



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the Coatesville
VA Medical Center
Pennsylvania



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Figure 1. Coatesville VA Medical Center, Pennsylvania (Source: <https://www.coatesville.va.gov/>, accessed on July 24, 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 Coatesville VA Medical Center (the facility). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

CHIP inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The 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 24, 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), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure, with the Executive Leadership Board having oversight for several working groups. The director was chair of the Executive Leadership Board, which was responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.

The facility's leadership team had been working together for 26 months, although several had served in their position for years. The director and ADPCS were permanently assigned November 27, 2016, and November 4, 2012, respectively. The chief of staff and associate director were also permanently assigned April 30, 2017 and May 14, 2017 respectively.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders had opportunities to improve facility engagement scores to promote a culture where employees felt safe bringing forward issues and concerns. The selected patient experience survey scores for facility leaders were better than the VHA average, and facility leaders had implemented processes and plans to maintain positive patient experiences.

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

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.² Although the leadership 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

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

² VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star rating" system to designate a facility's performance in individual measures, domains, and overall quality.

<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 6, 2019, but is not accessible by the public.)

actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "5-star" and SAIL CLC "2-star" quality ratings.³

The OIG noted deficiencies in all eight clinical areas reviewed and issued 16 recommendations that are attributable to the director, associate director, and chief of staff. These are briefly described below.

Quality, Safety, and Value

The OIG found there was general compliance with requirements for protected peer reviews and resuscitation episode review. However, the OIG identified concerns with the facility's interdisciplinary review of utilization management (UM) data and implementation of root cause analyses actions.⁴

Medical Staff Privileging

The OIG found general compliance with requirements for privileging. However, the OIG identified deficiencies with focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE) processes.⁵

Environment of Care

The parent facility and the Spring City VA Clinic generally met performance indicators evaluated for safety and privacy. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG noted improvement opportunities with environmental cleanliness, annual review of the facility's emergency resources and assets inventory, and testing of emergency generators.

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."

Medication Management

The OIG found general compliance with requirements for most of the performance indicators evaluated. The OIG noted that the staff responsible for conducting the monthly review of balance adjustments also had the security key to perform and document the balance adjustments; this was corrected while the OIG was still on site. However, the OIG identified deficiencies in the appointment process for controlled substance inspectors, completion of annual competency assessments by controlled substances inspectors, and verification of controlled substances orders.

Mental Health

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

Geriatric Care

The OIG found compliance with providers justifying the reason for medication initiation, providing patient/caregiver education, and medication reconciliation. However, the OIG identified that clinicians did not evaluate patient/caregiver understanding of the education provided.

Women's Health

The OIG found compliance with many of the performance indicators, including requirements for a designated women veterans program manager, clinical oversight of the women's health program, tracking of data related to cervical cancer screenings, and follow-up care when indicated. The OIG noted a concern with the Women Veterans Health Committee lacking radiology and laboratory representation in its membership.

High-Risk Processes

The facility complied with some of the performance indicators used by the OIG team to assess the operations and management of the urgent care center (UCC). However, the OIG found that facility managers were operating the UCC 24 hours per day without a waiver and noted insufficient registered nurses on duty during all hours of operation as well as a lack of support services.

Incidental Finding

Additionally, the OIG found that the facility's procedures for patients experiencing a medical emergency involved transportation in a station ambulance to the UCC, instead of a local emergency room.

Summary

In reviewing key healthcare processes, the OIG issued 16 recommendations for improvement directed to the facility director, associate director, and chief of staff. 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 66–67, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

A handwritten signature in black ink, reading "John D. Daigh, Jr., M.D." in a cursive script.

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

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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 Coatesville VA Medical Center (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

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

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

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

⁶ Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/>. (The website was accessed on January 24, 2019.)

