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VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Southeast Louisiana Veterans Health Care System

New Orleans, Louisiana

CHIP REPORT | REPORT # 19-00046-60 | JANUARY 16, 2020

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Figure 1. *Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana (Source: https://www.neworleans.va.gov/, accessed on October 10, 2019)*

Abbreviations

ADPCS	associate director for 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 Southeast Louisiana Veterans Health Care System (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 10, 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 Patient Care Services (ADPCS), deputy director (primarily nonclinical), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure with the Executive Leadership Council having oversight for several working groups. The director was chair of the Executive Leadership Council/Quality Safety and Value Committee, which oversees the Quality Council that has responsibility for tracking, identifying trends, and monitoring quality of care and patient outcomes.

The facility's leadership team had been working together for seven months, although several had served in their position for years. The director and chief of staff were permanently assigned in January 2015 and June 2015, respectively. The ADPCS was permanently assigned in January 2007. The deputy director and associate director positions were permanently assigned in July 2018 and November 2018, respectively.

The OIG noted that selected survey results indicated that employees appeared to be generally satisfied with facility leaders. Patient experience survey scores related to satisfaction with the facility were above VHA averages. The facility leaders appeared actively engaged with employees and patients, and were working to sustain and further improve employee and patient engagement and satisfaction.

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. However, at the time of the on-site visit, one OIG Clinical Assessment Program Review recommendation had not been closed. The chief of Quality Management provided evidence of monitoring and progress toward closing the recommendation.

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

[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."

and differences between the top and bottom performers" within VHA.[2] Although the leadership 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 "3-star" quality rating.[3] As of December 31, 2018, the facility's CLC was too new to rate and had not been assigned a quality star rating.

The OIG noted deficiencies in seven of the eight clinical areas reviewed and issued 17 recommendations that are attributable to the facility director, chief of staff, and ADPCS. These are briefly described below.

Quality, Safety, and Value

The OIG found that there was general compliance with requirements for protected peer review and patient safety. The OIG identified noncompliance with interdisciplinary reviews of utilization management data,[4] committee reviews of resuscitation episodes, and code responder training.

Medical Staff Privileging

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

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[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.)

[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."

Environment of Care

The facility and representative community based outpatient clinic generally complied with many of the performance indicators evaluated. The OIG did not note any issues with the availability of medical equipment, but learned of supply challenges during the facility activation. The OIG also identified noncompliance with medication safety practices.

Mental Health

The OIG team 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 the MST mandatory training.

Geriatric Care

For geriatric patients, clinicians documented reasons for prescribing medications and ensured patient and/or caregiver understanding when education was provided. However, the OIG identified inadequate patient and/or caregiver education related to newly prescribed medications and medication reconciliation to minimize duplicative medications and adverse interactions.

Women's Health

The OIG noted the facility performed adequately on indicators related to clinical oversight of the women's health program by a women's health medical director and follow-up care for abnormal cervical cancer pathology results. However, the OIG identified deficiencies with the designation of a women veterans program manager, Women Veteran Health Committee representation and reporting to an executive level committee, tracking and monitoring of cervical cancer screening data, and communication of abnormal results to patients.

High-Risk Processes

The OIG inspection team found general compliance with many of the performance indicators for the operations and management of the emergency department. However, the OIG team identified the lack of a backup call schedule for emergency department social workers.

Summary

In reviewing key healthcare processes, the OIG issued 17 recommendations for improvement directed to the facility director, chief of staff, and ADPCS. 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 F and G, pages 72–73, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendations 10, 13, and 17 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 Southeast Louisiana Veterans Health Care System (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:[8]

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.)

[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.

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

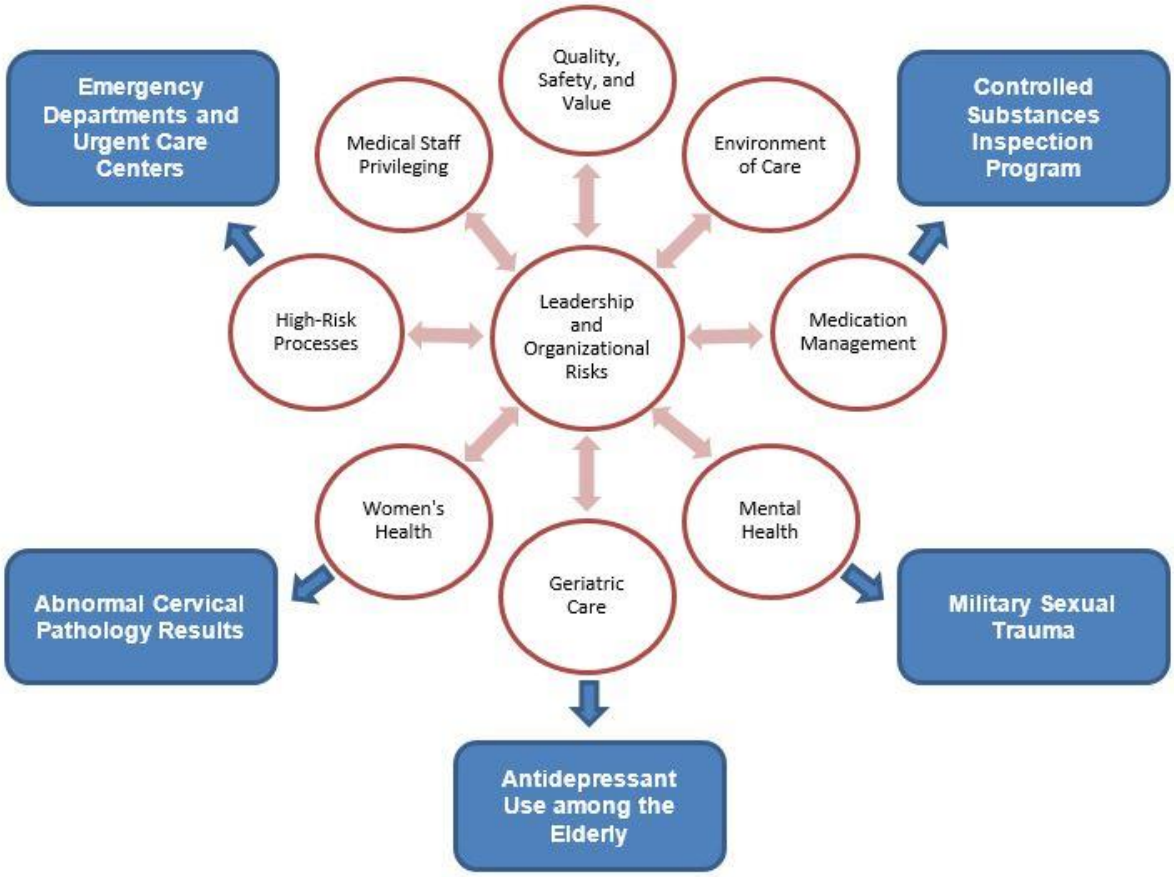

Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

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 March 11, 2017, through June 14, 2019, the last day of the unannounced week-long 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 Clinical Assessment Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

