triage non-critical alerts for action and providers continue to manage the critical test result alerts. The Pap tracker updated, April 2019, to monitor completed exams along with results to include follow-up care elements for abnormal exams. Abnormal exams tracked by PAP coordinator and women veterans program manager to ensure coordination of care. Compliance monitored for abnormal results communicated to patients within seven days with 90% compliance for six consecutive months.

High-Risk Processes: Operations and Management of Emergency Departments and Urgent Care Centers

VHA defines an emergency department as a "unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations." An urgent care center (UCC) "provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries."[133] A variety of emergency services may exist, dependent on "capability, capacity, and function of the local VA medical facility;" however, emergency care must be uniformly available in all VHA emergency departments and UCCs.[134]

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide "unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week." VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that "evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care."[135]

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can "undermine the timeliness of care and, ultimately, patient safety." Effective management processes that "support patient flow [in the emergency department or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care."[136]

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software (EDIS) tracking program to document and manage the flow of patients.[137]

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[133] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016 (amended March 7, 2017).

[134] VHA Directive 1101.05(2).

[135] VHA Directive 1101.05(2).

[136] TJC. Leadership standard LD.04.03.11.

[137] VHA Directive 1101.05(2); The Emergency Medicine Management Tool (EMMT) uses data collected from EDIS to generate productivity metrics. The use of EDIS and EMMT are key tools in accomplishing Emergency Medicine Improvement initiative goals.

VA emergency departments and UCCs must also be designed to promote a safe environment of care.[138] Managers must ensure medications are securely stored,[139] a psychiatric intervention room is available,[140] and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also require emergency departments to have communication systems available to accept requests by local emergency medical services for transporting unstable patients to VA emergency departments.[141]

The OIG examined the clinical risks of the emergency department/UCC areas by evaluating the staffing; the provision of care, including selected aspects of mental health and women's health; and the reduction of patient safety risks to optimize quality care and outcomes in those areas. In addition to conducting manager and staff interviews, the OIG team reviewed emergency department staffing schedules, committee minutes, and other relevant documents. The OIG evaluated the following performance indicators:

- General
  - Presence of an emergency department or UCC
  - Availability of acute care medical and/or surgical inpatient beds in facilities with emergency departments
  - Emergency department/UCC operating hours
  - Workload capture process
- Staffing for emergency department/UCC
  - Dedicated medical director
  - At least one licensed physician privileged to staff the department at all times
  - Minimum of two registered nurses on duty during all hours of operation
  - Backup call schedules for providers
- Support services for emergency department/UCC
  - Access during regular hours, off hours, weekends, and holidays
  - On-call list for staff required to respond

[138] VHA Directive 1101.05(2).

[139] TJC. Medication Management standard MM.03.01.01.

[140] A psychiatric intervention room is where individuals experiencing a behavioral health crisis, including serious disturbances, agitation, or intoxication may be taken immediately on arrival.

[141] VHA Directive 1101.05(2).

  - Licensed independent mental health provider available as required for the facility's complexity level
  - Telephone message system during non-operational hours
  - Inpatient provider available for patients requiring admission
- Patient flow
  - EDIS tracking program
  - Emergency department patient flow evaluation
  - Diversion policy
  - Designated bed flow coordinator
- General safety
  - Directional signage to after-hours emergency care
  - Fast tracks[142]
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
  - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

The facility generally met most of requirements for the above performance indicators. However, the OIG identified the facility lacked a backup call schedule for the emergency department providers that warranted a recommendation for improvement.

Adequate staffing during all hours of operation requires an effective backup call process as well. VHA requires that "all emergency department and UCC facilities must have written provider staffing contingency plans that includes a backup call schedule to address situations where expedient mobilization of provider resources are needed."[143] The OIG

[142] The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated.

[143] VHA Directive 1101.05(2).

determined that the emergency department lacked a backup call schedule, which could potentially impact the facility's ability to provide uninterrupted and timely patient care. The emergency department director confirmed that there was no backup call schedule and stated that the staff knew to contact the emergency department director if staff support was needed in the emergency department.

Recommendation 24

24. The chief of staff ensures that a backup call schedule is maintained for emergency department providers and monitors the department's compliance.

Facility concurred.