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

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

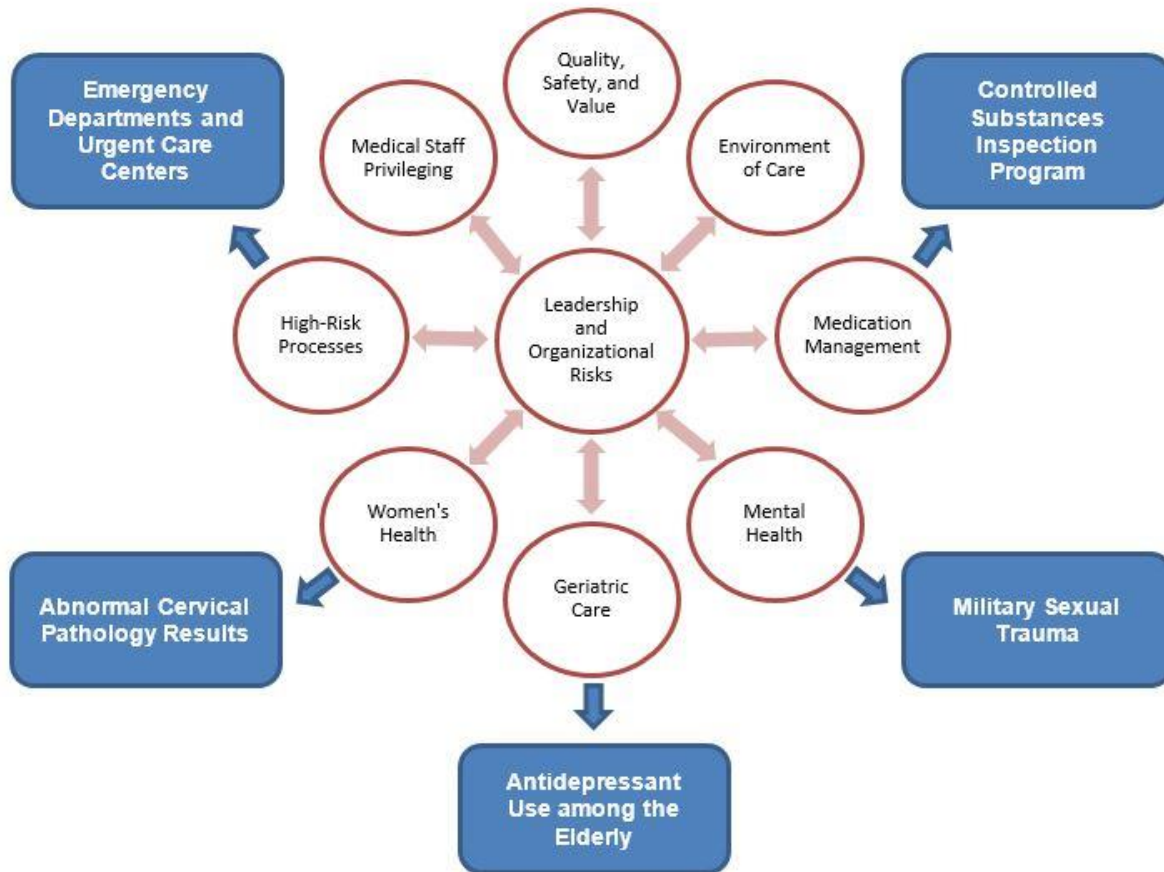


Figure 2. Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

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

Methodology

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

The inspection period examined operations from December 12, 2015, through June 27, 2019, the last day of the unannounced week-long site visit.¹⁰ While on site, the OIG referred issues and concerns beyond the scope of the CHIP review to our Hotline management team for further evaluation.