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

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

Executive Leadership Position Stability and Engagement

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

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

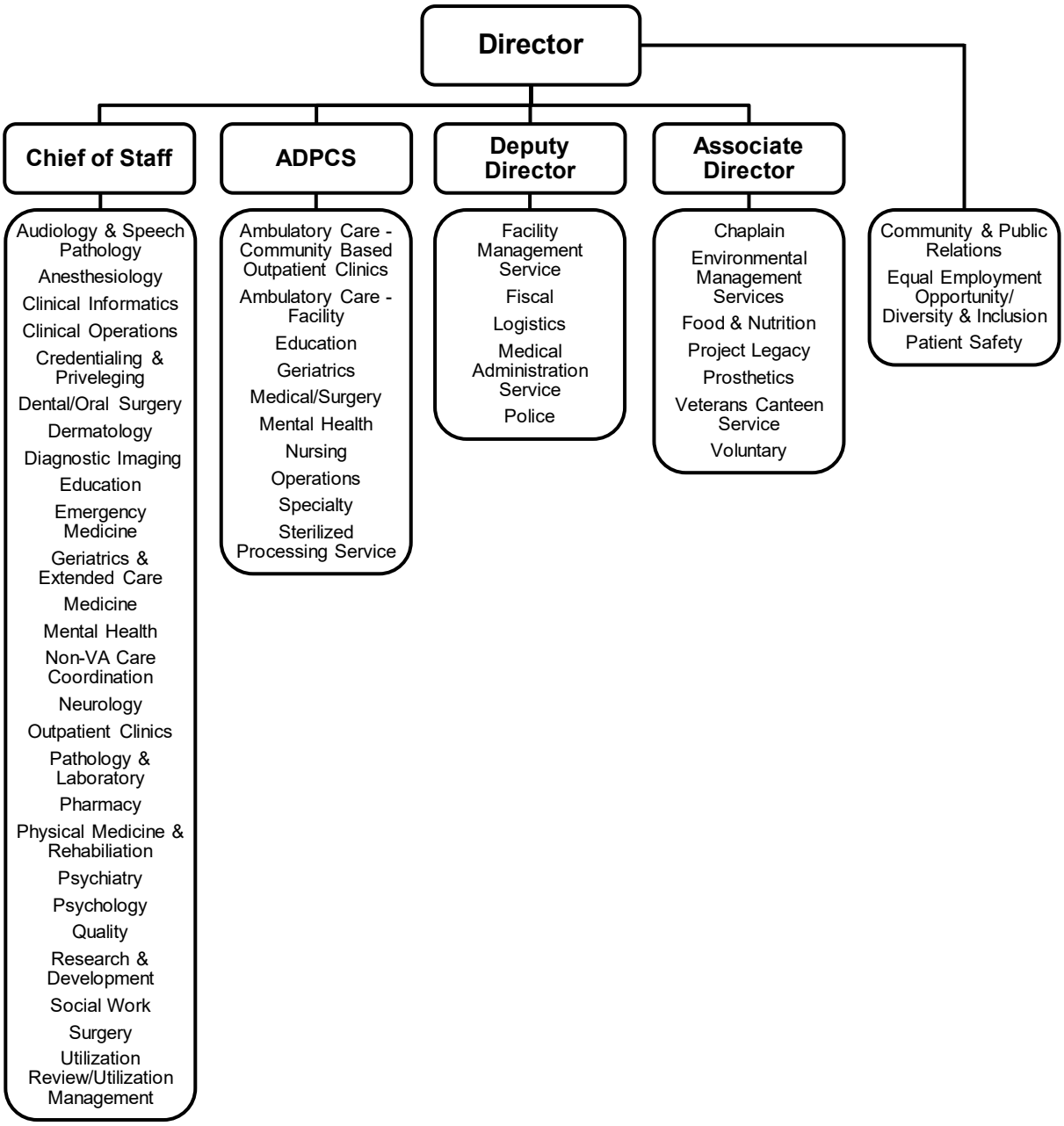

Figure 3. *Facility Organizational Chart*[12]
Source: Southeast Louisiana Veterans Health Care System (received June 11, 2019)

At the time of the OIG site visit, the executive team had been working together for seven months, although several team members have been in their position for many years (see Table 1).

[12] At this facility, the director is responsible for Community and Public Relations; Equal Employment Opportunity/Diversity and Inclusion; and Patient Safety.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	January 11, 2015
Chief of staff	June 14, 2015
Associate director for Patient Care Services	January 21, 2007
Deputy director	July 8, 2018
Associate director	November 11, 2018

Source: Southeast Louisiana Veterans Health Care System human resources officer (received June 10, 2019)

To help assess facility executive leaders' engagement, the OIG interviewed the director, chief of staff, ADPCS, deputy director, 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 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 director serves as the chairperson of the Executive Leadership Council/Quality Safety Value committee, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Council/Quality Safety Value Committee is also responsible for tracking and identifying trends and monitoring quality of care and patient outcomes. The Executive Leadership Council oversees various working groups, such as the Administrative Executive Operating Committee, Executive Committee of the Medical Staff, and Executive Committee of Nursing and Allied Services. See Figure 4.

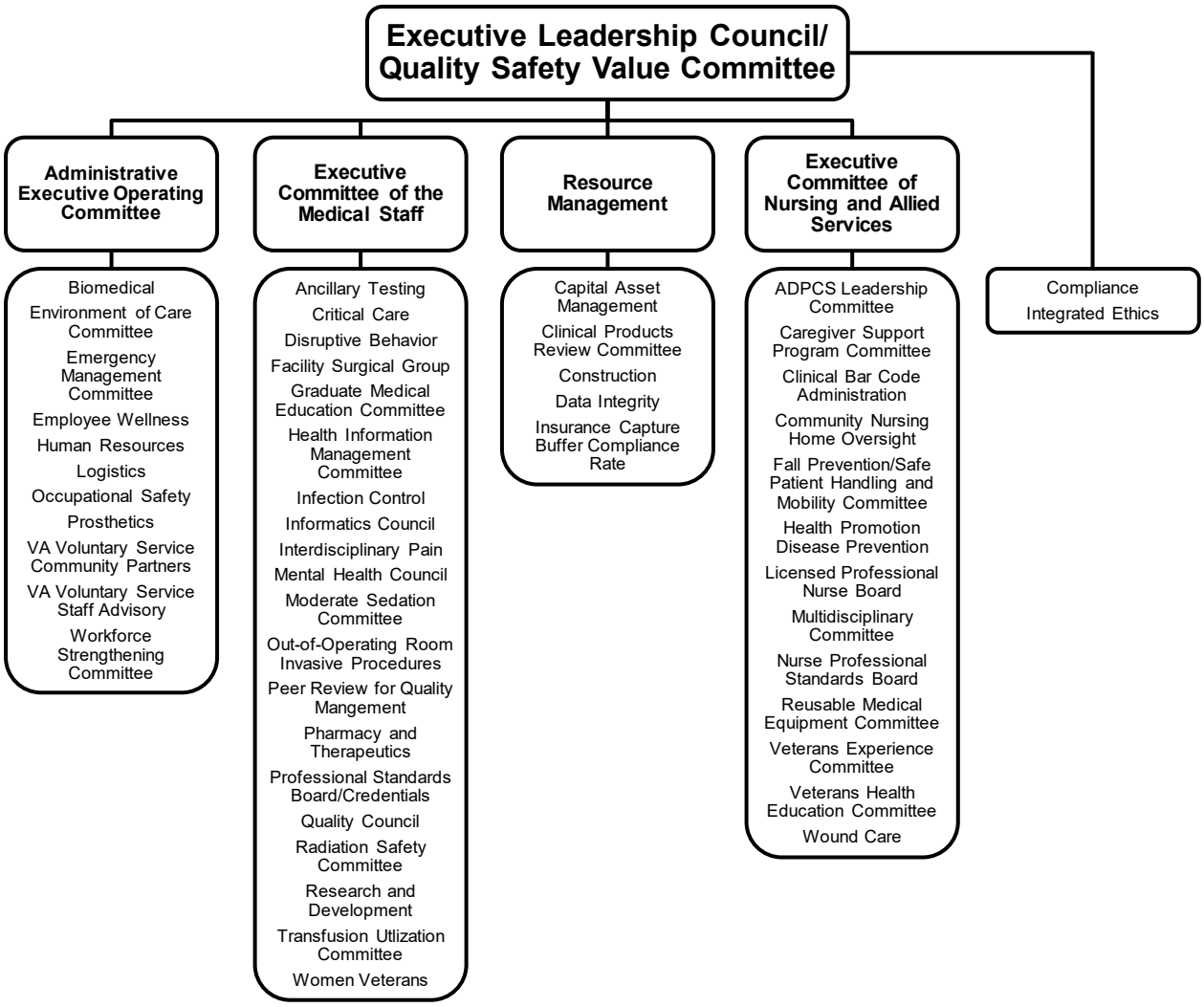

Figure 4. *Facility Committee Reporting Structure*[13]
Source: Southeast Louisiana Veterans Health Care System (received June 10, 2019)

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.

[13] The Executive Leadership Council committee directly oversees Compliance and Integrated Ethics.

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. However, the director and associate director scored consistently higher than the VHA and facility averages. In all, employees appear generally satisfied with facility leaders.[15]

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Deputy Director	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[16]	0–100 where HIGHER scores are more favorable	71.7	69.1	80.3	66.4	68.1	66.9	82.1
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	4.1	3.3	3.4	3.6	3.9

[14] Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, deputy director, 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	ADPCS Average	Deputy Director	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	3.4	4.1	3.5	3.5	3.7	4.3
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.5	4.1	3.5	3.7	3.8	3.9

Source: VA All Employee Survey (accessed May 10, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility average for the selected survey questions were generally similar to the VHA average. The averages for the executive leadership team members were generally similar to or better than the VHA and facility averages. Facility leaders appear to be maintaining an environment where employees feel safe bringing forth issues and concerns.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Deputy Director	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	3.6	4.2	3.7	3.7	3.9	4.5

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Deputy Director	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	4.2	3.8	3.7	3.2	3.9
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	1.5	0.9	1.8	1.3	0.9	0.3

Source: VA All Employee Survey (accessed May 10, 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 four relevant survey questions that reflect

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

patients' attitudes toward facility leaders (see Table 4). For this facility, all four patient survey results reflected higher care ratings than the VHA average. Patients were generally satisfied with the leadership and care provided. Facility leaders appeared to be actively engaged with patients through the monthly veterans' townhall meetings that are open to the public and the quarterly newsletter to patients, local businesses, and elected officials that highlights the facility's ongoing activities.