Target date for completion: 4/31/2020

Facility response: The chief of staff, and emergency department director, ensure the backup call schedule is maintained for the emergency department (ED). The ED director ensures a complete on-call list is posted monthly on Amion (on call physician scheduling software). Compliance monitored by review of a complete monthly backup call schedule on Amion for the ED for six consecutive months for 90% compliance.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• Managers consistently implement improvement actions recommended from peer review activities.	• Final peer reviews are completed within 120 calendar days from the determination of the need for the review or there is an extension approved in writing by the director. • A summary of the Peer Review Subcommittee's work is reviewed quarterly by the executive level medical committee. • All required representatives consistently participate in interdisciplinary reviews of utilization management data.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• Professional practice evaluations are completed by a provider with similar training and privileges.	• Service chiefs define and communicate expectations for FPPE criteria in advance and maintain appropriate documentation of the processes.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	• Parent facility ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Community based outpatient clinic ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Locked inpatient mental health unit ○ Mental health environment of care rounds ○ Nursing station security ○ Public area and general unit safety ○ Patient room safety ○ Infection prevention ○ Availability of medical equipment and supplies • Emergency management ○ Hazard vulnerability analysis (HVA) ○ Emergency operations plan (EOP) ○ Emergency power testing and availability	• None	• A clean and safe environment is maintained throughout the facility. • The facility maintains an inventory of assets and resources available in the event of a disaster and is reviewed annually. • The facility's emergency operations plan includes all required elements and is reviewed annually.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• None	• The controlled substances coordinator submits monthly summary of findings and quarterly trends, that include discrepancies and vulnerabilities, to the director. • Appropriate quality management committee reviews controlled substances monthly and quarterly reports at least on a quarterly basis. • The controlled substances coordinator conducts required annual competency assessments of the controlled substances inspectors. • Controlled substances inspectors complete monthly physical inventories of controlled substances in storage areas on the day initiated. • Reconciliation of one day dispensing from pharmacy to every automated dispensing cabinet and one day return of stock to pharmacy from every automated dispensing cabinet is performed during monthly controlled substances area inspections. • Controlled substances inspectors and coordinator carry out all required responsibilities for the verification of

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
			controlled substances orders during monthly area inspections. • Controlled substances inspectors verify, during monthly inspections, there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number listed on the "Destructions File Holding Report." • Controlled substances inspectors complete verification of prescription pad inventories count during monthly pharmacy inspections. • Controlled substances inspectors verify evidence of written signature for non-electronic controlled substances prescriptions during monthly area inspections. • Controlled substances inspectors complete the verification of the 72-hour inventory.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers	• None	• Providers complete military sexual trauma mandatory training within the required time frame.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Geriatric Care: Antidepressant Use among the Elderly	• Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation	• None	• None
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data • Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated	• Staff implement a process to track follow-up on findings from cervical cancer screenings. • Ordering providers communicate abnormal results to patients within the required time frame.	• Women Veterans Health Committee meets quarterly and is comprised of required core members.
High-Risk Processes: Operations and Management of Emergency Departments and UCCs	• General • Staffing for emergency department/UCC • Support services for emergency department/UCC • Patient flow • General safety • Medication security and labeling • Management of patients with mental health disorders	• None	• A backup call schedule is maintained for emergency department providers.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• Emergency department participation in local/regional EMS system • Women veteran services • Life support equipment		

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this high complexity (1a) affiliated[144] facility reporting to VISN 7.[145]

Table B.1. Facility Profile for Charlie Norwood VA Medical Center (509) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[146]	Facility Data FY 2017[147]	Facility Data FY 2018[148]
Total medical care budget dollars	$420,079,534	$467,246,111	$450,446,899
Number of:			
• Unique patients	44,026	45,040	45,949
• Outpatient visits	531,180	554,682	592,919
• Unique Employees[149]	2,124	2,124	2,076
Type and number of operating beds:			
• Blind rehabilitation	15	15	15
• Community living center	132	132	132
• Domiciliary	60	60	60
• Medicine	58	58	58
• Mental health	34	34	34
• Rehabilitation medicine	40	10	10
• Spinal cord injury	71	71	71
• Surgery	37	27	27

[144] Associated with a medical residency program.

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

[146] October 1, 2015, through September 30, 2016.

[147] October 1, 2016, through September 30, 2017.

[148] October 1, 2017, through September 30, 2018.

[149] Unique employees involved in direct medical care (cost center 8200).

Profile Element	Facility Data FY 2016[146]	Facility Data FY 2017[147]	Facility Data FY 2018[148]
Average daily census:			
• Blind rehabilitation	9	9	11
• Community living center	77	87	86
• Domiciliary	45	49	52
• Medicine	48	50	49
• Mental Health	13	17	16
• Rehabilitation medicine	8	8	8
• Spinal cord injury	48	47	43
• Surgery	11	10	9

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

VA Outpatient Clinic Profiles[150]

The VA outpatient clinics in communities within the catchment area of the facility provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table B.2. provides information relative to each of the clinics.

