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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital

Bedford, Massachusetts

CHIP REPORT | REPORT #19-00043-66 | JANUARY 13, 2020

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Figure 1. *Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts (Source: https://vaww.va.gov/directory/guide/, accessed on August 27, 2019)*

Abbreviations

ADNPCS	associate director for Nursing and Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
FPPE	focused professional practice evaluation
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 Edith Nourse Rogers Memorial Veterans Hospital (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 inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus each year.

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

1. Quality, safety, and value;
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 June 3, 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, associate director for Nursing and Patient Care Services (ADNPCS), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure with the Executive Board having oversight of the Medical Executive Board, Administrative Executive Board, and Integrated Ethics Council. The facility did not have a formal standing committee responsible for ensuring key quality, safety, and value functions, including tracking, identifying trends in, and monitoring quality of care and patient outcomes. However, the facility is in the process of establishing a revised governance structure that will include a Quality, Safety, and Value (QSV) Committee, which will report to the Executive Board.

The facility's leadership team had been working together for nearly 15 months. The director, chief of staff, ADNPCS, and associate director were permanently assigned in March 2018, October 2016, November 2014, and May 2015, respectively.

The OIG noted that selected employee satisfaction survey results indicated that employees appear generally satisfied with facility leaders but opportunities also appear to exist for the facility's leadership team to improve workplace attitudes by providing an environment where employees feel safe bringing forth concerns and are encouraged to do the right thing. The patient experience survey scores applicable to the facility demonstrated that patients were generally satisfied with the leadership and care provided.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[1] disclosures of adverse patient events, and patient safety indicator data and did not identify any substantial organizational risk factors.

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

[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.)

team members were knowledgeable within their areas of responsibility about selected SAIL metrics and SAIL community living center (CLC) measures, the leaders should continue to take actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "5-star" and SAIL CLC "2-star" quality ratings.[3]

The OIG noted deficiencies in seven of the eight clinical areas reviewed and issued 21 recommendations that are attributable to the director, chief of staff, and associate director. These are briefly described below.

Quality, Safety, and Value

The OIG found there was general compliance with requirements for protected peer and resuscitation episode reviews. However, the OIG identified noncompliance with interdisciplinary review of utilization management (UM) data,[4] annual completion of a minimum of eight root cause analyses, and timely submission of root cause analyses to the National Center for Patient Safety.

Medical Staff Privileging

The facility generally complied with requirements for privileging. However, the OIG identified concerns with focused and ongoing professional practice evaluations and focused professional practice evaluation for cause processes.[5]

Environment of Care

Generally, the OIG found performance indicators were achieved for the Lynn VA Clinic and did not note any issues with the availability of medical equipment and supplies at the parent facility. However, the OIG identified noncompliance with safety and cleanliness at the facility, general safety in the locked inpatient mental health unit, and emergency management.

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

[4] According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." This directive expired July 31, 2019.

[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."

Mental Health

The OIG also found that the facility complied with many of the mental health performance indicators, including the designation of a military sexual trauma (MST) coordinator, tracking of MST-related data, and provision of clinical care. The OIG noted a concern, however, with providers completing mandatory MST training.

Geriatric Care

For geriatric patients, the OIG identified deficiencies with clinicians' documentation of reasons for prescribing medications, patient and/or caregiver education related to newly prescribed medication, evaluation of patient/caregiver understanding when education was provided, and medication reconciliation processes.

Women's Health

The OIG also noted the facility performed adequately on indicators related to women's health, including requirements for a designated women veterans program manager, clinical oversight of the women's health program, tracking data related to cervical cancer screenings, communication of results to patients within the required time frame, and follow-up care when indicated. However, the Women Veterans Health Committee membership lacked representation from laboratory, medical and/or surgical subspecialties, and gynecology services.

High-Risk Processes

The OIG inspection revealed that the facility complied with some of the performance indicators used to assess the high-risk processes of Urgent Care Center (UCC) operations and management. However, the OIG identified that the UCC was operating continuously without a waiver and a lack of (1) an appointed UCC medical director, (2) UCC staffing by two registered nurses at all times, and (3) laboratory and pharmacy support services that warranted recommendations for improvement.

Summary

In reviewing key healthcare processes, the OIG issued 21 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 Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 72–73, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendation 19 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 Edith Nourse Rogers Memorial Veterans Hospital (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 (UCC) operations and management).[8]

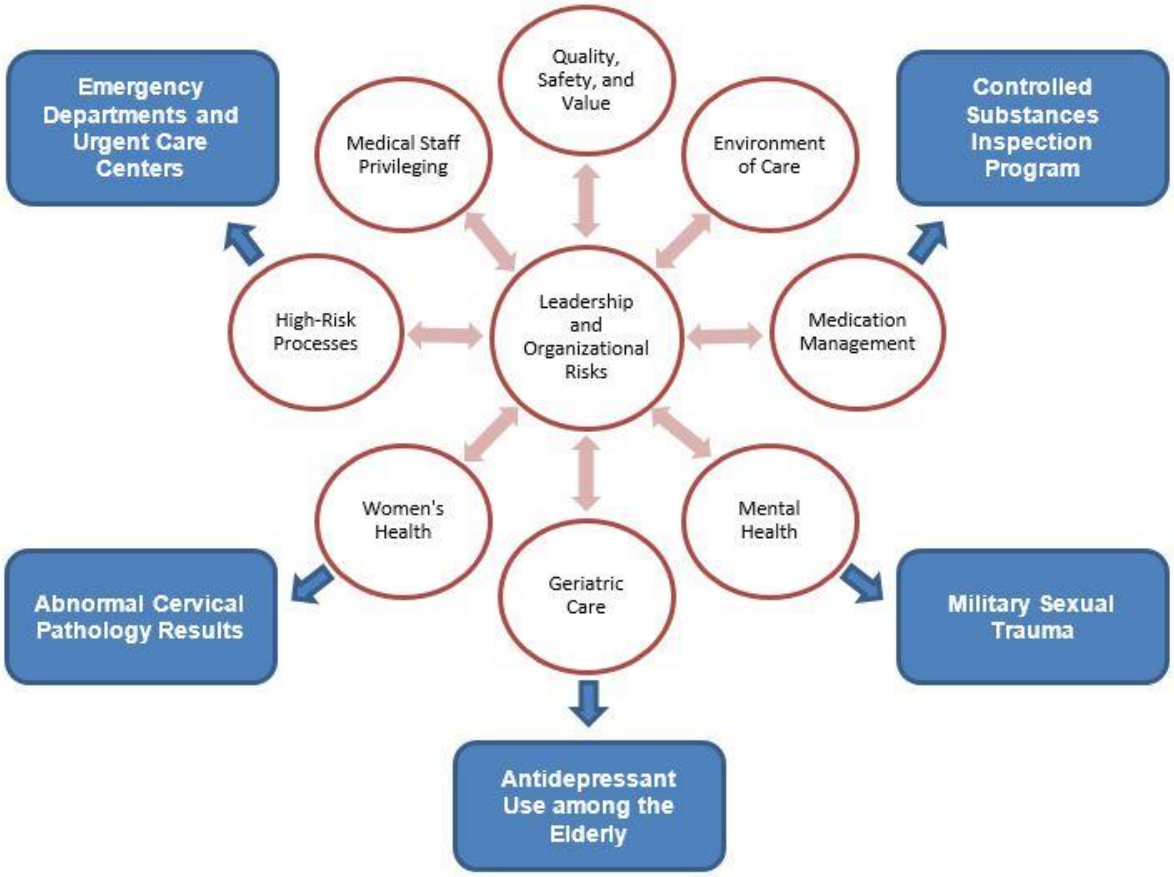

Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

[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 May 9, 2015, through June 6, 2019, the last day of the unannounced site visit.[10] While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the 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 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 Nursing and Patient Care Services (ADNPCS), and associate director (primarily nonclinical). The chief of staff and ADNPCS 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.)

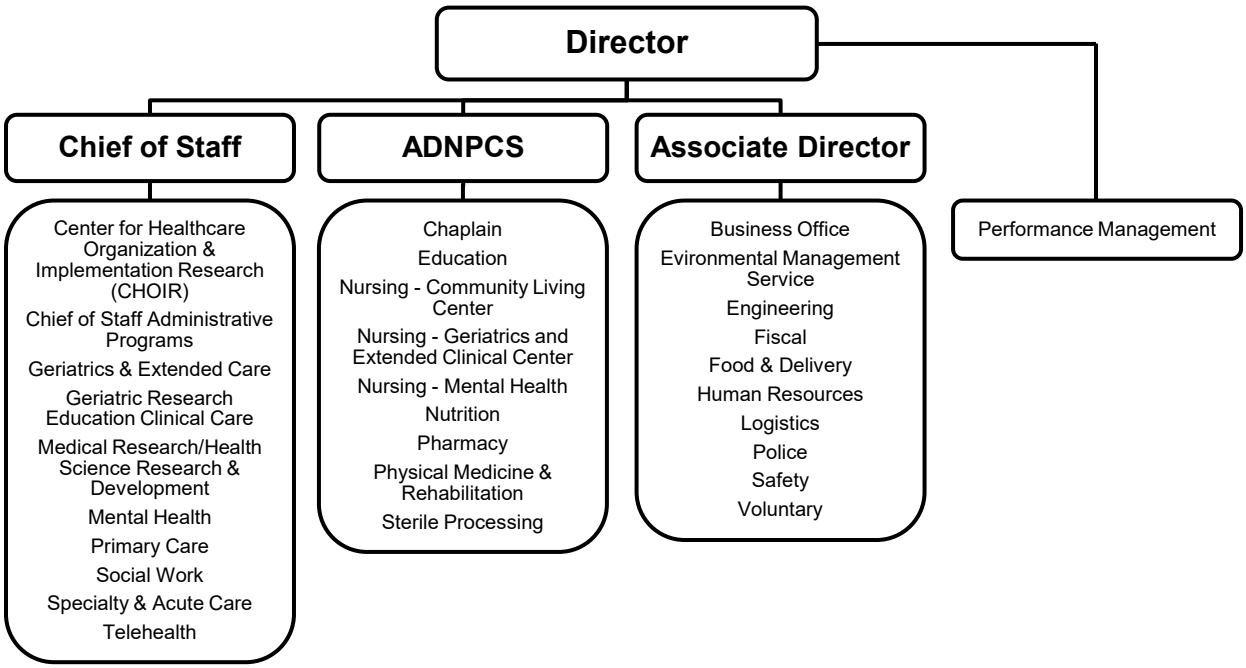

Figure 3. *Facility Organizational Chart*[12]
Source: Edith Nourse Rogers Memorial Veterans Hospital (*received June 4, 2019*)