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

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.9	80.3
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.2	91.2
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	77.4
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.5	77.9

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

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[18] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[19] During the on-site review, inspectors noted that the most recent OIG Clinical Assessment Program report had one open recommendation.[20] The acting chief of Quality Management has been monitoring the facility's progress and demonstrated that steps are being taken toward closing the recommendation.

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.[21] Additional results included the Long Term Care Institute's inspection of the facility's CLC.[22]

[18] 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.

[19] 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."

[20] 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.

[21] According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs. 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.

[22] 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 (*Clinical Assessment Program Review of the Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana*, Report No. 16-00566-314 August 7, 2017)	March 2017	18	1
TJC Hospital Accreditation	July 2018	27	0

Sources: OIG and TJC (Inspection/survey results verified with the acting chief of Quality Management on June 11, 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 March 11, 2017 (the prior comprehensive OIG inspection), through June 14, 2019.[23]

[23] 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 Southeast Louisiana Veterans Health Care System is a high complexity (1b) affiliated facility as described in Appendix B.)

Table 6. Summary of Selected Organizational Risk Factors (March 11, 2017, through June 14, 2019)

Factor	Number of Occurrences
Sentinel Events[24]	4
Institutional Disclosures[25]	5
Large-Scale Disclosures[26]	0

Source: Southeast Louisiana Veterans Health Care System's acting chief of Quality Management (received June 10, 2019)

The OIG also reviewed patient safety indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[27] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 7 summarizes patient safety indicator data from January 1, 2017, through December 31, 2018.

[24] 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."

[25] 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."

[26] 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."

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

Table 7. Patient Safety Indicator Data (January 1, 2017, through December 31, 2018)

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 16	Facility
Pressure ulcer	0.70	0.85	0.00
Death among surgical inpatients with serious treatable conditions	112.98	122.99	0.00
Iatrogenic pneumothorax[28]	0.17	0.31	0.00
Central venous catheter-related bloodstream infection	0.14	0.34	0.00
In-hospital fall with hip fracture	0.09	0.00	0.00
Perioperative hemorrhage or hematoma	2.56	3.57	0.00
Postoperative acute kidney injury requiring dialysis	1.00	2.02	0.00
Postoperative respiratory failure	4.38	4.33	0.00
Perioperative pulmonary embolism or deep vein thrombosis	2.97	3.70	0.00
Postoperative sepsis	3.56	7.74	0.00
Postoperative wound dehiscence (rupture along incision)	0.81	0.64	0.00
Unrecognized abdominopelvic accidental puncture or laceration	1.00	1.03	0.00

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

None of the applicable patient safety indicator measures show a reported rate per 1,000 hospital discharges in excess of the reported rates for VISN 16 and VHA. The chief of staff reported that inpatient surgery only began six months prior to the OIG site visit, after credentialing and privileging procedures were successfully completed for surgeons.

During the inspection, the OIG learned that the facility experienced supply shortages in the intensive care and post-anesthesia units during the past 12 months. Facility leaders and the chief of Logistics acknowledged that the facility experienced challenges with supplies during the facility's initial activation from an outpatient-only facility to an inpatient and outpatient hospital. The chief of Logistics explained that during the activation, the focus was on clinical functions and not the supply inventory system, which was initially set up to accommodate the outpatient

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

setting with only seven supply closets. At the time of the OIG visit, the chief reported maintaining over 70 supply closets, hiring additional logistics staff to meet and maintain the increased volume of required medical supplies needed, and using multiple vendors to ensure clinical staff have the necessary supplies when needed.

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.[29]

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 5 describes the distribution of facilities by star rating.[30] As of June 30, 2018, the facility was rated as "3-star" for overall quality.

[29] 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.)

[30] 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.

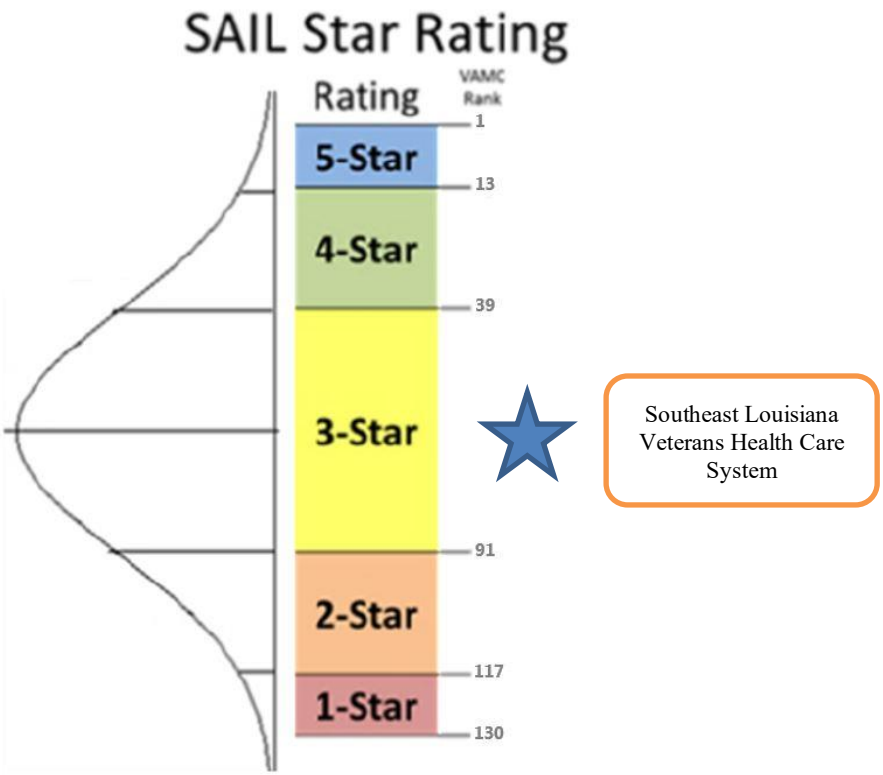

Figure 5. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed May 10, 2019)

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 registered nurse (RN) turnover, call responsiveness, and rating (of) primary care (PC) provider). Metrics that need improvement are denoted in orange and red (for example, mental health (MH) experience (exp) of care, best place to work, and MH continuity (of) care).[31]