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

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

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

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

Results and Recommendations

Leadership and Organizational Risks

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

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

Executive Leadership Position Stability and Engagement

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

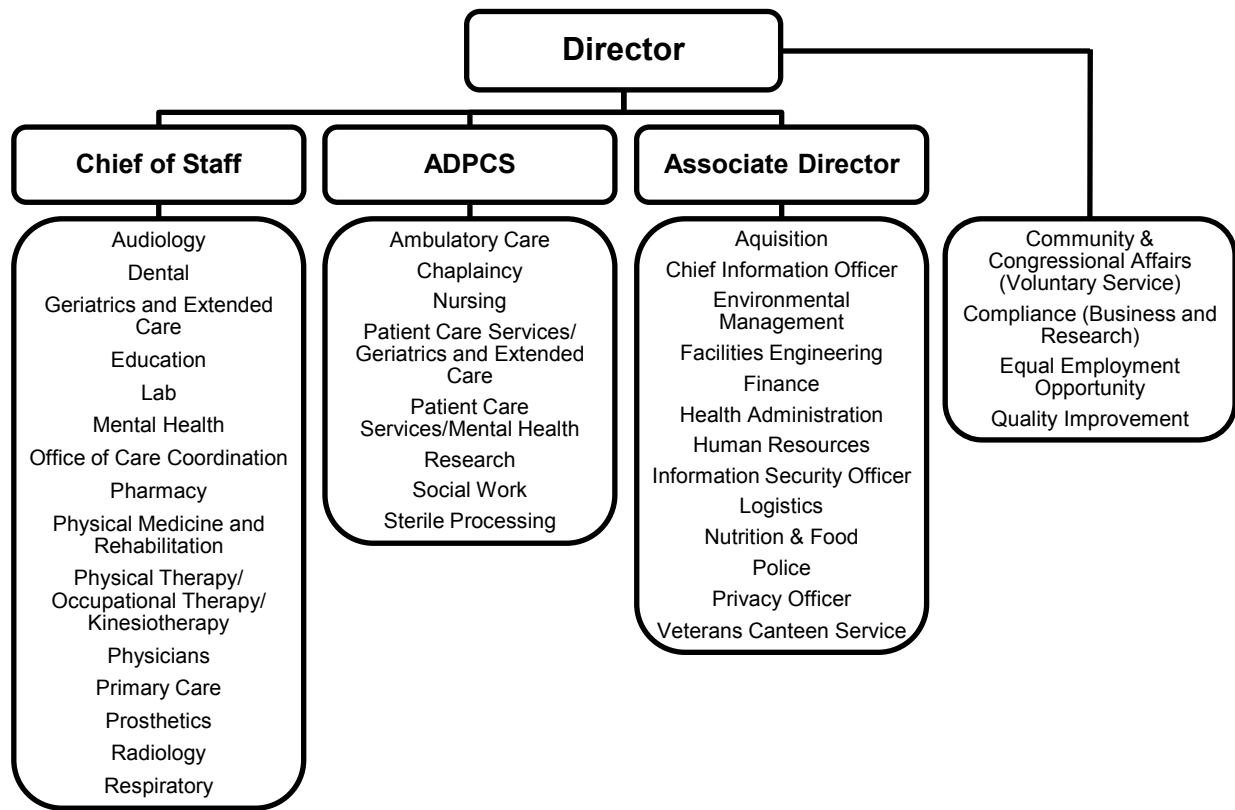


Figure 3. Facility Organizational Chart¹²

Source: Coatesville VA Medical Center (received June 24, 2019)

At the time of the OIG site visit, the executive team had been working together for approximately 25 months, although several team members have been in their position for years (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	November 27, 2016
Chief of staff	April 30, 2017
Associate director for Patient Care Services	November 4, 2012
Associate director	May 14, 2017

Source: Coatesville VA Health Care System human resources officer (received June 26, 2019)

¹² At this facility, the medical center director is responsible for Community and Congressional Affairs (Voluntary Service); Compliance (Business and Research); Equal Employment Opportunity; and Quality Improvement.

To help assess facility executive leaders' engagement, the OIG interviewed the director, chief of staff, ADPCS, 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.

These leaders are engaged in monitoring patient safety and care through the Executive Leadership Board. In February 2019, the committee changed from the Administrative/Clinical Operations Management Board, chaired by the chief of staff, to the Executive Leadership Board, chaired by the director. The Executive Leadership Board is responsible for tracking and identifying trends and monitoring quality of care and patient outcome with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Board oversees various working groups, such as the Medical Executive Board, Administrative Executive Board, Nursing Professional Executive Council, and Performance and Excellence Board. See Figure 4.