At the time of the OIG site visit, the permanently assigned executive team had been working together for almost 15 months, however several team members had been in their position for many years (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	March 18, 2018
Chief of staff	October 2, 2016
Associate director for Nursing and Patient Care Services	November 2, 2014
Associate director	May 3, 2015

Source: Edith Nourse Rogers Memorial Veterans Hospital human resources officer (received June 4, 2019)

To help assess facility executive leaders' engagement, the OIG interviewed the director, chief of staff, ADNPCS, and associate 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

[12] At this facility, the medical center director is responsible for Performance Management.

leaders were generally knowledgeable within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL community living center (CLC) measures. These are discussed in greater detail below.

The facility's Executive Board oversees the Medical Executive Board, Administrative Executive Board, and Integrated Ethics Council. See Figure 4.[13]

The facility did not have a formal standing committee responsible for ensuring key quality, safety, and value functions, including tracking, identifying trends in, and monitoring quality of care and patient outcomes. The Executive Board, chaired by the facility director, did not provide documentation in meeting minutes that an executive-level quality group monitored patient safety or quality of care data and information. The Executive Board agendas contained links to reports from the Medical and Administrative Executive Boards; however, there was no documentation in the meeting minutes that the reports were reviewed or discussed. The facility director stated that the "reason for not establishing a standing committee under the Executive Board and for not ensuring aggregated data was that the mechanism for ensuring that Quality and Safety activities were effectively deployed, monitored and maintained and in full compliance with VHA standards, regulations, and policies was…[that key staff] directly report these to the Executive Board. Because this has not effectively resulted in the appropriate level of analysis and review needed, the facility is in the process of establishing a revised governance structure which will include a Quality, Safety, and Value (QSV) Committee which will report to the Executive Board. A newly formed safety committee will report to QSV."

[13] The OIG received a supplemental committee reporting structure on December 19, 2019. See Appendix F.

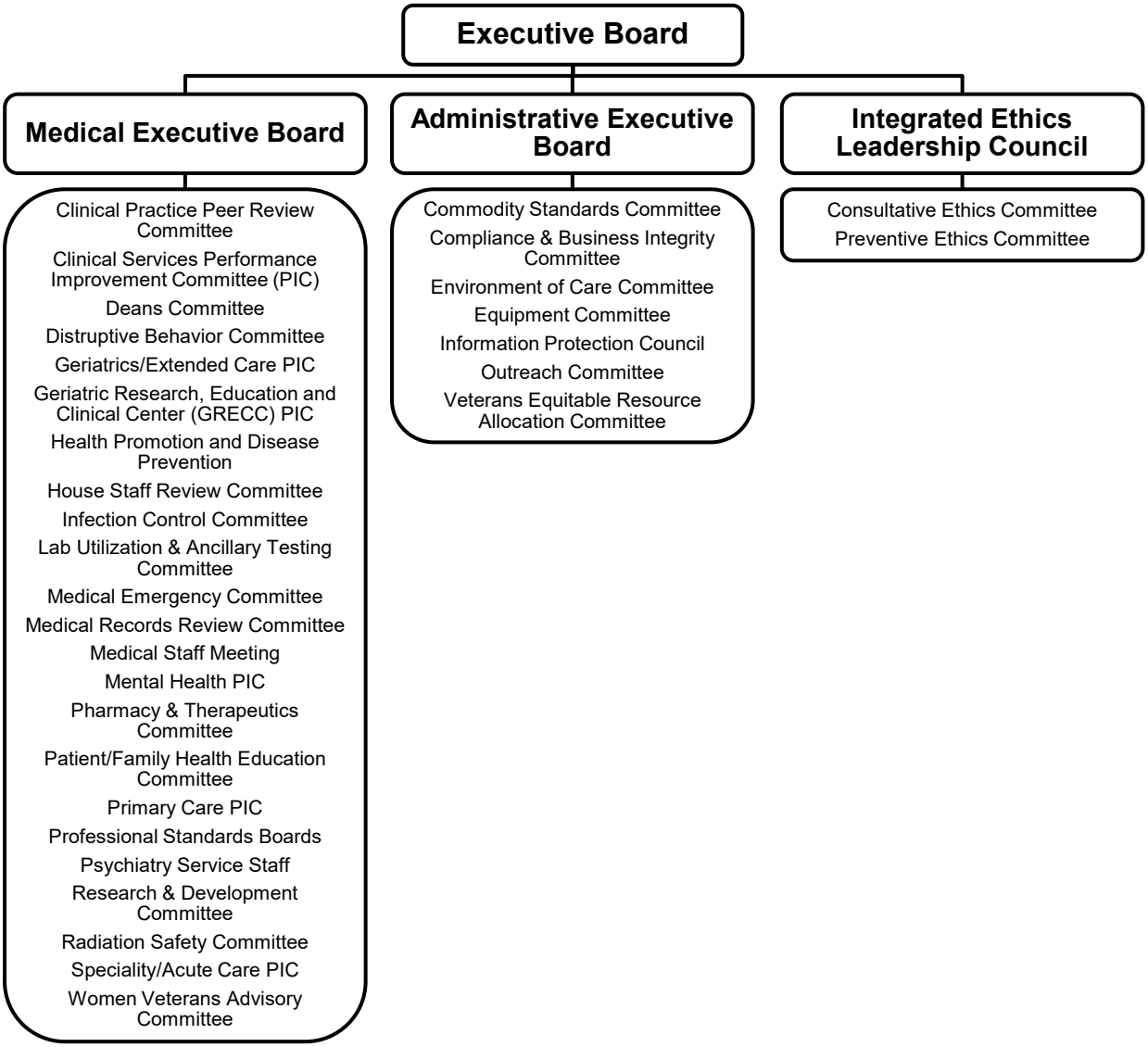

Figure 4. *Facility Committee Reporting Structure*
Source: Edith Nourse Rogers Memorial Veterans Hospital (received June 3, 2019)

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, 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 generally similar to the VHA average.[15] However, the director, chief of staff, and associate director scored higher than the VHA and facility averages, while the ADNPCS scores were similar to or lower than the VHA and facility averages. In all, employees appear generally satisfied with facility leaders.

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	ADNPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[16]	0–100 where HIGHER scores are more favorable	71.7	70.1	83.5	72.7	63.5	87.5
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	3.3	3.9	3.5	3.2	3.6

[14] Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADNPCS, and associate director.

[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] 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	ADNPCS Average	Assoc. 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	3.5	3.7	3.7	3.3	4.0
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.6	4.0	3.8	3.6	4.3

Source: VA All Employee Survey (accessed May 2, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that facility averages for selected questions were similar to the VHA average. Additionally, the director and associate director averages for the selected survey questions were better than the VHA average. The ADNPCS and chief of staff scored lower than the VHA average for these selected questions. Opportunities appear to exist for the facility's leadership team to improve workplace attitudes by providing an environment where employees feel safe bringing forth concerns and are encouraged to do the right thing.

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	ADNPCS Average	Assoc. 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	3.7	4.5	3.5	3.5	4.5

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADNPCS Average	Assoc. 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	3.6	4.5	3.6	3.4	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	1.3	1.8	2.1	0.4

Source: VA All Employee Survey (*accessed May 2, 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.[17]

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

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

attitudes toward facility leaders (see Table 4). Both outpatient survey results applicable to this facility reflected better care ratings than the VHA average. Patients were generally satisfied with the leadership and care provided.

Table 4. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)[18]

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	n/a
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	n/a
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	84.1
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	84.9

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

[18] The facility does not have inpatient beds.

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.[19] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[20] Indicative of effective leadership, the facility has closed all recommendations for improvement.[21]

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.[22] Additional results included the Long Term Care Institute's inspection of the facility's CLC in December 2018; at the time of the OIG visit, 9 of 15 findings were closed.[23] The ADNPCS reported development of an action plan to address the LTCI findings and stated "there is a wait time between receiving the report, developing action plans, having them approved by the VISN and Central Office, and then waiting for them [VISN and Central Office] to agree to 'close' items."

[19] 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.

[20] 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."

[21] 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.

[22] 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.

[23] 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.)

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 Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts, Report No. 15-00598-446, July 22, 2015*)	May 2015	13	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts, Report No. 15-00138-392, July 13, 2015*)	May 2015	7	0
TJC Hospital Accreditation	June 2018	28	0
TJC Behavioral Health Care Accreditation		9	0
TJC Home Care Accreditation		9	0

Sources: OIG and TJC (*Inspection/survey results verified with the risk manager on June 4, 2019*)

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. Table 6 lists the reported patient safety events from May 9, 2015 (the prior comprehensive OIG inspection), through June 6, 2019.[24]

[24] 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 Edith Nourse Rogers Memorial Veterans Hospital is a low complexity (3) affiliated facility as described in Appendix B.)