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

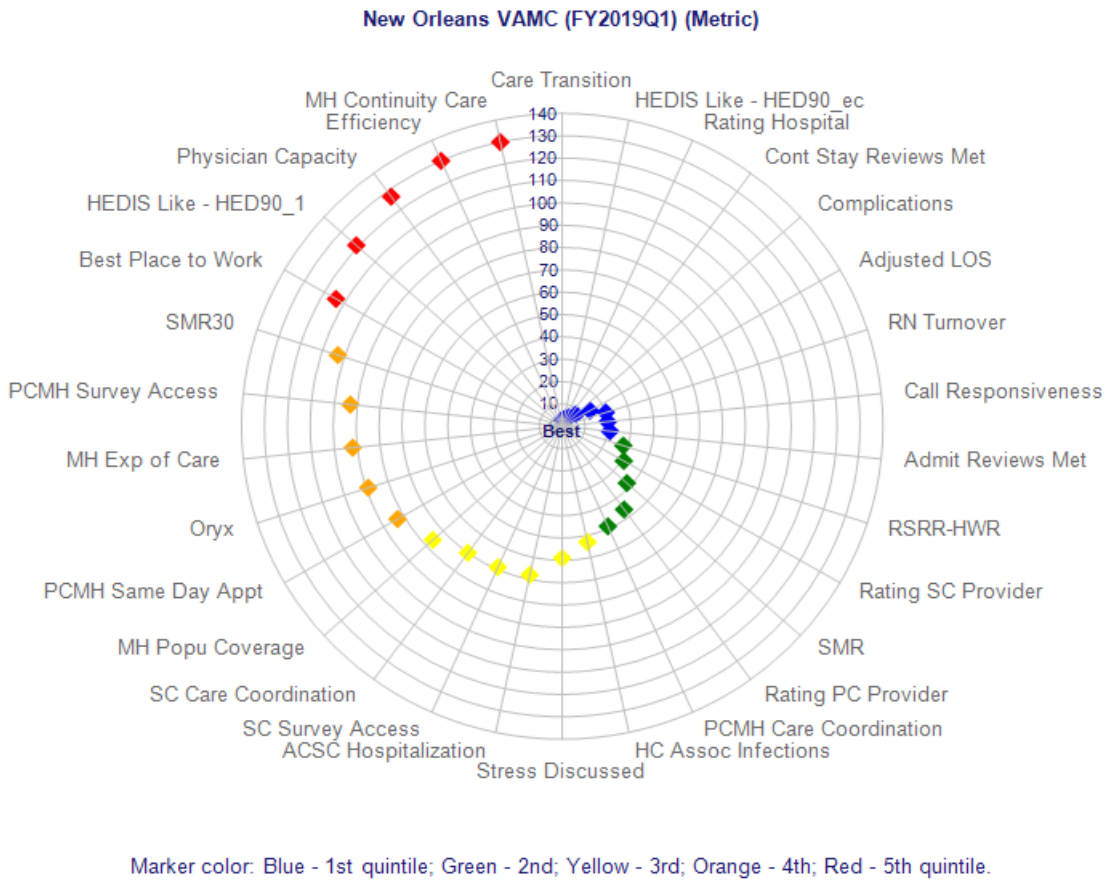

Figure 6. *Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as 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*.[32] The SAIL CLC provides a single resource to review quality measures and health inspection results. It

[32] 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.[33] As of December 31, 2018, the facility's CLC was too new to rate.

Although the CLC was too new for a star rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures for opportunities for improvement. 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 catheter in bladder–long stay (LS), urinary tract infections (UTI) (LS), and newly received antipsychotic (antispsych) medications (meds)–short stay (SS)). Metrics that need improvement are denoted in orange and red (for example, improvement in function (SS), moderate-severe pain (LS), and help with activities of daily living (ADL) (LS)).[34]

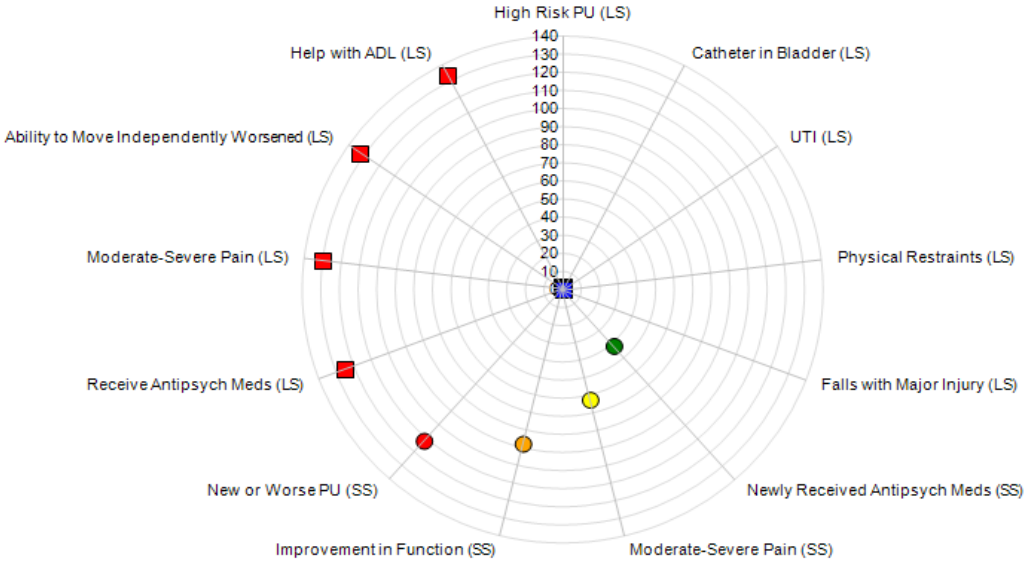

Figure 7. *Facility CLC Quality Measure Rankings (as of December 31, 2018)*
LS = Long-Stay Measure *SS = Short-Stay Measure*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

[33] *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.)

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

Leadership and Organizational Risks Conclusion

The facility's executive leadership team appeared relatively stable, with all five positions permanently filled prior to the OIG's on-site visit. Selected survey results indicated that employees were generally satisfied and that leaders appear to be maintaining an environment where employees feel safe bringing forth issues and concerns. Patient experience survey data indicated that facility leaders appeared actively engaged with patients and leaders had implemented processes to sustain and further improve patient satisfaction. The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to maintain positive perceptions of the facility through active stakeholder engagement). The OIG's review of the facility's accreditation findings, sentinel events, disclosures, and patient safety indicator data did not identify any substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and CLC metrics but should continue to take actions to sustain and improve performance of measures contributing to the facility SAIL "3-star" quality rating (as of December 2018, the facility's CLC was too new to rate).

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.[35] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[36] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[37]

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,[38] utilization management (UM) reviews,[39] patient safety incident reporting with related root cause analyses,[40] and cardiopulmonary resuscitation (CPR) episode reviews.[41]

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.[42]

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[35] 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.)

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

[37] VHA Directive 1026.

[38] 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.

[39] 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.

[40] 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."

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

[42] 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.[43]

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.[44]

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.[45]

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:[46]

- 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

[43] VHA Directive 1117(2).

[44] VHA Handbook 1050.01.

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

[46] 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[47]
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Annual completion of a minimum of eight root cause analyses[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 OIG inspection team found general compliance with requirements for protected peer review and patient safety. However, the OIG team identified noncompliance with interdisciplinary

[47] VHA Directive 1190.

[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]."

reviews of UM data, committee review of resuscitation episodes, and code responder training that warranted recommendations for improvement.

VHA requires that an interdisciplinary facility group review UM data. This group must include, "but not be limited to, representatives from UM, medicine, nursing, social work, case management, mental health, and chief Business Office revenue utilization review."[49] From May 22, 2018, through May 21, 2019, the Quality Council reviewed the UM data. However, the Council lacked consistent representation from nursing, social work, mental health, and chief Business Office revenue utilization review. This resulted in a lack of expertise in the review and analysis of utilization management data. The associate chief of staff of Clinical Operations stated the reason for noncompliance was lack of staffing in nursing, social work, mental health, and chief Business Office revenue utilization review.

Recommendation 1

1. The chief of staff makes certain that required representatives participate in interdisciplinary reviews of utilization management data and monitors the representatives' compliance.

Facility concurred.

Target date for completion: May 2020

Facility response: Utilization management interdisciplinary reviews were conducted with the activation of inpatient services and reviewed monthly by the Quality Council. The newly formed Utilization Management Committee (UMC) is being added to the committee/governance structure under the Executive Committee of the Medical Staff (ECMS). The policy and charter were developed, and the committee was implemented with first formal meeting on November 5, 2019. Core required members of the committee were assigned per recommendation. Minutes are reported to the Quality Council, ECMS, and Executive Leadership Council monthly. The Chief of Staff will ensure compliance with required member participation at 90% or greater for a minimum of six consecutive months.

VHA also requires that the facility establish a committee to review each resuscitation episode under the facility's responsibility and that the reviews include an assessment to determine if errors or deficiencies in technique or procedures, lack of availability or malfunction of equipment, clinical issues or patient care issues, and delays in initiating CPR or resuscitation.[50] The OIG found that individual resuscitation episodes reviewed by the CPR Committee (subcommittee of the Critical Care Committee) did not include assessments of all required elements for each resuscitation episode. This likely resulted in missed opportunities to identify

[49] VHA Directive 1117(2).

[50] VHA Directive 1177.

and address deficiencies that could contribute to the ability to adequately respond to a cardiopulmonary event. The CPR and Critical Care Committee chairpersons reported that although code evaluation sheet templates were available, the committees only used computerized patient record system progress notes to review code episodes, resulting in incomplete reviews of required aspects of each resuscitation episode.

Recommendation 2

2. The chief of staff ensures that the Cardiopulmonary Resuscitation Committee reviews each resuscitative episode under the facility's responsibility and the reviews include required elements and monitors committee's compliance.

Facility concurred.

Target date for completion: April 2020

Facility Response: The Cardiopulmonary Resuscitation Committee (CRC) was assigned new leadership in June 2019. The committee meets monthly and minutes are recorded. All required elements are reviewed. The CRC summarizes findings and reports these to the Critical Care Committee (CCC). The CCC acts upon findings of the CRC committee and reports to the Executive Committee of the Medical Staff (ECMS). The Chief of Staff (COS) will ensure compliance with all components of review at 90% or greater for a minimum of six consecutive months.