In the review of Executive Leadership Board minutes from April 2018 through April 2019, the OIG noted concerns regarding the board's involvement in following actions from implementation to closure; meeting minutes did not clearly indicate when actions related to issues or items presented to the board were in progress or had been closed. Additionally, although Executive Leadership Board minutes documented that program managers reviewed relevant directives over the past 12 months to assess program compliance, the OIG noted that the facility was not compliant with VHA requirements related to utilization management, emergency management, and women veterans programs (see Quality, Safety, and Value; Environment of Care; and Women's Health).

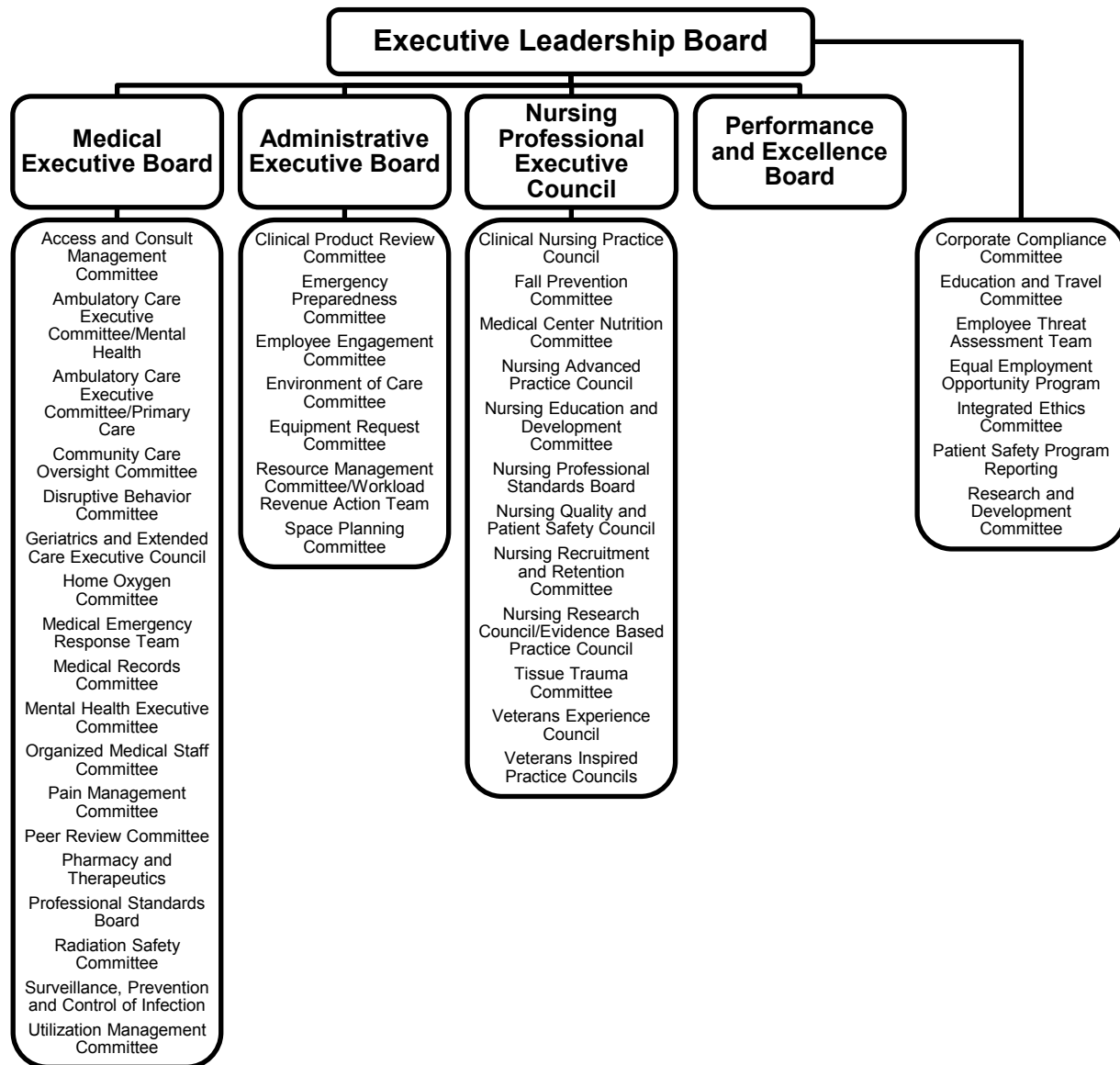


Figure 4. Facility Committee Reporting Structure¹³

Source: Coatesville VA Medical Center (received June 24, 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