Table 6. Summary of Selected Organizational Risk Factors (May 9, 2015, through June 6, 2019)

Factor	Number of Occurrences
Sentinel Events[25]	0
Institutional Disclosures[26]	5
Large-Scale Disclosures[27]	0

Source: Edith Nourse Rogers Memorial Veterans Hospital's risk manager, (received June 4, 2019)

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.[28]

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.[29] As of June 30, 2018, the facility was rated as "5-star" for overall quality.

[25] 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."

[26] 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."

[27] 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."

[28] 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.)

[29] 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.

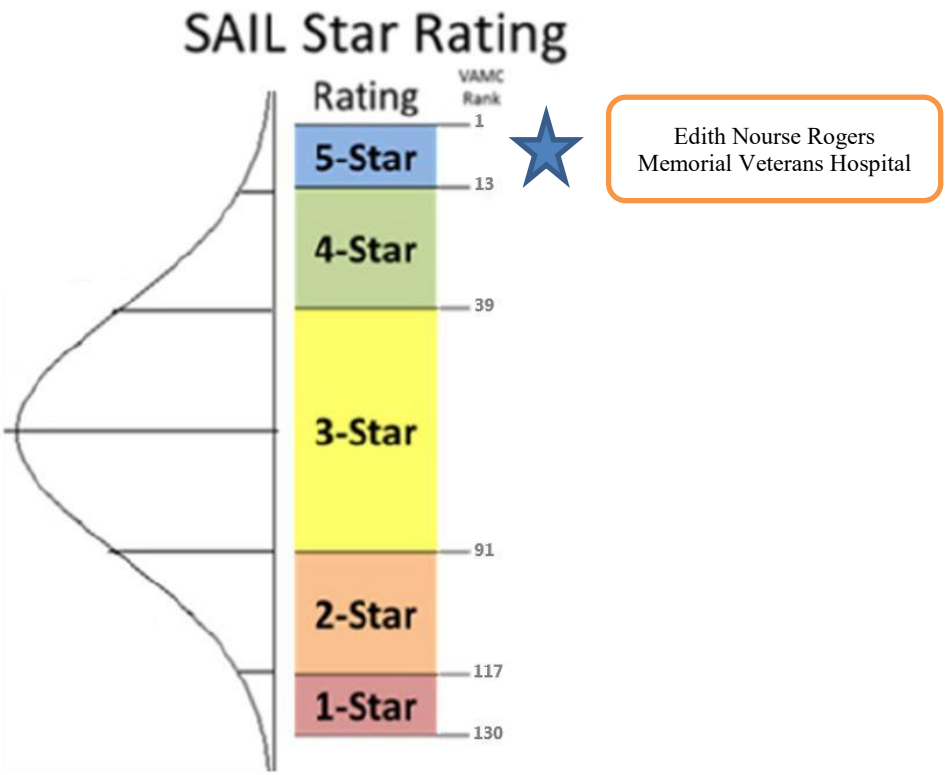

Figure 5. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed May 2, 2019)

Figure 6 illustrates the facility's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of mental health (MH) population (popu) coverage, rating (of) primary care (PC) provider, mental health (MH) continuity (of) care, and stress discussed). Metrics that need improvement are denoted in orange and red (for example, best place to work, registered nurse (RN) turnover, and physician capacity).[30]

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

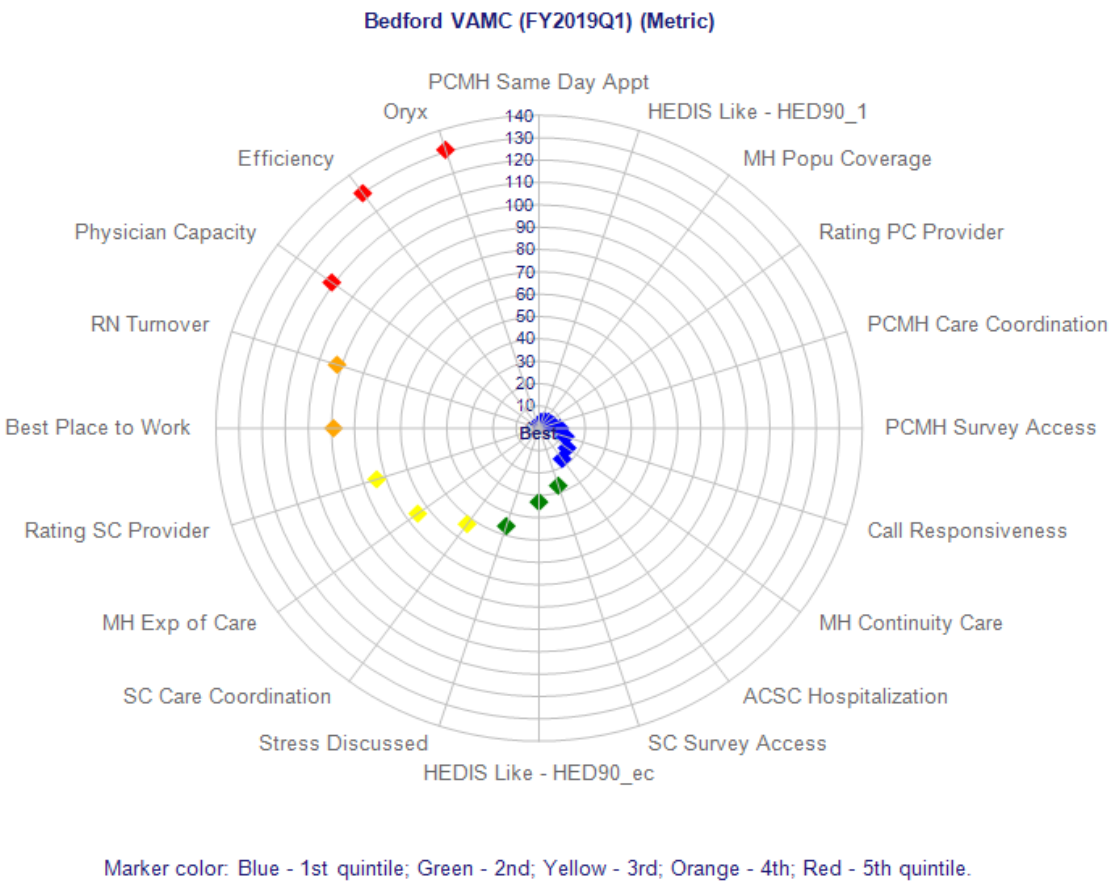

Figure 6. *Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

The SAIL Value Model also includes "SAIL CLC," which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in The Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare*.[31] The SAIL CLC provides a single resource to review quality measures and health inspection results. It

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

includes star ratings for an unannounced survey, staffing, quality, and overall results.[32] Table 7 summarizes the rating results for the facility's CLC as of December 31, 2018. The facility has an overall "2-star" rating and its rating for quality is also a "2-star."

Table 7. Facility CLC Star Ratings (as of December 31, 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 7 illustrates the facility's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of moderate-severe pain–long stay (LS), moderate-severe pain–short stay (SS), and new or worse pressure ulcer (PU)). 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, ability to move independently worsened (LS), urinary tract infection (UTI) (LS), and newly received antipsychotic medications (antipsych meds) (SS)).[33]

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

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

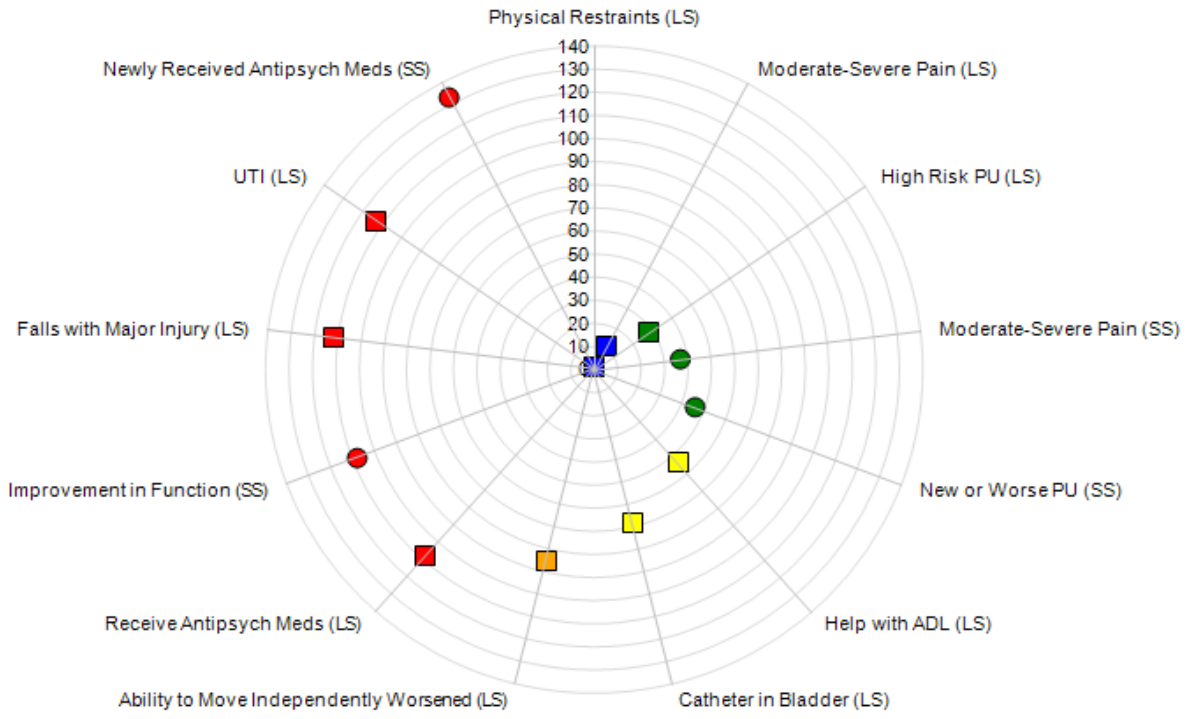

Figure 7. *Facility CLC Quality Measure Rankings (as of December 31, 2018)*
LS = Long-Stay Measure *SS = Short-Stay Measure*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

Although the facility's executive leadership team was stable, with tenure ranging from about 15 months to several years, the OIG noted opportunities to improve employee satisfaction and to promote and foster an environment where employees feel safe bringing forward issues and concerns. Survey data on outpatient experiences revealed above-average patient satisfaction scores, suggesting that patients are generally satisfied with the care received at the facility. The OIG is concerned that there was no standing committee responsible for ensuring key quality, safety, and value functions and that the Executive Board meeting minutes did not show evidence that quality data was reviewed, discussed, analyzed, or integrated on a regular basis. The OIG's review of the facility's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and SAIL CLC metrics but should continue to take actions to sustain and improve performance of measures contributing to the facility "5-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.[34] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[35] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[36]

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,[37] utilization management (UM) reviews,[38] patient safety incident reporting with related root cause analyses,[39] and cardiopulmonary resuscitation (CPR) episode reviews.[40]

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 nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[41]

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[34] 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.)