For code team responders, VHA requires that clinical staff are trained in basic or advanced cardiac life support to appropriately respond to resuscitation events.[51] Of the eight cases reviewed, two physician code leaders and five registered nurses lacked evidence of basic or advanced cardiac life support certification. Lack of current certification prevents the facility from validating the knowledge and skill level of code responders, which may impact patient safety. The chair of the CPR Committee cited the reason for noncompliance was a lack of internal oversight.

Recommendation 3

3. The chief of staff confirms clinical staff responding to resuscitation events have basic or advanced cardiac life support certification and monitors clinical staff compliance.

[51] VHA Directive 1177.

Facility concurred.

Target date for completion: April 2020

Facility Response: Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) certifications are monitored monthly and reported quarterly.

Physician: Residents provide physician coverage for the Code Blue Response team. Current ACLS status is reported quarterly and monitored through the residency programs at Louisiana State University and Tulane University. Specific resident service types for Code Blue Team participation have been defined and a process for assignments to code blue response team based on current ACLS certification is in place.

Nursing: Intensive Care Unit (ICU) Manager reviews ACLS Certification report from VA Talent Management System (TMS) monthly.

The Chief of Staff (COS) will ensure code blue response team member 100% compliance with certifications for a minimum of six consecutive months or two quarters.

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).[52]

Clinical privileges need to be specific, based on the individual's clinical competence. They are recommended by service chiefs and 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.[53]

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."[54]

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.[55] 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.[56]

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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[52] 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.)

[53] VHA Handbook 1100.19.

[54] VHA Handbook 1100.19.

[55] 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).

[56] 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.)

- Three 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.[57]
- Ten LIPs hired within 18 months before the site visit.
- Twenty LIPs re-privileged within 12 months before the visit.
- Five providers who underwent a FPPE for cause within 12 months prior to the visit.

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[58]
  - 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

[57] The 18-month period was from November 10, 2017, through May 10, 2019. The 12-month review period covered May 10, 2018, through May 10, 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.

[58] 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 identified concerns with the processes for FPPEs, OPPEs, and FPPEs for cause.

For FPPEs, VHA requires that service chiefs include defined time frames to ensure an efficient process by preventing undefined or indefinite evaluation of providers.[59] VHA also requires that another provider with similar training and privileges evaluates the privilege-specific competence of the practitioner and document evidence of competently performing the requested privileges.[60] The OIG found that 2 of 10 FPPEs lacked documentation of the time frame for evaluation. This resulted in inefficiencies and unclear expectations for the providers being evaluated as well as for the clinical supervisors performing the evaluations. Additionally, in 2 of 10 applicable provider profiles, the OIG found that 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 chief of staff attributed the noncompliance to misunderstanding of the standards and believed facility efforts met requirements.

Recommendation 4

4. The chief of staff ensures service chiefs include defined time frames in focused professional practice evaluations and monitors service chiefs' compliance.

[59] VHA Handbook 1100.19.

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

Facility concurred.

Target date for completion: May 2020

Facility Response: The chief of staff implemented a revision of the Focused Professional Practice Evaluation (FPPE) policy and templates to ensure service chiefs are provided with a process for an intensive, time-limited peer review evaluation of a practitioner's performance that confirms current clinical competence. The Executive Committee of the Medical Staff (ECMS) has delegated to the Professional Standards Board the responsibility for monitoring compliance with the FPPE policy and results of FPPE to include transitioning to ongoing professional practice evaluation (OPPE), continuation of the FPPE, or providers' failure to meet FPPE benchmarks. The ECMS has set a compliance target at 90% or greater and will monitor compliance with defining time frames in FPPEs for a minimum of six consecutive months.

Recommendation 5

5. The chief of staff confirms that service chiefs ensure that focused professional practice evaluations are completed by providers with similar training and privileges and monitors service chiefs' compliance.

Facility concurred.

Target date for completion: May 2020

Facility Response: The chief of staff implemented a revision of the Focused Professional Practice Evaluation (FPPE) policy and templates to ensure service chiefs are provided with a process for an intensive, time-limited peer review evaluation of a practitioner's performance that confirms current clinical competence. The Executive Committee of the Medical Staff (ECMS) has delegated to the Professional Standards Board the responsibility for monitoring compliance with the FPPE policy and results of FPPE to include transitioning to ongoing professional practice evaluation (OPPE), continuation of the FPPE, or providers' failure to meet FPPE benchmarks. The ECMS has set a compliance target at 90% or greater and will monitor compliance with completion of FPPEs by providers with similar training and privileges for a minimum of six consecutive months.

For OPPEs, VHA requires ongoing monitoring of privileged practitioners by service chiefs. This ongoing monitoring process can include activities such as periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients. Data must be service and "practitioner specific, reliable, easily retrievable, timely, justifiable, comparable, and risk adjusted where

appropriate."[61] VHA also requires that LIPs' OPPEs are evaluated by providers with similar training and privileges.[62] For one of the solo/few providers reviewed, the OPPE review was not specific to the service/section. Additionally, for this provider, OIG inspectors found no evidence that a provider with similar training and privileges made the determination to recommend continuing current privileges based in part on OPPE activities. This resulted in insufficient evidence to confirm the quality of care delivered by providers. The OPPE included non-specialty-specific cases and was completed by the service chief in lieu of a specialty-specific provider because there was no provider available in the specialty. The chief of staff was unaware of OPPE procedures for solo providers.

Recommendation 6

6. The chief of staff makes certain service chiefs include service-specific criteria for ongoing professional practice evaluations and monitors service chiefs' compliance.

Facility concurred.

Target date for completion: February 2020

Facility Response: The chief of staff implemented a revision of the Ongoing Professional Practice Evaluation (OPPE) policy and templates. The Executive Committee of the Medical Staff (ECMS) has delegated to the Professional Standards Board the responsibility for monitoring compliance with the OPPE policy. The ECMS has set a compliance target at 90% or greater and will monitor compliance with completion of OPPEs that include service-specific criteria for a minimum of six consecutive months or one cycle. Note: The current 6-month OPPE cycle (July 2019–December 2019) ends December 31, 2019. OPPE will be completed during the month of January 2020 and audited by Credentialing and Privileging staff for compliance.

Recommendation 7

7. The chief of staff confirms that service chiefs ensure that ongoing professional practice evaluations are completed by providers with similar training and privileges and monitors service chiefs' compliance.

[61] VHA Handbook 1100.19.

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

Facility concurred.

Target date for completion: February 2020

Facility Response: The chief of staff implemented a revision of the Ongoing Professional Practice Evaluation (OPPE) policy and templates. The Executive Committee of the Medical Staff (ECMS) has delegated to the Professional Standards Board the responsibility for monitoring compliance with the OPPE policy. The ECMS has set a compliance target at 90% or greater and will monitor compliance with completion of OPPEs by providers with similar training and privileges for a minimum of six consecutive months or one evaluation cycle.

Note: The current 6-month OPPE cycle (July 2019–December 2019) ends December 31, 2019. OPPE will be completed during the month of January 2020 and audited by Credentialing and Privileging staff for compliance.

VHA requires that FPPEs for cause have clearly defined expectations and outcomes that are accepted by the provider in advance of the evaluation, are time-limited, and do not limit the provider's ability to practice independently for more than 30 days.[63] For two of five provider profiles reviewed, the OIG team found that the FPPEs limited independent practice by the provider for greater than 30 days and did not have clearly defined time frames or contain specific expectations with benchmarks and outcomes. The team also noted a lack of evidence that the expectations were shared with the providers in advance. As a result, providers were not aware of the initiation, reason, expectations, or outcomes of the FPPE for cause, which could have hindered the evaluation of the providers. The chief of staff attributed the noncompliance to service chiefs' lack of understanding of the requirements.

Recommendation 8

8. The chief of staff makes certain that service chiefs clearly define and share in advance with providers the time frame, expectations, and outcomes for focused professional practice evaluations for cause that do not limit providers' ability to practice independently for more than 30 days and monitors service chiefs' compliance.

[63] 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).

Facility concurred.

Target date for completion: May 2020

Facility Response: The chief of staff implemented a revision of the Focused Professional Practice Evaluation (FPPE) policy and templates to ensure service chiefs are provided with a process for an intensive, time-limited peer review evaluation of a practitioner's performance that confirms current clinical competence. The Executive Committee of the Medical Staff (ECMS) has delegated to the Professional Standards Board the responsibility for monitoring compliance with the FPPE policy, including FPPE for Cause. The ECMS has set a compliance target at 90% or greater and will monitor compliance for a minimum of six consecutive months to ensure completion of FPPE for cause demonstrates service chiefs clearly define and share in advance with providers the time frame, expectations, and outcomes for FPPE for Cause and that the evaluation does not limit the provider's ability to practice independently for more than 30 days.