¹³ The Executive Leadership Board directly oversees the Corporate Compliance Committee; Education and Travel Committee; Employee Threat Assessment Team; Equal Employment Opportunity Program; Integrated Ethics Committee; Patient Safety Program Reporting; and Research and Development Committee.

for discussions, indicate areas for further inquiry, and be considered along with other information on facility leadership.

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2017, through September 30, 2018.¹⁴ Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for the selected survey leadership questions was lower than the VHA average, while those for the members of the executive leadership team were higher than the VHA average.¹⁵ The leaders appear to have opportunities to improve facility-wide satisfaction and emphasized the importance of front-line supervisors, shared plans to invest in front-line supervisor training, and mentioned ways to reduce the facility's footprint. The director also shared initiatives to increase communication, improve civility, and encourage staff to bring forward concerns to maintain and improve employee satisfaction.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>Servant Leader Index Composite</i> ¹⁶	0–100 where HIGHER scores are more favorable	71.7	70.3	89.6	78.5	84.5	90.6

¹⁴ Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, 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	Assoc. Director Average
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.1	4.6	3.6	3.9	4.2
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.3	4.6	3.7	4.1	4.3
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.4	4.7	3.8	3.9	4.2

Source: VA All Employee Survey (accessed May 23, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility averages for the selected survey questions were similar to the VHA average, and facility leaders were better than the facility and VHA averages. Facility leaders appear to have opportunities to provide an environment where employees feel safe about doing the right thing.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.6	4.6	4.1	4.3	4.4

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>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).</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.6	4.6	4.2	4.1	4.1
All Employee Survey: <i>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)?</i>	0 (Never) – 6 (Every Day)	1.5	1.6	1.0	1.2	1.0	1.2

Source: VA All Employee Survey (accessed May 23, 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 for two of the four survey questions applicable

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

to this facility that reflect patients' attitudes toward facility leaders (see Table 4). The two patient survey results reflected higher care ratings than the VHA average. Facility leaders appeared to be actively engaged with patients. To enhance facility safety, the director established a canine (K-9) unit to detect contraband like illegal drugs and assist with tracking and locating lost individuals. Facility leadership has also partnered with a local food bank to have a mobile fresh food market on site, increasing access to healthy, affordable food options for veterans visiting or residing at the facility. The facility also offered a variety of integrative alternative therapy approaches, such as pain management and goat yoga.

**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): <i>Would you recommend this hospital to your friends and family?</i> ¹⁸	The response average is the percent of "Definitely Yes" responses.	66.9	n/a
Survey of Healthcare Experiences of Patients (inpatient): <i>I felt like a valued customer.</i> ¹⁹	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.2	n/a
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>I felt like a valued customer.</i>	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.3	84.7
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>I felt like a valued customer.</i>	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.5	81.9

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

n/a = not applicable

¹⁸ The facility does not have inpatient beds.

¹⁹ The facility does not have inpatient beds.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.²⁰ Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).²¹ Indicative of effective leadership, the facility has closed all recommendations for improvement.²²

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.²³ Additional results included the Long Term Care Institute's inspection of the facility's CLC.²⁴

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

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

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

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

²⁴ The Long Term Care Institute states that it has been to over 4,000 healthcare facilities conducting quality reviews and over 1,145 external regulatory surveys since 1999. The Long Term Care Institute is "focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings." Long Term Care Institute. <http://www.ltc.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 (<i>Combined Assessment Program Review of the Coatesville VA Medical Center, Coatesville, Pennsylvania, Report No. 15-04708-115, February 9, 2016</i>)	December 2015	10	0
OIG (<i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of the Coatesville VA Medical Center, Coatesville, Pennsylvania, Report No. 15-05163-106, February 9, 2016</i>)	December 2015	4	0
TJC Hospital Accreditation	March 2017	23	0
TJC Behavioral Health Care Accreditation		4	0
TJC Home Care Accreditation		4	0

Source: OIG and TJC (Inspection/survey results received from the director of Quality Improvement on June 25, 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 December 12, 2015 (the prior comprehensive OIG inspection), through June 27, 2019.²⁵

²⁵ 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 Coatesville VA Medical Center is a low complexity (3) facility as described in Appendix B.)