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

[36] VHA Directive 1026.

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

[38] According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." This directive expired July 31, 2019.

[39] 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."

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

[41] VHA Directive 1190.

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.[42]

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.[43]

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.[44]

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:[45]

- 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
  - Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee

[42] VHA Directive 1117(2).

[43] VHA Handbook 1050.01.

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

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

  - 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[46]
- UM[47]
  - 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[48]
  - 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

Quality, Safety, Value Conclusion

The facility generally complied with requirements for protected peer and resuscitation episode reviews. However, the OIG identified concerns with the facility's interdisciplinary review of UM

[46] VHA Directive 1190.

[47] The facility does not provide inpatient care.

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

data, annual completion of a minimum of eight root cause analyses, and submission of completed root cause analyses to the National Center for Patient Safety within 45 days.

Specifically, VHA requires that "UM data are reviewed on an ongoing basis by an interdisciplinary group, including but not limited to representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR [chief Business Office revenue-utilization review]."[49] The OIG reviewed UM performance data and committee minutes from June 1, 2018, through February 28, 2019, and found that the facility's interdisciplinary group responsible for reviewing UM data lacked the required representation from nursing, medicine, case management, and the chief Business Office revenue-utilization review. As a result, the group conducted reviews and analyses of UM performance data without adequate interdisciplinary perspectives. The director of Performance Management indicated that there was a lack of oversight of UM.

Recommendation 1

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

Facility concurred.

Target date for completion: September 2020

Facility response: The Utilization Management/Flow Committee was established and held its first meeting on September 12, 2019. This committee, co-chaired by the Director of Performance Management and Utilization Management Coordinator meets monthly to review utilization management data, monitors and patient flow information with interdisciplinary membership as required by the Veteran Health Administration Directive 1117(2). To ensure ongoing compliance, the Director of Performance Management will provide minutes tracking monthly attendance of Utilization Management/Flow Committee to the Quality Safety and Value Committee to assure > 90% of required members are in attendance for 6 months. The Quality, Safety, Value Committee will, in turn, report this data to the Executive Board, chaired by the Medical Center Director, each month.

VHA states the "facility director is responsible for…ensuring a minimum of eight patient safety analysis processes, i.e., RCAs [root cause analyses] and Aggregated Reviews, are completed each fiscal year."[50] The OIG found the facility did not complete six of eight required root cause analysis reviews from October 1, 2017, through September 30, 2018. Completion of fewer than the required number of patient safety analyses may result in missed opportunities for the facility

[49] VHA Directive 1117(2).
[50] VHA Handbook 1050.01.

to identify contributing factors and implement actions to prevent patient harm events. The patient safety manager reported that staff turnover impacted performance on this measure.

Recommendation 2

2. The facility director ensures that the patient safety manager completes the minimum requirement of eight root cause analyses each year and monitors compliance.

Facility concurred.

Target date for completion: September 2020

Facility response: The Patient Safety Officer established a tracking tool to monitor the volume of root cause analyses completed by month to ensure the minimum target of eight root cause analyses are completed each Fiscal Year. The Patient Safety Officer will report the percent of completed root cause analyses with an interim target completion of 50% of root cause analyses by March 2020. Monitoring and reporting will continue through September 2020 to assure 100% of required root cause analyses are completed by the end of Fiscal Year 2020. Monthly monitoring of progress will be provided by the Patient Safety Officer to the Quality, Safety, Value Committee to ensure ongoing compliance. Minutes of the Quality, Safety, Value Committee will be submitted to the Executive Board each month to ensure the Medical Center Director is kept apprised of progress.

Additionally, VHA requires that root cause analysis be performed timely and "submitted to the [National Center for Patient Safety] within 45 days of the facility becoming aware that [a root cause analysis] is required."[51] The OIG found that two of five root cause analyses were not submitted within 45 days to the National Center for Patient Safety.[52] Late submissions may delay the identification of trends and addressing possible vulnerabilities throughout VHA. The patient safety manager cited staff turnover as a reason for noncompliance.

Recommendation 3

3. The facility director ensures that the patient safety manager submits each root cause analysis to the National Center for Patient Safety within the required time frame and monitors compliance.

[51] VHA Handbook 1050.01.

[52] National Center for Patient Safety (NCPS) is "the Department of Veterans Affairs (VA) National Center for Patient Safety[,]…established to lead the VA's patient safety efforts and to develop and nurture a culture of safety throughout the Veterans Health Administration. The goal is "nationwide reduction and prevention of inadvertent harm to patients as a result of their care." VHA Patient Safety Program. https://vaww.cmopnational.va.gov/CR/ncpsoit/PSM%20Orientation/Getting%20Started/2-%20VHA%20Patient%20Safety%20Program.aspx. (accessed June 24, 2019) (This is an internal website that is not accessible to the public.)

Facility concurred.

Target date for completion: September 2020

Facility response: The Patient Safety Officer established a tracking tool that tracks timeliness of root cause analysis completion within required time frames. The Patient Safety Officer will report results monthly to the Quality, Safety, Value Committee to assure greater than 90% of root cause analyses are reported to the National Center for Patient Safety within the required time frame. Compliance will be monitored for 6 months followed by quarterly reports thereafter to assure compliance is maintained. Minutes of the Quality, Safety, Value Committee will be forwarded to the Medical Center Director each month and reviewed at the Executive Board for compliance oversight.

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).[53]

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.[54]

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 (OPPE), is essential to confirm the quality of care delivered."[55]

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.[56] 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.[57]

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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[53] 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.)

[54] VHA Handbook 1100.19.

[55] VHA Handbook 1100.19.

[56] 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).

[57] 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.)

- Six 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[58]
- Nine LIPs hired within 18 months before the site visit
- Twenty-one LIPs re-privileged within 12 months before the visit
- One provider 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[59]
  - 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's 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

[58] The 18-month period was from December 3, 2017, through June 3, 2019. The 12-month review period covered June 3, 2018, through June 3, 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.

[59] 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 facility generally complied with requirements for privileging. However, the OIG had concerns with FPPE, OPPE, and FPPE for cause processes that warranted recommendations for improvement.

VHA requires that FPPE criteria are "defined in advance, using objective criteria accepted by the practitioner [and] recommended by the Service Chief and Executive Committee of the Medical Staff" (known as the Medical Executive Board).[60] In the nine profiles reviewed, the OIG found that FPPE criteria was not defined in advance. This could result in providers misunderstanding the FPPE expectations. The acting chiefs for Specialty and Acute Care, Geriatric and Extended Care, and chief of Psychiatry reported being unaware of the requirement to document FPPE process discussions during provider orientation.

Recommendation 4

4. The chief of staff ensures that service chiefs clearly define and communicate focused professional practice evaluation criteria in advance with providers and monitors service chiefs' compliance.

[60] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: September 2020

Facility response: The Chief of Staff, in collaboration with the Medical Staff Office, developed a standardized Focused Professional Practice Evaluation initiation memo to be used by all services for the purpose of defining and communicating professional practice evaluation criteria in advance of the review with the respective provider. All new providers and anyone requesting a new privilege will be presented the memo along with specific Focused Professional Practice Evaluation criteria at the time of Focused Professional Practice Evaluation initiation. The memo will be signed and dated by both service chief and the provider upon start date or effective date of privilege granting for existing provider, acknowledging the initiation of the Focused Professional Practice Evaluation and its timeframe, criteria, expectations and triggers. Compliance with this process will be monitored monthly and reported to the Health Care Delivery Committee to ensure achievement of greater than 90% compliance with Service Chief notification to the provider in advance of the initiation of the Focused Professional Practice Evaluation. Monthly reports will be provided to the Health Care Delivery Committee and reported up to the Medical Center Director through the Executive Board each month for 6 months to ensure ongoing compliance.

For OPPEs, VHA states that "each Service Chief must establish additional criteria for granting of clinical privileges within the service consistent with the needs of the service and the facility as well as within the available resources to provide these services."[61] The OIG noted that 19 (including 15 general and 4 solo/few practitioners) of 27 OPPE profiles reviewed did not include service-specific criteria. This resulted in LIPs providing care without thorough evaluations of their competency, which could potentially impact the quality of care and patient safety. Although general evaluation criteria were applied across the services, the acting chief of Specialty and Acute Care and the Psychiatry and Mental Health service chiefs reported that they were unaware of the service-specific requirement.