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 nine inpatient areas—medical/surgical units 2B and 2C; surgical unit 3B; CLC units Live Oak, Cypress, Hickory, and Magnolia units; mental health; and intensive care unit—in addition to the post-anesthesia care unit, emergency department, women's health clinic, and primary care clinic. The team also inspected the emergency management program and the Franklin 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

[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.

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

Environment of Care Conclusion

The parent facility and the representative community based outpatient clinic met many of the performance indicators, including cleanliness and infection prevention requirements, general privacy, and women veterans program. Performance indicators for locked mental health inpatient unit and emergency management were also met. The OIG team did not note issues with the availability of medical equipment. However, staff reported historical issues with supplies in the intensive care and post-anesthesia care units during the facility activation (described under Leadership and Organizational Risk). Additionally, at the parent facility, the OIG team found expired and unlabeled medications which warranted a recommendation for improvement.[72]

Specifically, VHA requires multi-dose medications to be labeled with an expiration date upon opening.[73] In the post-anesthesia care and Live Oak CLC units, OIG inspectors found open and undated multi-dose medication vials in the medication refrigerator. This resulted in the lack of assurance of safe medication administration practices. The unit nurse managers attributed the noncompliance to inattention to detail by nursing staff.

Recommendation 9

9. The associate director for Patient Care Services ensures that nursing staff label multi-dose medication vials with an expiration date upon opening and monitors staff compliance.

[72] Post anesthesia care unit, Live Oak CLC unit.

[73] VHA Directive 1108.06, *Inpatient Pharmacy Services*, February 8, 2017.

Facility concurred.

Target date for completion: May 2020

Facility Response: A monitoring process is in place to check all open vials every Monday. Multi-dose vial labeling data is reported to Nursing Quality and Safety Council and reviewed by Nursing Leadership Committee monthly. The Associate Director of Patient Care Services reviews data monthly and will monitor for 90% or greater compliance for a minimum of six consecutive months.

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.[74] 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.[75]

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.[76]

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;[77] 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[78]
- Requirements for controlled substances inspectors

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

[75] 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.

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

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

[78] 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[79]
  - Accountability for all prescription pads in pharmacy
  - Verification of hard copy outpatient pharmacy controlled substance prescriptions
  - Verification of twice a week (three-days apart) inventories of the main vault[80]
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[81]

[79] 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."

[80] 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*.)

[81] 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 as reflected by 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."[82] 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.[83]

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.[84] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[85]

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.[86] Those who screen positive must have access to appropriate MST-related care.[87] 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.[88]

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

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

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

[84] VHA Directive 1115.

[85] 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.)

[86] 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."

[87] VHA Directive 1115.

[88] VHA Handbook 1160.01.

[89] 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.[90]

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant document and staff training records and interviewed key employees. The team also reviewed the electronic health records of 44 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. However, there was a concern noted with providers not completing mandatory MST training that warranted a recommendation for improvement.

VHA requires that all mental health and primary care providers complete MST mandatory training and providers hired after July 1, 2012 complete the training no later than 90 days after assuming their position.[91] Of the 11 providers hired after July 1, 2012, the OIG team found that

[90] 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.

[91] 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*, refers to specific MST training requirements for providers assuming their position before or after July 1, 2012.

one did not complete the training and four did not complete the training within 90 days. This could potentially prevent clinicians from providing a consistent level of counseling, clinical care, and service to veterans who experienced MST. The MST coordinator attributed the noncompliance to a lack of oversight.

Recommendation 10

10. The chief of staff confirms that providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.[92]

Facility concurred.

Target date for completion: November 30, 2019

Facility Response: The Chief of Staff (COS) confirms Military Sexual Trauma (MST) mandatory training is monitored monthly for staff completion within the timeframe of no later than 90 days after assuming their position. The COS reviews data monthly and results are reported monthly to the Executive Committee of the Medical Staff. The COS reviewed and monitored data monthly for 90% or greater compliance for six consecutive months. We request closure of this recommendation based on evidence provided.

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

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."[93] 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.[94]

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."[95]

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.[96] 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."[97] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[98] 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.[99] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[93] 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.)

[94] *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.)

[95] 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.)

[96] 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.)

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

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

[99] 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.[100]

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 46 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[101] 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 team found compliance with providers justifying the reason for medication initiation and evaluating patient/caregiver understanding of education, when it was provided. However, the OIG found that clinicians did not provide adequate patient and/or caregiver education specific to the newly prescribed medication nor reconcile patients' medications.

TJC requires that clinicians educate patients and families about safe and effective use of medications[102] and that the patient's medical record contains information that reflects the patient's care, treatment, and services.[103] The OIG estimated that clinicians provided this education to 76 percent of patients at the facility, based on electronic health records reviewed.[104] Providing medication education is important because patients need to be able to manage their own health at home.

According to TJC, the required process of medication reconciliation is when "a clinician compares the medications a patient should be using (and is actually using) to the new

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

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

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

[103] TJC. Record of Care, Treatment, and Services standard RC.02.01.01.

[104] The OIG is 95 percent confident that the true compliance rate is somewhere between 63.2 and 87.7 percent, which is statistically significantly below the 90 percent benchmark.

medications that are ordered for the patient and resolves any discrepancies."[105] TJC also requires patients' medical records to contain information that reflects the patient's care, treatment, and services.[106] Additionally, VHA requires that clinicians review and reconcile medications relevant to the episode of care.[107] The OIG estimated that clinicians performed medication reconciliation for 78 percent of the patients at the facility, based on electronic health records reviewed.[108] Failure to maintain accurate patient medication information and reconcile medications increases the risk of duplications, omissions, and adverse interactions in the patient's actual drug regimen.

Clinical managers cited several reasons for noncompliance, including many rotating and new providers at the facility, limited patient care time, competing priorities, and frequent changes to documentation requirements.

Recommendation 11

11. The chief of staff makes certain that clinicians provide and document patient and/or caregiver education about newly prescribed medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: May 2020

Facility Response: The medical staff recognized the impact and challenges with antidepressant use among the elderly in early 2019 with development, approval, and implementation of a stricter prescribing process through the Criteria for Use process. The Chief of Staff (COS) has set a compliance target at 90% or greater with clinician provision and documentation of patient/caregiver education about newly prescribed medications for a minimum of six consecutive months. The Chief of Geriatrics and Extended Care will monitor compliance.

Recommendation 12

12. The chief of staff ensures clinicians review and reconcile medications and maintain accurate medication information in patients' electronic health records and monitors clinicians' compliance.

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

[106] TJC. Record of Care, Treatment, and Services standard RC.02.01.01.

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

[108] The OIG is 95 percent confident that true compliance rate is somewhere between 65.9 and 89.5 percent, which is statistically significantly below the 90 percent benchmark.

Facility concurred.

Target date for completion: May 2020

Facility Response: The medical staff recognized the impact and challenges with antidepressant use among the elderly with development, approval, and implementation of a stricter prescribing process through the Criteria for Use process. Additionally, there is a focus medical center wide on medication reconciliation with a currently active interdisciplinary LEAN (a collaborative team effort to improve performance by systematically removing waste and reducing variation) process improvement team. The Chief of Staff has set a compliance target at 90% or greater with clinician review and reconciliation of medications and maintenance of accurate medication information in patient's electronic health records for a minimum of six consecutive months. The Chief of Geriatrics and Extended Care (GEC) will monitor 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.[109] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[110] In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus infection, use of oral contraceptives for five or more years, and having given birth to three or more children.[111] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[112]

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.[113]

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.[114]

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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[109] 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.)

[110] 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.)

[111] 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.)

[112] 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.)

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

[114] 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.[115]

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 49 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 some of the performance indicators, including requirements for clinical oversight of the women's health program by a women's health medical director or clinical champion and provision of follow-up care for abnormal cervical pathology results when indicated. However, the OIG determined that the facility did not have a designated women veterans program manager, the Women Veterans Health Committee lacked required representation and did not report to an executive level committee, the facility did not collect and track cervical cancer screening data, and providers did not communicate abnormal results to patients within the required time frame, that warranted recommendations for improvement.

[115] VHA Directive 1330.01(2).