**Table 6. Summary of Selected Organizational Risk Factors
(December 12, 2015, through June 27, 2019)**

Factor	Number of Occurrences
Sentinel Events ²⁶	1
Institutional Disclosures ²⁷	8
Large-Scale Disclosures ²⁸	0

Source: Coatesville VA Health Care System's Risk Manager (received June 26, 2019)

Patient safety indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services provide information on potential in-hospital complications and adverse events following surgeries and procedures.²⁹ However, this data is not applicable since inpatient medical/surgical care is not provided at the facility.

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.³⁰

²⁶ 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.”

²⁷ 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.”

²⁸ 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.”

²⁹ Agency for Healthcare Research and Quality. <https://www.qualityindicators.ahrq.gov/>. (The website was accessed on December 11, 2017.)

³⁰ 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.)

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.³¹ As of June 30, 2018, the facility was rated as “5-star” for overall quality.

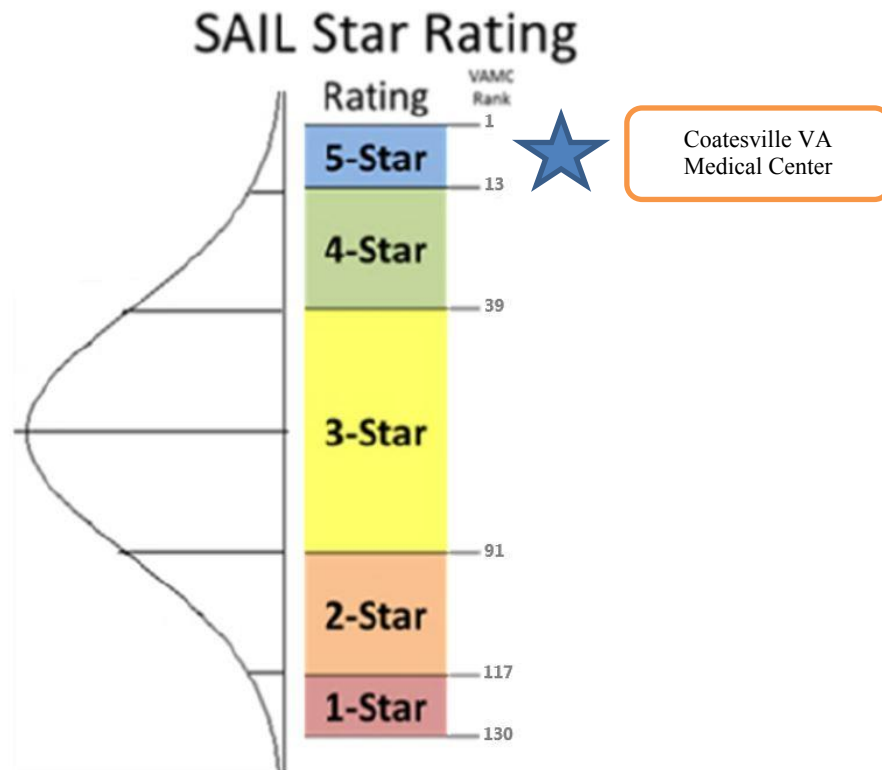


Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)

Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed May 23, 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 rating (of) specialty care (SC) provider, mental health (MH) continuity (of) care, stress discussed, and rating (of) primary care (PC) provider). Metrics that need improvement are denoted in orange and red (for example, call responsiveness, best place to work, and efficiency).³²

³¹ 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.

³² For information on the acronyms in the SAIL metrics, please see Appendix D.