Table B.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)[151]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[152] Provided	Diagnostic Services[153] Provided	Ancillary Services[154] Provided
Athens, GA	509GA	10,890	7,790	Dermatology Endocrinology	EKG	Nutrition Pharmacy Social work Weight management
Aiken, SC	509GB	9,887	3,574	Dermatology Endocrinology	EKG	Pharmacy Social work Weight management

[150] Includes all outpatient clinics in the community that were in operation as of August 15, 2018.

[151] The definition of an "encounter" can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015 and has not been updated.) An encounter is a "professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

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

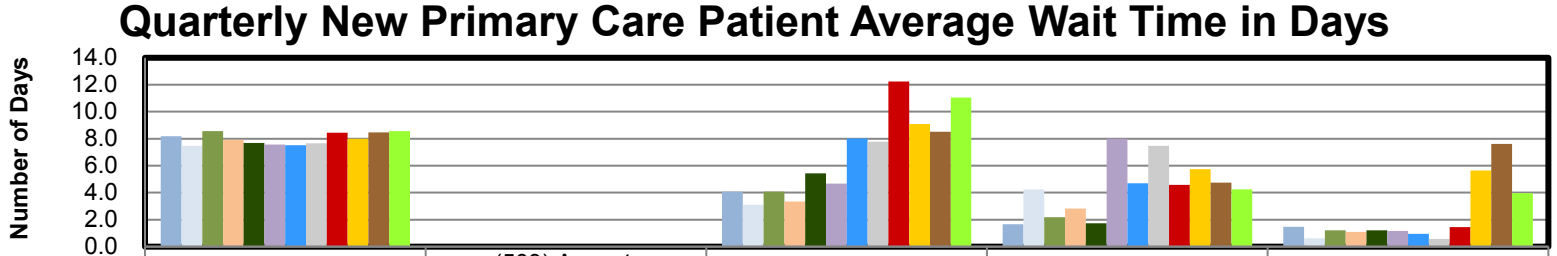
[153] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[152] Provided	Diagnostic Services[153] Provided	Ancillary Services[154] Provided
Statesboro, GA	509QA	4,444	1,251	n/a	n/a	Pharmacy Social work

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

Appendix C: Patient Aligned Care Team Compass Metrics[155]