Specifically, VHA requires that "Each Administrative Parent (Health Care System) must have a full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health care that ensure privacy, security, and dignity and improves the overall quality of care provided to women Veterans."[116] The Women's Health Medical Director stated that the facility had been without a designated full-time women veterans program manager since September 2018. This resulted in a lack of oversight for the women veterans program. Clinical leaders were aware of the requirement and cited difficulty selecting a qualified applicant as the reason for noncompliance.

Recommendation 13

13. The facility director ensures that the facility has a full-time women veterans program manager.[117]

Facility concurred.

Target date for completion: August 5, 2019

Facility Response: A full-time Women Veterans program manager was hired effective date of 8/4/2019 and is on duty. The Program manager has conducted Women Veteran committee meetings. We request closure of this recommendation based on evidence provided.

According to VHA, the core membership of the Women Veterans Health Committee is required to include a women veterans program manager; a women's health medical director; "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care; and a member from executive leadership." VHA also requires that "The committee must maintain an active charter, meet quarterly at a minimum, and report to leadership with signed minutes at the Clinical Executive Board CEB level."[118] The OIG found that, in addition to a lack of a full-time women veterans program manager, the committee also lacked representation from business office/non-VA medical care and executive leadership, and did not report to an executive level committee. Further, designated committee members from medical/surgical subspecialty, mental health, gynecology, radiology, laboratory, and quality management did not consistently attend meetings. This resulted in deficient expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality care for women veterans. Clinical leaders attributed the noncompliance to competing priorities and staffing issues.

[116] VHA Directive 1330.01(2).

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

[118] VHA Directive 1330.01(2).

Recommendation 14

14. The chief of staff confirms that the Women Veterans Health Committee includes required core members and reports to a clinical executive level committee and monitors the committee's compliance.

Facility concurred.

Target date for completion: May 2020

Facility Response: The Women Veteran's Health Committee now includes required core members per VA policy. This committee meets monthly and reports data to the Executive Committee of the Medical Staff monthly. The Chief of Staff will monitor attendance and will ensure compliance with required member participation at 90% or greater for a minimum of six consecutive months.

According to VHA, each facility must have a process to track data, "including notification of patients who are due for screening, tracking of completion of screening, results reporting, and follow-up care" related to cervical cancer screenings.[119] The OIG determined there was no evidence of a systematic process for tracking patients due for screening and follow-up care data. The women veterans program manager acknowledged that women's health staff collect and track timeliness of notification of cervical cancer screen results; however, the staff did not collate, analyze, or report the results in a manner consistent with quality improvement activities. Lack of a systematic process for notifying patients due for screenings and tracking follow-up care may cause delays in addressing patients' abnormal results and implementing appropriate action plans. Clinical leaders attributed the noncompliance to substandard data quality and reported working to improve the data collection and tracking process.

Recommendation 15

15. The chief of staff ensures that program managers implement a process to track and monitor cervical cancer screenings and follow-up care and monitors program managers' compliance.

[119] VHA Directive 1330.01(2).

Facility concurred.

Target date for completion: May 2020

Facility Response: The Women's Health program managers will track and monitor cervical cancer screenings and follow-up care. Tracking includes notification of patients who are due for screening, completion of screening, results reporting, and follow-up care. The data is aggregated and reported to the Women Veteran's Health Committee and to the Executive Committee of the Medical Staff monthly. The compliance target is set at 90%. The Chief of Staff will ensure compliance with the process to track and monitor screenings and follow-up care at 90% or greater for a minimum of six consecutive months.

VHA also requires the ordering provider to notify patients of abnormal cervical cancer screening results within seven calendar days from the date the results are available.[120] The OIG determined that ordering providers communicated abnormal results to patients in a timely manner in 82 percent of the electronic health records reviewed.[121] This resulted in delayed patient notification and timely follow-up care. Clinical leaders acknowledged inadvertent tardiness by the ordering and surrogate providers and that the covering surrogate providers failed to notify patients within seven days.

Recommendation 16

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

Facility concurred.

Target date for completion: May 2020

Facility Response: Women's Health leadership monitors abnormal results and assures communication of results to patients within the required time frame of 7 calendar days from date results are available. The data is monitored and aggregated and reported to the Women Veteran's Health Committee and to the Executive Committee of the Medical Staff monthly. The Chief of Staff will ensure providers compliance at 90% or greater with the process to track and monitor abnormal results notification to patients within the required time frame for a minimum of six consecutive months.

[120] VHA Directive 1330.01(2).

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

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."[122] 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.[123]

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."[124]

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."[125]

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.[126]

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

[123] VHA Directive 1101.05(2).

[124] VHA Directive 1101.05(2).

[125] TJC. Leadership standard LD.04.03.11.

[126] 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.[127] Managers must ensure medications are securely stored,[128] a psychiatric intervention room is available,[129] 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.[130]

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

[127] VHA Directive 1101.05(2).

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

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

[130] 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[131]
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
  - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

The facility generally complied with many of the performance indicators used by the OIG team to assess the operations and management of the emergency department. However, the OIG identified the lack of a backup call schedule for emergency department social workers that warranted a recommendation for improvement.

Specifically, VHA requires that emergency departments have a written staffing contingency plan that includes a backup call schedule to address situations when expedient mobilization of provider resources is needed.[132] The OIG team found that the emergency department lacked a

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

[132] VHA Directive 1101.05(2).

backup call schedule for social workers. This could impact the facility's ability to provide uninterrupted and timely patient care and/or social work service. The Social Work Service chief attributed the noncompliance to shortage of social work staff.

Recommendation 17

17. The chief of staff ensures the chief of Social Work maintains a backup call schedule for emergency department social workers.[133]

Facility concurred.

Target date for completion: June 14, 2019

Facility Response: Social Work service was added to the on-call program, AMION, which is an electronic system maintained and updated continually to include back up/on call status for all clinical services. We request closure of this recommendation based on evidence provided.

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

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	Seventeen OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director, chief of staff and ADPCS. 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	• Staff responding to resuscitation events have basic or advanced cardiac life support certification.	• Required representatives participate in interdisciplinary reviews of UM data. • CPR Committee reviews each resuscitative episode under the facility's responsibility and the reviews include required elements.

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	• Service chiefs ensure that FPPEs are completed by providers with similar training and privileges. • Service chiefs include service-specific criteria for OPPEs. • Service chiefs ensure that OPPEs are completed by providers with similar training and privileges.	• Service chiefs include defined time frames in FPPEs. • Service chiefs clearly define and share in advance with providers the time frame, expectations, and outcomes for FPPEs for cause that do not limit providers' ability to practice independently for more than 30 days.

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	• Nursing staff label multi-dose medication vials with an expiration date upon opening.	• None

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	• Providers complete MST 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 about newly prescribed medications. • Clinicians review and reconcile patients' medications.	• None

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	• Program managers implement a process to track cervical cancer screenings and follow-up care. • Providers communicate abnormal results to patients within the required time frame.	• The facility has a full-time women veterans program manager. • The Women Veterans Health Committee includes required core members and reports to a clinical executive level committee.
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	• None	• The chief of Social Work maintains a backup call schedule for emergency department social workers.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this high complexity (1b) affiliated[134] facility reporting to VISN 16.[135]

Table B.1. Facility Profile for Southeast Louisiana Veterans Health Care System (629) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[136]	Facility Data FY 2017[137]	Facility Data FY 2018[138]
Total medical care budget dollars	$457,791,097	$439,296,199	$558,306,098
Number of:			
• Unique patients	43,149	43,157	44,906
• Outpatient visits	553,821	577,388	661,620
• Unique employees[139]	1,225	1,601	2,189
Type and number of operating beds:			
• Community living center	0	10	40
• Medicine	0	24	72
• Mental health	0	20	20
• Surgery	0	10	18
Average daily census:			
• Community living center	—	—	5
• Medicine	—	0	15
• Mental health	—	1	10
• Surgery	—	—	0

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

[134] Associated with a medical residency program.

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

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

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

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

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

VA Outpatient Clinic Profiles[140]

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)[141]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[142] Provided	Diagnostic Services[143] Provided	Ancillary Services[144] Provided
Baton Rouge, LA	629BY	27,333	2,107	Cardiology Dermatology Endocrinology Gastroenterology Neurology Pulmonary/ Respiratory disease Rehab physician Eye Podiatry	Laboratory & Pathology Radiology	Pharmacy Social work Weight management Dental Nutrition

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

[141] 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."