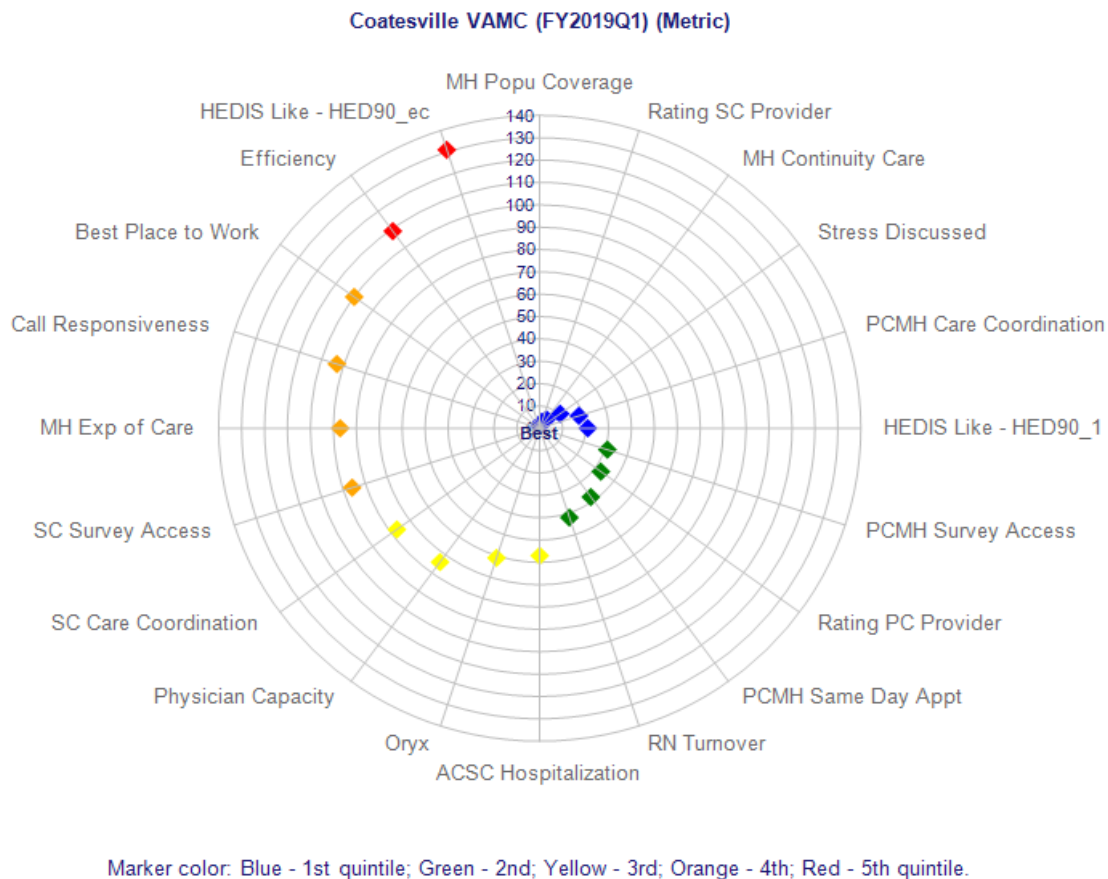


Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)

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*.³³ The SAIL CLC provides a single resource to review quality measures and health inspection results. It

³³ 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.³⁴ Table 7 summarizes the rating results for the facility’s CLC as of March 31, 2019. Although the facility has an overall “5-star” rating, its rating for quality is only a “2-star.”

**Table 7. Facility CLC Star Ratings
(as of March 31, 2019)**

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

Source: VHA Support Service Center

In exploring the reasons for the “2-star” quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 7 illustrates the facility’s CLC quality rankings and performance compared with other VA CLCs as of March 31, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of new or worse pressure ulcer (PU)–short stay (SS) and high risk pressure ulcer (PU) long stay (LS)). Metrics that need improvement and were likely the reasons why the facility had a “2-star” for quality are denoted in orange and red (for example, moderate-severe pain (LS), ability to move independently worsened (LS), and newly received antipsychotic medications (meds) (SS)).³⁵

³⁴ *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.)