Recommendation 5

5. The chief of staff ensures that service chiefs include service-specific criteria in ongoing professional practice evaluations and monitors compliance.

[61] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: September 2020

Facility response: Ongoing Professional Practice Evaluation forms for services which have been identified as not having service-specific criteria are currently being rewritten by the respective service chief to ensure that they include service/specialty-specific criteria going forward. All new criteria will be reviewed and approved by the Health Care Delivery Committee prior to implementation. Additionally, all services' Ongoing Professional Practice Evaluation forms will continue to be reviewed annually by the Health Care Delivery Committee to assure continued relevance. The Chief of Staff or designee will audit service specific criteria to assure greater than 90% of ongoing professional practice evaluations include service specific criteria for a period of 6 months. Results will be reported to the Health Care Delivery Committee and forwarded to the Executive Board for Medical Director for oversight.

Additionally, VHA requires that "another provider 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."[62] The OIG noted that in two of six solo practitioners' OPPE profiles reviewed, the 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. The acting chief of Specialty and Acute Care reported difficulty finding similar providers to conduct endocrinology and endodontic reviews.

Recommendation 6

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

Facility concurred.

Target date for completion: September 2020

Facility response: The Chief of Staff initiated a process through the Professional Standards Board to ensure providers who review others for ongoing professional practice evaluations have similar training and privileges that includes use of a checklist to assure requirements for review have been established. The Chief of Staff or designee will audit ongoing professional practice evaluation forms for completion of this requirement to achieve greater than 90% compliance for 6 months. Results of the audit will be reported to the Health Care Delivery Committee for oversight an ongoing compliance monitoring.

[62] VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

VHA requires FPPEs for cause to be time-limited and have clearly defined expectations and outcomes that are accepted by the provider in advance of the evaluation.[63] In one applicable profile reviewed, the OIG found that expectations were not clearly defined, time limited, or shared with the provider in advance. Failure to clearly define expectations can hinder the evaluation of the provider. The acting chief of Specialty and Acute Care reported verbal communications with the provider in advance but did not document the conversation.

Recommendation 7

7. The chief of staff ensures that service chiefs clearly define, share, and document in advance the expectations and outcomes for time-limited focused professional practice evaluations for cause with providers and monitors service chiefs' compliance.

Facility concurred.

Target date for completion: September 2020

Facility response: The Chief of Staff and Medical Staff Office developed a standardized Focused Professional Practice Evaluation for cause initiation memo to be used by all services that clearly defines and documents advanced notification of expectations and outcomes for time-limited focused professional practice evaluations for cause. Each Service Chief will present the memo along with specific Focused Professional Practice Evaluation criteria when a provider is placed on a Focused Professional Practice Evaluation for cause. The memo will be signed and dated by both service chief and provider acknowledging the initiation of the Focused Professional Practice Evaluation and its criteria, timeframe and expectations. Monitoring of completion will be conducted by the Chief of Staff or designee to ensure achievement 90% or greater compliance advanced communication of expectations and outcomes for six consecutive months. Results will be reported to the Health Care Delivery Committee to ensure continued compliance and oversight.

[63] Office of Quality and Performance, July 2016 (Revision 2).

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.[64]

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.[65]

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.[66]

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.[67] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[68]

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

[65] 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).

[66] 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.)

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

[68] 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,[69] and National Fire Protection Association standards.[70] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[71]

In all, the OIG team inspected eight areas—community living centers (buildings 4 and 62), the acute and chronic mental health units, women's health clinic, urgent care center, and primary care areas A and B. The team also inspected the Lynn 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
  - Nursing station security
  - Public area and general unit safety[72]

[69] 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.)

[70] 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.)

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

[72] VHA Directive 1028.

  - 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 found general compliance with the performance indicators for the Lynn VA Clinic and did not note any issues with the availability of medical equipment and supplies. However, the OIG identified deficiencies in the CLC, the inpatient mental health unit, and emergency management that warranted recommendations for improvement.

Specifically, TJC requires that the hospital establishes and maintains a safe, suitable environment and that areas used by patients are clean.[73] In CLC building 4, the OIG found stained, cracked, and chipped floor tiles; stained ceiling tiles; and missing window screens. The establishment and maintenance of a safe and functional clinical environment influences patient outcomes and promotes patient safety. The associate director cited that chronic staffing problems impacted the frequency of cleaning. The chief of engineering noted that age and weather damage caused the screens in many locations throughout the CLC facility to become unserviceable.

Recommendation 8

8. The associate director ensures that floors and ceilings tiles are repaired, cleaned, and maintained and window screens are replaced and monitors compliance.

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

Facility concurred.

Target date for completion: September 2020

Facility response: The Associate Director will ensure weekly environment of care rounds are conducted throughout the facility with attention to condition of floors, ceiling tiles and window screens for each location inspected. Action plans to address findings will be established to ensure greater than 90% of each finding has an associated action plan in place within 14 days of discovery. This will be monitored by the Environment of Care Committee for 6 months to ensure continued compliance. The Chief of Environmental Management Service will report results monthly to the Environment of Care Committee as well as to the Health Care Operations [Committee] which is chaired by the Associate Director, to ensure ongoing compliance and oversight.

Additionally, TJC requires that hospitals implement infection prevention and control activities when storing medical equipment, devices, and supplies.[74] The OIG team found expired medical supplies stored in the inpatient chronic mental health unit supply room. Use of expired medical supplies may pose risks for those seeking healthcare services. The nurse manager reported the expiration dates were overlooked because the supplies were seldomly used.

Recommendation 9

9. The associate director ensures expired medical supplies are removed from supply rooms and monitors compliance.

Facility concurred.

Target date for completion: September 2020

Facility response: The Chief of Logistics service ensures daily rounds and checks for outdated medical supplies are conducted each weekday. Using the "First In First Out" method, Logistics staff will ensure products are utilized prior to expiration with daily visual inspection and rapid removal of damaged product. The Chief of Logistics will report monthly compliance with daily rounds to ensure expired medical supplies are removed to the Environment of Care Committee to assure greater than 90% of daily inspections occur for 6 months. Results will be shared monthly with the Health Care Operations Committee which is chaired by the Associate Director, by the Chief of Logistics to assure ongoing compliance and oversight.

VHA requires that VA police periodically test and document response time to panic alarm testing in locked mental health units.[75] The OIG found no evidence of panic alarm testing in the

[74] TJC. Infection Prevention and Control standard IC.02.02.01.

[75] Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients, December 8, 2016.

facility's acute locked mental health unit. This may result in an unsafe environment for patients, visitors, and staff since timely police responses greatly impact the overall success of police intervention and reduce organizational risks. A VA police physical security specialist reported not documenting alarm testing or drills because he/she did not believe it was specifically mandated within VA police directives.

Recommendation 10

10. The associate director ensures that VA police test panic alarms and evidence of testing is documented and monitors compliance.

Facility concurred.

Target date for completion: September 2020

Facility response: The Chief of Police will ensure that the panic alarm monitoring is conducted, and timeliness of response results documented as required each month to assure 90% compliance with requirements for 6 months. Audits of testing and response time will be reported monthly to the Environment of Care Committee by the Chief of Police or designee. Results will be forwarded to the Health Care Operations Committee by the Chief of Police or designee [to] ensure ongoing compliance.

VHA requires facilities to have a comprehensive emergency management plan that includes an annual review of the hazard vulnerability analysis and inventory of resources and assets that may be needed during emergencies. The reviews are to be documented and evaluated by the Emergency Management Committee and approved by the executive leadership team.[76] The OIG found no evidence of a review of the hazard vulnerability analysis and inventory of resources and assets that may be needed during emergencies for the previous 12 months. This resulted in a lack of assurance that the facility is prepared for contingency operations during emergencies. A facility manager reported that the facility emergency manager was on extended medical leave, and there were a number of acting safety managers since 2018. During this time period, some requirements were not known to the acting safety managers, and updates to these plans were not completed.

Recommendation 11

11. The facility director ensures that the comprehensive emergency management plan and its required elements are reviewed annually by the Emergency Management Committee and approved by executive leadership and monitors compliance.

[76] VHA Directive 0320.01.

Facility concurred.

Target date for completion: September 2020

Facility response: The newly hired Emergency Management Specialist initiated a review of the Emergency Management and Operations Plan in November 2019 and will provide findings and recommendations as needed at the next Emergency Management [Committee] Meeting scheduled for December 2019. A tracking tool to ensure follow up of recommendations and assure annual review is conducted has been established. Monthly reports of progress and activity will be provided by the Emergency Management Specialist or designee to the Environment of Care Committee for 6 months to assure greater than 90% of compliance with progress of actions. Findings will be reported to the Health Care Operations Committee and the Medical Center Director via the Executive Board to ensure ongoing compliance and oversight. The tracking tool will include annual review and approval by executive leadership and will also be reflected in Executive Board minutes.

VHA also requires that facilities develop and annually review their emergency operations plan.[77] The OIG found that the facility did not have a current emergency operations plan. This resulted in a lack of assurance that the facility is prepared for contingency operations during emergencies. The associate director reported that the various acting safety managers were unaware of the requirement.

Recommendation 12

12. The facility director ensures an emergency operations plan is developed and reviewed annually.

Facility concurred.

Target date for completion: September 2020

Facility response: The newly hired Emergency Management Specialist initiated a review of the current Emergency Management Operations Plan in November 2019 and will provide findings and recommendations as needed at the next Emergency Management [Committee] Meeting scheduled for December 2019. Action steps developed will be tracked monthly by the Emergency Management Specialist or designee to assure timely completion of actions by the specified target dates. Monthly reports of compliance with progress on specific actions required will be provided to the Environment of Care Committee and the Health Care Operations Committee for 6 months to assure greater than 90% of compliance with action. Progress reports will also be provided monthly to the Medical Center Director via the Executive Board reporting.