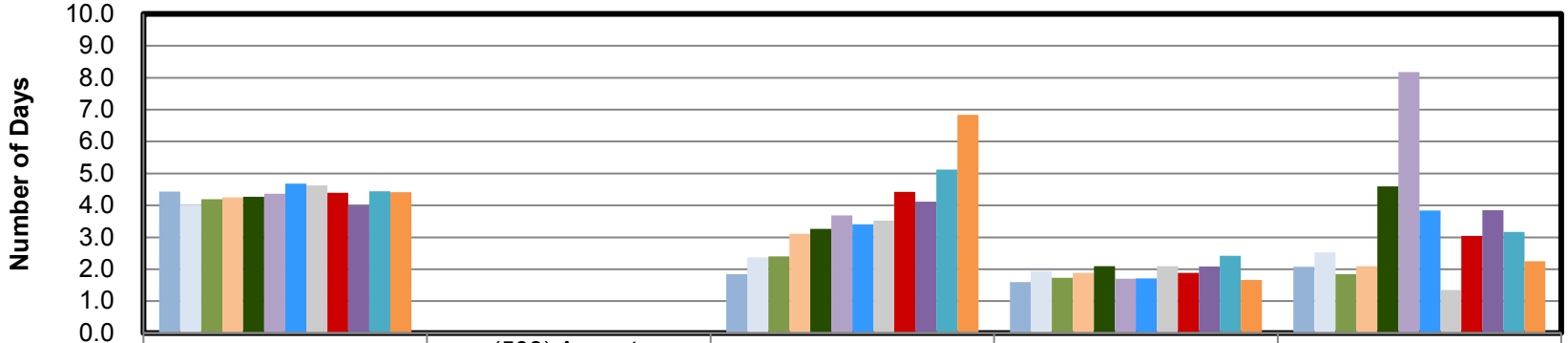


	VHA Total	(509) Augusta Downtown, GA (Charlie Norwood)	(509GA) Athens, GA	(509GB) Aiken, SC	(509QA) Statesboro, GA
JAN-FY18	8.2	n/a	4.1	1.7	1.5
FEB-FY18	7.5	n/a	3.1	4.3	0.6
MAR-FY18	8.6	n/a	4.1	2.2	1.2
APR-FY18	7.9	n/a	3.4	2.8	1.1
MAY-FY18	7.7	n/a	5.4	1.7	1.2
JUN-FY18	7.6	n/a	4.7	8.0	1.2
JUL-FY18	7.5	n/a	8.0	4.7	0.9
AUG-FY18	7.7	n/a	7.8	7.5	0.6
SEP-FY18	8.5	n/a	12.2	4.6	1.5
OCT-FY19	8.0	0.0	9.1	5.7	5.7
NOV-FY19	8.5	0.0	8.5	4.8	7.6
DEC-FY19	8.6	0.0	11.0	4.2	4.0

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
Data Definition: "The average number of calendar days between a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Note that prior to FY15, this metric was calculated using the earliest possible create date. The absence of reported data is indicated by "n/a."

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

Quarterly Established Primary Care Patient Average Wait Time in Days



	VHA Total	(509) Augusta Downtown, GA (Charlie Norwood)	(509GA) Athens, GA	(509GB) Aiken, SC	(509QA) Statesboro, GA
JAN-FY18	4.4	n/a	1.8	1.6	2.1
FEB-FY18	4.0	n/a	2.4	1.9	2.5
MAR-FY18	4.2	n/a	2.4	1.7	1.9
APR-FY18	4.3	n/a	3.1	1.9	2.1
MAY-FY18	4.3	n/a	3.3	2.1	4.6
JUN-FY18	4.4	n/a	3.7	1.7	8.2
JUL-FY18	4.7	n/a	3.4	1.7	3.8
AUG-FY18	4.6	n/a	3.5	2.1	1.3
SEP-FY18	4.4	n/a	4.4	1.9	3.0
OCT-FY19	4.0	0.0	4.1	2.1	3.8
NOV-FY19	4.4	0.0	5.1	2.4	3.2
DEC-FY19	4.4	0.0	6.8	1.7	2.2

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." The absence of reported data is indicated by "n/a."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[156]

Measure	Definition	Desired Direction
ACSC hospitalization	Ambulatory care sensitive conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit reviews met	Percent acute admission reviews that meet interqual criteria	A higher value is better than a lower value
APP capacity	Advanced practice provider capacity	A lower value is better than a higher value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Care transition	Care transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont stay reviews met	Percent acute continued stay reviews that meet interqual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/capacity	Efficiency and physician capacity	A higher value is better than a lower value
Employee satisfaction	Overall satisfaction with job	A higher value is better than a lower value

[156] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019 but is not accessible by the public.)

Measure	Definition	Desired Direction
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS like – HED90_1	HEDIS-EPRP based PRV TOB BHS	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS-eOM based DM IHD	A higher value is better than a lower value
MH wait time	Mental health care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	ORYX	A higher value is better than a lower value
PC routine care appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC urgent care appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
Physician capacity	Physician capacity	A lower value is better than a higher value
PC wait time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value

Measure	Definition	Desired Direction
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value

Measure	Definition	Desired Direction
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC routine care appt	Timeliness in getting a SC routine care appointment (specialty care)	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SC urgent care appt	Timeliness in getting a SC urgent care appointment (specialty care)	A higher value is better than a lower value
Seconds pick up calls	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty care wait time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value
Telephone abandonment rate	Telephone abandonment rate	A lower value is better than a higher value

Source: VHA Support Service Center

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions[157]

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

[157] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on March 6, 2019, but is not accessible by the public.)

Appendix F: Acting VISN Director Comments

Department of Veterans Affairs Memorandum

Date: October 30, 2019

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

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

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

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

1. I have had the opportunity to review the Draft Report: Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center, Augusta, GA.
2. VISN 7 submits concurrence to recommendations 1- 24 and the Charlie Norwood VA Medical Center submission.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(Original signed by:)

Scott R. Isaacks, FACHE

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

Appendix G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 30, 2019

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

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

To: Director, VA Southeast Network (10N7)

1. In response to the VA Office of Inspector General (OIG) Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center, Augusta, Georgia, we concur with the recommendations.

2. Augusta VA Medical Center submits the status update providing justification and documentation to recommendation numbers 1 through 24. I concur with Augusta VA Medical Centers action plan and ongoing implementation for recommendations 1 through 24 and request for closure of recommendations 3 and 11.

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

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

(Original signed by:)

Robin E. Jackson, PhD

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

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