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

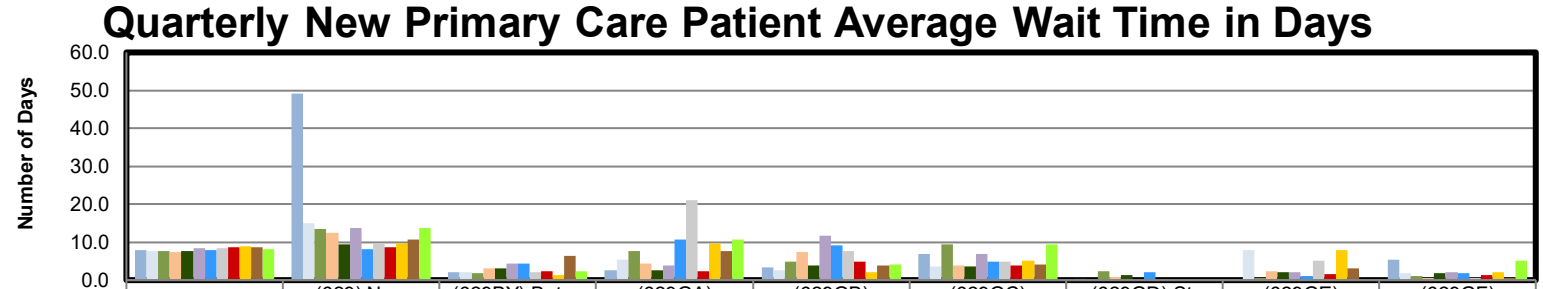
[143] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[142] Provided	Diagnostic Services[143] Provided	Ancillary Services[144] Provided
Houma, LA	629GA	6,670	4,532	Dermatology Endocrinology Gastroenterology Anesthesia	Radiology	Social work Weight management Nutrition
Hammond, LA	629GB	9,016	6,366	Dermatology Endocrinology Gastroenterology Anesthesia GYN Podiatry	n/a	Social work Weight management Nutrition
Slidell, LA	629GC	6,815	3,470	Dermatology Endocrinology Gastroenterology Rehab physician	n/a	Social work Weight management Nutrition
Reserve, LA	629GD	4,132	2,506	Dermatology Endocrinology Gastroenterology Pulmonary/ Respiratory disease	n/a	Social work Nutrition
Franklin, LA	629GE	1,579	836	Dermatology Gastroenterology	n/a	n/a
Bogalusa, LA	629GF	1,860	1,775	Cardiology Dermatology Endocrinology Gastroenterology	n/a	Social work
Baton Rouge, LA	629QA	n/a	10,275	Endocrinology Rehab physician	Laboratory & Pathology	Prosthetics Social work

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

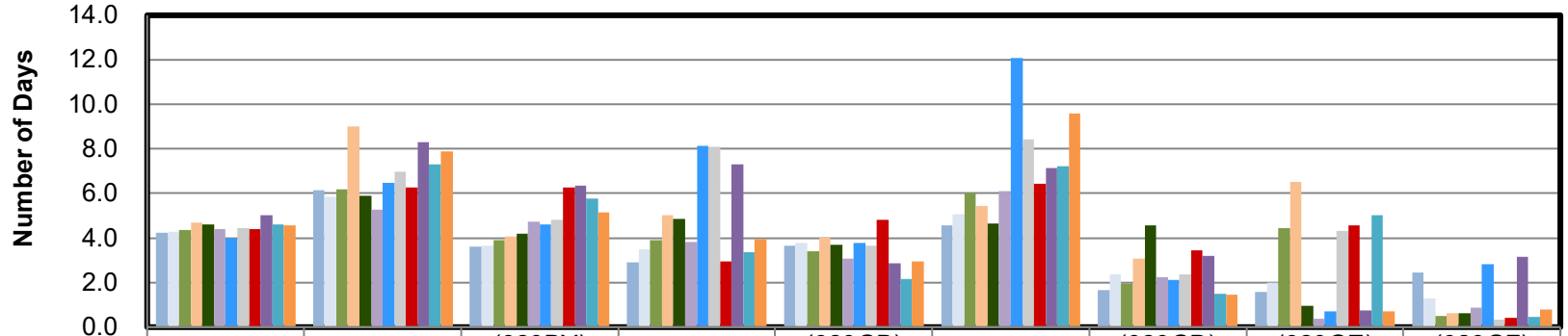
Appendix C: Patient Aligned Care Team Compass Metrics[145]



	VHA Total	(629) New Orleans, LA	(629BY) Baton Rouge, LA	(629GA) Houma, LA	(629GB) Hammond, LA	(629GC) Slidell, LA	(629GD) St. John, LA	(629GE) Franklin, LA	(629GF) Bogalusa, LA
APR-FY18	7.9	49.2	2.0	2.7	3.3	7.0	0.3	0.0	5.3
MAY-FY18	7.7	14.9	2.0	5.5	2.7	3.6	0.0	8.0	1.9
JUN-FY18	7.6	13.4	1.8	7.7	4.9	9.5	2.3	0.5	1.2
JUL-FY18	7.5	12.6	3.2	4.5	7.4	3.9	0.8	2.2	0.6
AUG-FY18	7.7	9.4	3.2	2.7	3.8	3.6	1.4	2.0	1.9
SEP-FY18	8.5	13.7	4.4	3.9	11.8	6.8	0.0	2.1	2.0
OCT-FY19	8.0	8.1	4.4	10.6	9.1	4.8	2.0	1.2	1.9
NOV-FY19	8.5	9.7	2.1	21.1	7.8	4.8	0.0	5.0	0.6
DEC-FY19	8.6	8.6	2.4	2.4	4.9	3.9	0.0	1.5	1.3
JAN-FY19	9.0	9.6	1.3	9.6	2.2	5.0	0.0	8.0	2.1
FEB-FY19	8.5	10.6	6.3	7.7	3.7	4.1	0.0	3.1	0.5
MAR-FY19	8.1	13.8	2.3	10.6	4.0	9.4	0.0	0.0	5.2

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (629QA) Baton Rouge South, LA, as no data were reported. The OIG has on file the facility's explanation for the increased wait times for (629) New Orleans, LA.
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.

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



	VHA Total	(629) New Orleans, LA	(629BY) Baton Rouge, LA	(629GA) Houma, LA	(629GB) Hammond, LA	(629GC) Slidell, LA	(629GD) St. John, LA	(629GE) Franklin, LA	(629GF) Bogalusa, LA
APR-FY18	4.3	6.1	3.6	2.9	3.6	4.5	1.6	1.6	2.5
MAY-FY18	4.3	5.9	3.6	3.5	3.8	5.1	2.4	2.0	1.3
JUN-FY18	4.4	6.2	3.9	3.9	3.4	6.0	2.0	4.4	0.5
JUL-FY18	4.7	9.0	4.1	5.0	4.0	5.5	3.1	6.5	0.6
AUG-FY18	4.6	5.9	4.2	4.9	3.7	4.6	4.6	0.9	0.6
SEP-FY18	4.4	5.3	4.7	3.8	3.1	6.1	2.3	0.4	0.9
OCT-FY19	4.0	6.5	4.6	8.1	3.8	12.1	2.1	0.7	2.8
NOV-FY19	4.4	7.0	4.8	8.1	3.6	8.4	2.4	4.3	0.3
DEC-FY19	4.4	6.3	6.3	3.0	4.8	6.5	3.4	4.5	0.4
JAN-FY19	5.0	8.3	6.4	7.3	2.9	7.1	3.2	0.8	3.1
FEB-FY19	4.6	7.3	5.8	3.4	2.1	7.2	1.5	5.0	0.5
MAR-FY19	4.6	7.9	5.2	3.9	3.0	9.6	1.5	0.7	0.8

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (629QA) Baton Rouge South, LA, as no data were reported
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[146]

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

[146] 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[147]

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.

[147] *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: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 6, 2019

From: Director, South Central VA Health Care Network(10N16)

Subj: Comprehensive Healthcare Inspection of the Southeast Louisiana Veterans Health Care System, New Orleans, LA

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

Director, Management Review Service (VHA 10EG GOAL Action)

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the recommendations, the facility's response, and the request to close three recommendations based on the evidence provided by the Southeast Louisiana Veterans Health Care System, New Orleans, LA.

(Original signed by:)

Skye McDougall, PhD

Network 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.

Appendix G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 4, 2019

From: Director, Southeast Louisiana Veterans Health Care System (629/00)

Subj: Comprehensive Healthcare Inspection of the Southeast Louisiana Veterans Health Care System, New Orleans, LA

To: Director, South Central VA Health Care Network (10N16)

In response to the Draft Comprehensive Healthcare Inspection report (54CH01) received November 20, 2019, I have reviewed and concur with the recommendations and submit action plans. I request closure on 3 recommendations based on evidence provided.

(Original signed by:)

Fernando O. Rivera, FACHE
SLVHCS 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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