[77] VHA Directive 0320.01.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.[78] 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.[79]

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.[80]

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;[81] 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[82]
- Requirements for controlled substances inspectors

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

[79] 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.

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

[81] The two quarters were from October 1, 2018, through March 31, 2019.

[82] 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[83]
  - Accountability for all prescription pads in pharmacy
  - Verification of hard copy-controlled substances prescriptions
  - Verification of twice a week (three days apart) inventories of the main vault[84]
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[85]

[83] 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."

[84] VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (This handbook was rescinded on May 1, 2019, and replaced by VHA Directive 1108.01, *Controlled Substances Management*.)

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

Medication Management Conclusion

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

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 for training, or inactive duty training."[86] 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.[87]

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.[88] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[89]

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.[90] Those who screen positive must have access to appropriate MST-related care.[91] 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.[92]

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.[93] All mental health and primary care providers must complete MST mandatory

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

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

[88] VHA Directive 1115.

[89] 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.)

[90] 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."

[91] VHA Directive 1115.

[92] VHA Handbook 1160.01.

[93] 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.[94]

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 31 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 concern noted with providers completing mandatory MST training that warranted a recommendation for improvement.

VHA requires that all mental health and primary care providers complete the MST mandatory training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[95] The OIG found 3 of 10 providers hired after July 1, 2012, did not

[94] 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, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers,* February 2, 2016.

[95] VHA Directive 1115.01. Acting Deputy Under Secretary for Health for Operations and Management.

complete training within 90 days after entering their position, and one had not completed the training. This could potentially prevent clinicians from providing appropriate counseling, care, and service to veterans who experienced MST. The MST coordinator reported that the incomplete training was due to a Talent Management System malfunction.[96]

Recommendation 13

13. The facility director confirms that primary care and mental health providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: September 2020

Facility response: Monthly reports of Military Sexual Trauma mandatory training are produced by the medical center Talent Management System Administrator or designee and reviewed by the Military Sexual Trauma lead to ensure primary care and mental health providers achieve 90% or greater compliance with timeliness of recommended training completion for 6 months. Reports of compliance will be provided by the Military Sexual Trauma lead or designee to the Health Care Delivery Committee monthly for 6 months. Results will also be reported to the Medical Center Director via the Executive Board monthly to assure ongoing compliance.

[96] Talent Management System (TMS) is the system of record for all Veterans Affairs (VA) training.

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."[97] 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.[98]

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."[99]

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.[100] 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."[101] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[102] 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.[103] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[97] 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.)

[98] *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.)

[99] 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.)

[100] 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.)

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

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

[103] 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.[104]

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 20 selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[105] 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

The OIG identified deficiencies with clinicians' documentation of reasons for prescribing medications, patient and/or caregiver education related to newly prescribed medication, evaluation of patient/caregiver understanding when education was provided, and medication reconciliation processes that warranted recommendations for improvement.

TJC requires a diagnosis, condition or indication for use for each medication ordered anywhere in the medical record.[106] The OIG determined that providers justified the reason for initiating the medication in 75 percent of patients at the facility based on the electronic health records reviewed.[107] Without a rationale for the medication, the clinical record lacks information that reflects and supports the patient's care or treatment. The acting chief of Geriatric and Extended Care and chiefs of Psychiatry and Pharmacy reported that providers documented patient symptoms and complaints in their notes, but medication justifications were not always clearly documented.

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

[105] The seven selected antidepressant medications are amitriptyline, clomipramine, desipramine, doxepin (>6mg/day), imipramine, nortriptyline, and paroxetine.

[106] TJC Record of Care, Treatment, and Services standard RC.02.01.01 EP2; VHA Directive 1164.

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

Recommendation 14

14. The chief of staff makes certain that clinicians justify and document the reason for initiating the medication and monitors clinicians' compliance.

Facility concurred.

Target date for completion: September 2020

Facility response: A medication ordering, and justification template was developed by the Medical Center Clinical Applications Coordinator, Performance Management Specialist and Assistant Chief of Pharmacy to facilitate the justification and documentation of antidepressant use in elderly patients age 65 years and older. Required elements for patient education were included in the documentation tool. The template was reviewed by the Geriatrics/Extended Care Performance Improvement Committee in November 2019 and a recommendation for approval to move forward with deployment at that time. Deployment is expected in January 2020 with audits of compliance with use of tool to be monitored by the Chief of Staff or designee to assure greater than 90% compliance with use of the tool. Results will be reported monthly by the Geriatrics/ Extended Care Performance Improvement Committee chair or designee monthly to the Health Care Delivery Committee to assure ongoing compliance.

TJC requires that clinicians educate patients/caregivers about safe and effective use of medications and assess their understanding of the education provided.[108] VHA also requires that care "must be recorded and authenticated [in the medical record] immediately after the care event…to ensure that the proper documentation is available. This ensures quality patient care."[109] The OIG determined that clinicians provided this education to 50 percent of patients, based on electronic health records reviewed.[110] In addition, the OIG determined that clinicians evaluated the patients' understanding of education in 40 percent of patients.[111] Medication education is critical to ensuring that patients and/or their caregivers have the information they need to manage their own health at home. While the acting chief of Geriatric and Extended Care and chiefs of Psychiatry and Pharmacy reported that they believed clinicians provided patient/caregiver education, documentation was inconsistent. Providers also did not have a clear understanding of who was responsible for documentation when there were multiple providers.

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

[109] VHA Handbook 1907.01., *Health Information Management and Health Records*, March 19, 2015.

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

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

Recommendation 15

15. The chief of staff ensures that clinicians provide and document patient and/or caregiver education and evaluate understanding of education provided about the safe and effective use of newly prescribed medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: September 2020

Facility response: Required elements for patient education and documentation of patient/ caregiver understanding about safe and effective use of the newly prescribed medication have been incorporated in the elderly antidepressant use template. Audits will be conducted monthly by the Chief of Staff or designee to ensure proper documentation is completed. Use of the tool will be audited monthly for 6 months to assure greater than 90% compliance. Results will be reported by the Geriatrics/Extended Care Performance Improvement Committee Chair or designee monthly to the Health Care Delivery Committee to assure ongoing compliance.

According to TJC, in medication reconciliation, a clinician compares the medication a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies.[112] Additionally, VHA requires that providers review and reconcile medications relevant to the episode of care.[113] The OIG also determined that medication reconciliation was performed in 80 percent of patients at the facility based on the electronic health records reviewed.[114] Failure to reconcile medications increases the risk that there may be duplications, omissions, and interactions in the patient's actual drug regimen. The acting chief of Geriatric and Extended Care and chiefs of Psychiatry and Pharmacy reported that due to lack of training, providers did not consistently use the clinical reminder template, and due to competing care priorities, providers were spending more time with the patient and less time documenting all required elements of the visit.

Recommendation 16

16. The chief of staff ensures clinicians review and reconcile medication information and maintain and communicate accurate patient medication information in patients' electronic health record and monitors clinicians' compliance.

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

[113] VHA Directive 1164.

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

Facility concurred.

Target date for completion: September 2020

Facility response: A medication ordering, and justification template was developed by the Medical Center Clinical Applications Coordinator, Performance Management Specialist and Assistant Chief of Pharmacy to facilitate the justification and documentation of antidepressant use in elderly patients age 65 years and older and approved by the Geriatrics/Extended Care Performance Improvement Committee in November 2019 to assist providers with review and reconciliation of medication. Required elements for patient education were also included in the documentation tool. Use of the tool will be audited by the Chief of Staff or designee monthly for 6 months to assure > 90% compliance for use. Results will be reported monthly by the Chair of the Geriatrics/Extended Care Performance Improvement Committee or designee to the Health Care Delivery Committee to assure ongoing compliance.

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.[115] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[116] 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.[117] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[118]

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.[119]

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.[120]

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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[115] 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.)

[116] 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.)

[117] 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.)

[118] 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.)

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

[120] 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.[121]

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 six 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, clinical oversight of the women's health program, tracking of data related to cervical cancer screenings, communication of results to patients within the required time frame, and follow-up care when indicated. The OIG noted a concern with the Women Veterans Health Committee membership that warranted a recommendation for improvement.

Specifically, VHA requires that the core membership of the Women Veterans Health Committee includes a women veterans program manager, a women's health medical director,

[121] VHA Directive 1330.01(2).

"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."[122] The OIG reviewed the Women Veterans Health Committee minutes (Women Veteran's Health Council) from October 18, 2018, through March 30, 2019, and found a lack of representation from laboratory, medical and/or surgical subspecialties, and gynecology services. This may have resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans. The women veterans program manager reported being unaware of the requirement to include laboratory representation on the committee, but medical/surgical subspecialties and gynecology were not represented due to scheduling conflicts and patient care prioritization.

Recommendation 17

17. The facility director confirms that the Women Veterans Health Committee is comprised of required core members and monitors the committee's compliance.

Facility concurred.

Target date for completion: September 2020

Facility response: The Women's Health Committee membership was reviewed and updated by the Chief of Staff to assure compliance with VHA Directive requirements in July 2019. Monthly tracking of membership attendance continues with new core members added to the charter. Attendance percentage of core members is being tracked to assure greater than 90% compliance will be monitored for 6 months. Minutes of the Women's Health Committee, including attendance will be shared monthly with the Health Care Delivery Committee by the Women Veterans Program Manager. Results will also be shared at the Executive Board for confirmation of attendance by the Medical Center Director.

[122] VHA Directive 1330.01(2).

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."[123] 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.[124]

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."[125]

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."[126]

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.[127]

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

[124] VHA Directive 1101.05(2).

[125] VHA Directive 1101.05(2).

[126] TJC. Leadership standard LD.04.03.11.

[127] 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.[128] Managers must ensure medications are securely stored,[129] a psychiatric intervention room is available,[130] and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also requires emergency departments to have communication systems available to accept requests by local emergency medical services for transporting unstable patients to VA emergency departments.[131]

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

[128] VHA Directive 1101.05(2).

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

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

[131] 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[132]
- 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 complied with some of the performance indicators used by the OIG team to assess the operations and management of the UCC. The OIG noted that the facility had one provider who functioned as the medical officer of the day (MOD) after 4:30 pm. Although the MOD provides medical coverage to the entire facility after hours, this is permissible according to recent VHA guidance. However, the OIG identified several deficiencies, including the UCC operating continuously and a lack of (1) an appointed UCC medical director, (2) UCC staffing

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

with two registered nurses at all times, and (3) laboratory and pharmacy support services that warranted recommendations for improvement.

VHA requires that VA medical facilities operating a UCC 24 hours a day, 7 days a week, must request and receive approval for a waiver from the national director of Emergency Medicine.[133] The OIG was informed by facility managers that the UCC operates 24 hours a day, 7 days a week. The facility had applied for a waiver, but the waiver was denied. The facility continued to operate the UCC continuously around the clock as directed by the VISN director. This resulted in a lack of assurance that the facility provides urgent care with proper staffing and support. The VISN director stated that time was needed to address issues and options with stakeholders prior to changing the UCC's hours of operations.

Recommendation 18

18. The facility director requests the required waiver for urgent care clinic operations 24 hours a day, 7 days a week and continues such operations only if the waiver is approved.

Facility concurred.

Target date for completion: July 2020

Facility response: The waiver to maintain 24/7 operations was not approved, therefore restructure [of] the Urgent Care is underway. The Chief of Staff is finalizing a reduced operations project plan with an established work plan and target dates. Phase 1 transition will begin February 3, 2020 with Urgent care operating from 8am to 12am each day including weekends and holidays. In phase 2, in April 2020, Urgent Care hours will be reduced to be open from 8am to 6 pm Monday through Friday only and closed on holidays. Progress on this transition will be tracked monthly to ensure greater than 90% compliance with completion of project milestones for 6 months. Results will be reported monthly by the project lead to the Health Care Delivery Committee and reported to the Medical Center Director monthly through the Executive Board.

VHA requires appointment of a medical director who is responsible for directing the care provided within the UCC.[134] The OIG did not find evidence of an appointment letter for the acting UCC medical director. Failure to formally assign this position leaves the UCC without official leadership authority to guide the UCC and ensure proper resources to deliver care. The chief of staff was unaware that the acting UCC medical director had not received a formal appointment letter.

[133] VHA Directive 1101.05(2).
[134] VHA Directive 1101.05(2).

Recommendation 19

19. The facility director makes certain that a medical director for the urgent care center is formally appointed.[135]

Facility concurred.

Target date for completion: Completed

Facility response: The Chief of Staff on behalf of the Medical Center Director, formally appointed a medical director for the urgent care in December 2019.

VHA requires that UCCs have a minimum of two registered nurses with UCC experience and competencies covering the UCC during all hours of operation.[136] The OIG found that the UCC had coverage from only one registered nurse between 12:00 a.m. and 7:30 a.m. This could potentially delay urgent care and lead to negative patient outcomes. The nurse manager reported a nurse staffing shortage as the reason for inadequate coverage in the UCC.

Recommendation 20

20. The chief of staff ensures the urgent care center has a minimum of two registered nurses on staff during all hours of operation and monitors compliance.

Facility concurred.

Target date for completion: September 2020

Facility response: The Chief of Staff reviews staffing plans for urgent care to ensure sufficient registered nurses are available during all hours of urgent care operations. Nursing coordinators are available to assist the evening/ night registered nurses when patient conditions/ volume situations occur. Given the plans for reduced operations in the urgent care beginning February 3, 2020, recruitment for additional registered nurses will not proceed. Once phase 2 reduction of hours is complete, there will be two registered nurses scheduled throughout hours of operation. Staffing plans will be monitored monthly by the Chief of Staff or designee to assure greater than 90% compliance with meeting staffing requirements for 6 months. Monthly reports will be provided to the Health Care Delivery Committee by the Chief of Staff or designee to assure ongoing compliance.

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

[136] VHA Directive 1101.05(2).

VHA states that laboratory and pharmacy services must be available when the UCC is open "to ensure that necessary and appropriate care can be consistently delivered to patients in a timely fashion."[137] The chief of staff informed the OIG that the facility did not have on-site laboratory or pharmacy services to support the UCC after hours, on the weekends, and during holidays. Failure to provide laboratory or pharmacy services during all hours of operation could negatively impact patient care. The chief of staff reported that the volume of work does not support having a laboratory or pharmacist on site after hours.

Recommendation 21

21. The chief of staff ensures that appropriate support services are in place during all hours of UCC operation and monitors compliance.

Facility concurred.

Target date for completion: July 2020

Facility response: The Chief of Staff has established policies and procedures to assure appropriate support services such as laboratory and radiology services are available during all hours of Urgent Care Operations. Given the plans for reduced operations in the urgent care, effective February 3, 2020, and closure from 6pm to 8am in April 2020, the medical center will maintain current practices for lab and radiology availability. For radiology, an on-call system is in place to address radiologic needs from 4pm- 8am. Laboratory services are available 8a[m]-4p[m]. Urgent care performs specimen collection during alternate hours and utilizes courier services to process the specimens as needed. The Chief of Staff or designee will monitor requests for laboratory and radiology services during hours the services are closed on a monthly basis to ensure greater than 90% of requests are completed. Reports will be provided by the Chief of Staff or designee to the Health Care Delivery Committee each month for 6 months to assure ongoing compliance.

[137] VHA Directive 1101.05(2).

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-one 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	• None	• Required representatives consistently participate in interdisciplinary reviews of UM data. • The patient safety manager completes the minimum requirement of eight root cause analyses each year. • The patient safety manager submits each root cause analysis to the National Center for Patient Safety within the required time frame.

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	• None	• Service chiefs clearly define and communicate FPPE criteria in advance with providers. • Service chiefs include service-specific criteria in OPPEs. • OPPEs are completed by a provider with similar training and privileges. • Service chiefs clearly define, share, and document in advance the expectation and outcomes for time-limited FPPEs for cause with providers.

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	• Floors and ceilings tiles are repaired, cleaned, and maintained and window screens are replaced. • Expired medical supplies are removed from supply rooms. • VA police test panic alarms and evidence of testing is documented. • The comprehensive emergency management plan and its required elements are reviewed annually by the Emergency Management Committee and approved by executive leadership. • An emergency operations plan is developed and 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	• None
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	• Primary care and mental health providers complete military sexual trauma mandatory training within the required time frame.
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	• Clinicians provide and document patient/caregiver education and evaluate understanding of education provided about the safe and effective use of newly prescribed medications. • Clinicians review and reconcile patients' medications and maintain and communicate accurate patient medication information in patients' electronic health record.	• Clinicians justify and document the reason for initiating the medication.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
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	• None	• The Women Veterans Health Committee 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 • Emergency department participation in local/regional EMS system • Women veteran services • Life support equipment	• The UCC has a minimum of two registered nurses on staff during all hours of operation. • Appropriate support services are in place during all hours of UCC operation.	• The required waiver for UCC operations 24 hours a day, 7 days a week is requested and UCC operations only continue if the waiver is approved. • A medical director for the UCC is formally appointed.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) affiliated[138] facility reporting to VISN 1.[139]

Table B.1. Facility Profile for Edith Nourse Rogers Memorial Veterans Hospital (518) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[140]	Facility Data FY 2017[141]	Facility Data FY 2018[142]
Total medical care budget in dollars	$197,836,500	$200,346,463	$214,763,017
Number of: • Unique patients	19,748	19,744	19,424
• Outpatient visits	226,437	219,802	217,484
• Unique employees[143]	1,114	1,188	1,162
Type and number of operating beds: • Community living center	304	304	304
• Domiciliary	50	56	56
• Mental Health	48	48	48
• Residential psychiatry	42	42	42
Average daily census: • Community living center	222	220	227
• Domiciliary	35	41	45
• Mental health	41	41	34
• Residential psychiatry	26	29	30

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.

[138] Associated with a medical residency program.

[139] The VHA medical centers are classified according to a facility complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs."

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

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

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

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

VA Outpatient Clinic Profiles[144]

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)[145]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[146] Provided	Diagnostic Services[147] Provided	Ancillary Services[148] Provided
Haverhill, MA	518GB	4,665	1,113	Dermatology Hematology/ Oncology Anesthesia	EKG	Nutrition
Gloucester, MA	518GE	3,482	330	n/a	EKG	Nutrition
Lynn, MA	518GA	3,481	1,436	n/a	EKG	Nutrition

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

[144] Includes all outpatient clinics in the community that were in operation as of February 8, 2019.

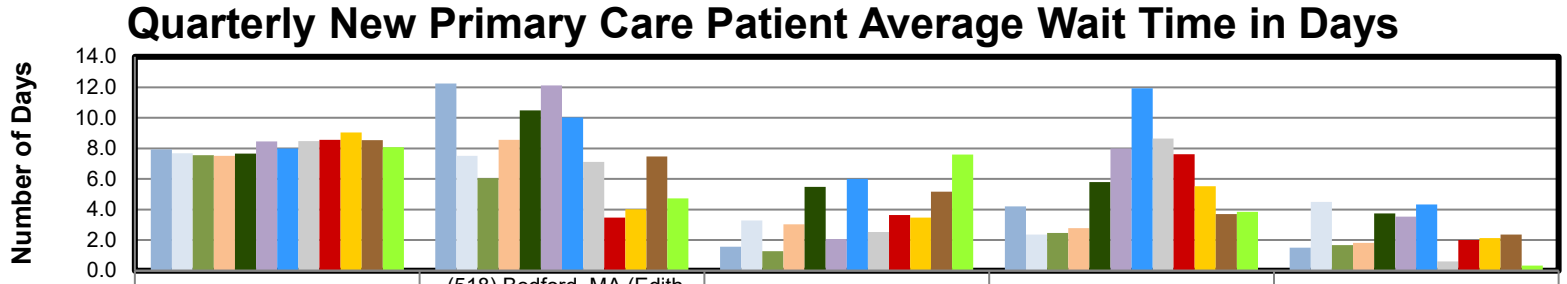
[145] The definition of an "encounter" can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015, and has not been updated.) An encounter is a "professional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

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

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

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

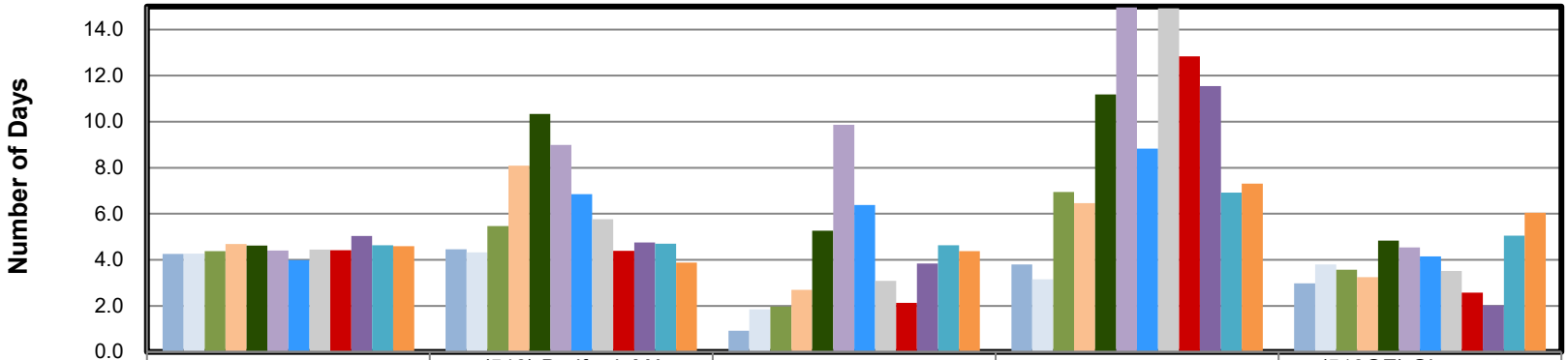
Appendix C: Patient Aligned Care Team Compass Metrics[149]



	VHA Total	(518) Bedford, MA (Edith Nourse Rogers)	(518GA) Lynn, MA	(518GB) Haverhill, MA	(518GE) Gloucester, MA
APR-FY18	7.9	12.3	1.6	4.2	1.5
MAY-FY18	7.7	7.5	3.3	2.4	4.5
JUN-FY18	7.6	6.0	1.3	2.5	1.7
JUL-FY18	7.5	8.6	3.0	2.8	1.8
AUG-FY18	7.7	10.5	5.5	5.8	3.7
SEP-FY18	8.5	12.1	2.1	8.0	3.5
OCT-FY19	8.0	10.0	6.0	11.9	4.3
NOV-FY19	8.5	7.1	2.5	8.7	0.6
DEC-FY19	8.6	3.5	3.6	7.6	2.0
JAN-FY19	9.0	4.0	3.5	5.5	2.1
FEB-FY19	8.5	7.5	5.2	3.7	2.4
MAR-FY19	8.1	4.7	7.6	3.9	0.3

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.

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



	VHA Total	(518) Bedford, MA (Edith Nourse Rogers)	(518GA) Lynn, MA	(518GB) Haverhill, MA	(518GE) Gloucester, MA
APR-FY18	4.3	4.5	0.9	3.8	3.0
MAY-FY18	4.3	4.3	1.8	3.2	3.8
JUN-FY18	4.4	5.5	2.0	6.9	3.6
JUL-FY18	4.7	8.1	2.7	6.5	3.2
AUG-FY18	4.6	10.3	5.3	11.2	4.8
SEP-FY18	4.4	9.0	9.9	15.0	4.5
OCT-FY19	4.0	6.9	6.4	8.8	4.1
NOV-FY19	4.4	5.8	3.1	14.9	3.5
DEC-FY19	4.4	4.4	2.1	12.8	2.6
JAN-FY19	5.0	4.8	3.8	11.5	2.0
FEB-FY19	4.6	4.7	4.6	6.9	5.0
MAR-FY19	4.6	3.9	4.4	7.3	6.1

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

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[150]

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

[150] 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

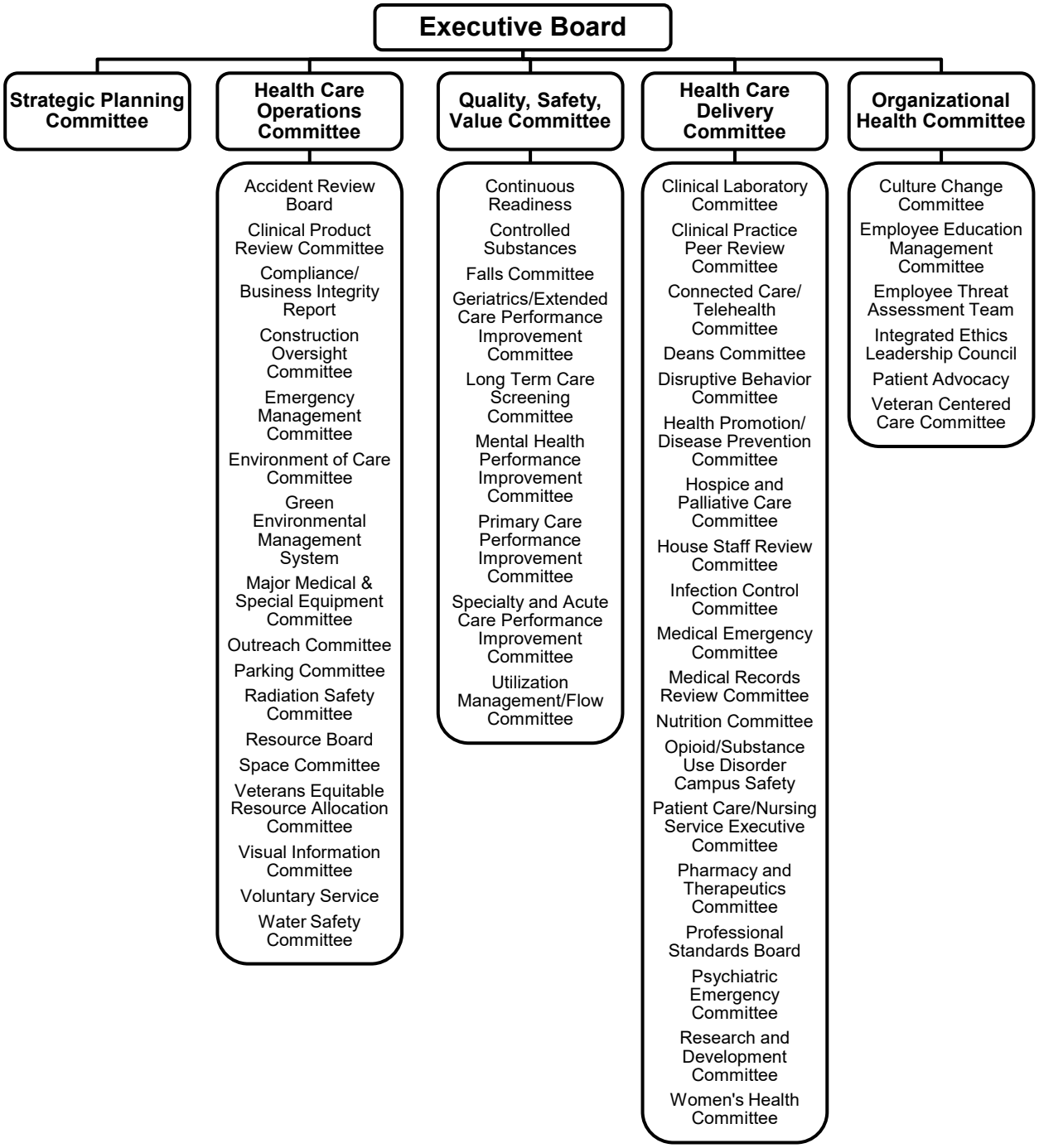
Source: VHA Support Service Center

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions[151]

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.

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

Appendix F: Facility Committee Structure



Source: Received from the facility director on December 19, 2019.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 11, 2019

From: Director, VA New England Healthcare System (10N1)

Subj: Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA

To: Director, Chicago Office of Healthcare Inspections (54CH02)

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA. I appreciate the Office of Inspector General's oversight and the extensive work done as part of this review. I concur with the recommendations and am committed to timely implementation.
2. I have reviewed the action plans and projected completion dates. I concur with the plan and have complete confidence that the plans will be effective.

(Original signed by:)

Ryan S. Lilly, MPA

Director, New England Healthcare System (VISN 1)

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 H: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 19, 2019

From: Director, Edith Nourse Rogers Memorial Veterans Hospital (518/00)

Subj: Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA

To: Director, VA New England Healthcare System (10N1)

1. I have reviewed and concur with the findings and recommendations in the report of the CHIP Review of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts.
2. Corrective action plans have been established, with some having already been implemented and/or complemented.

(Original signed by:)

Joan Clifford

Medical Center Director

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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