³⁵ For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.

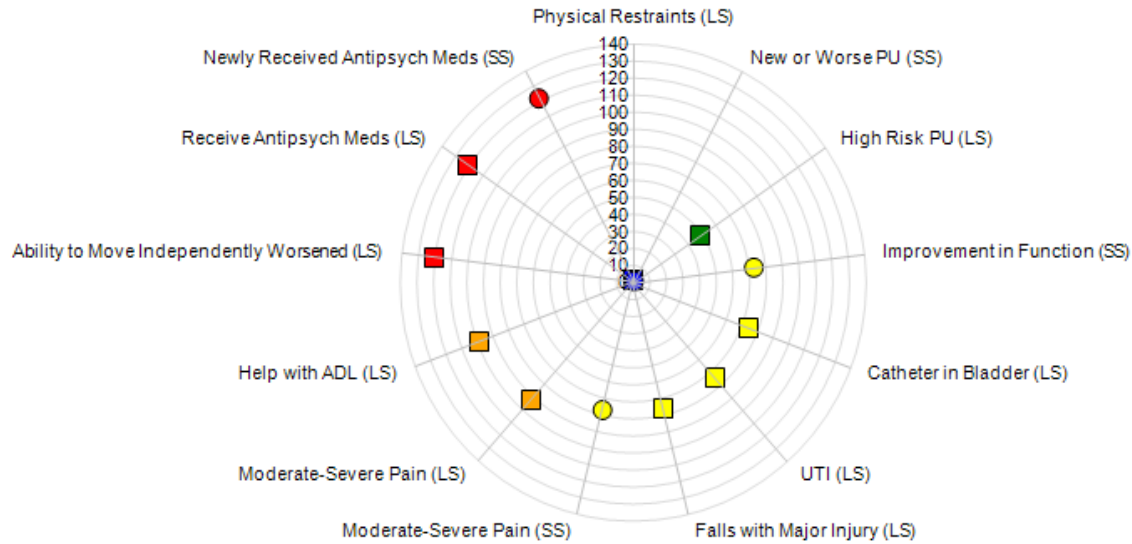


Figure 7. Facility CLC Quality Measure Rankings (as of March 31, 2019)

LS = Long-Stay Measure SS = Short-Stay Measure

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility has generally stable executive leadership. The facility leaders seemed actively engaged with patients and were working to sustain and further improve employee and patient engagement and 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 accreditation organization findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. However, the OIG had concerns regarding the Executive Leadership Board not following actions until completion. Despite program managers reporting to leaders compliance with VHA requirements for utilization management, emergency management, and women veterans programs, the OIG noted noncompliance (see Quality, Safety and Value; Environment of Care; and Women's Health). The leadership team was aware of SAIL and CLC data but should continue to take actions to maintain and improve care and performance of measures likely contributing to the facility's SAIL "5-star" and CLC "2-star" quality ratings.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.³⁶ VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.³⁷ VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.³⁸

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,³⁹ utilization management (UM) reviews,⁴⁰ patient safety incident reporting with related root cause analyses,⁴¹ and cardiopulmonary resuscitation (CPR) episode reviews.⁴²

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.⁴³

³⁶ 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.)

³⁷ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

³⁸ VHA Directive 1026.

³⁹ The definition of a peer review can be found within VHA Directive 1190. 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.

⁴⁰ 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.

⁴¹ 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."

⁴² VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

⁴³ 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.⁴⁴

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.⁴⁵

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.⁴⁶

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:⁴⁷

- 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

⁴⁴ VHA Directive 1117(2).

⁴⁵ VHA Handbook 1050.01.

⁴⁶ VHA Directive 1177; VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017.

⁴⁷ 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 unit⁴⁸
- UM⁴⁹
 - 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 analyses⁵⁰
 - 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 found general compliance with requirements for protected peer reviews and resuscitation episode reviews. However, the OIG identified concerns with the facility's

⁴⁸ VHA Directive 1190.

⁴⁹ This facility does not provide inpatient care.

⁵⁰ According to VHA Handbook 1050.01, "the requirement for a total of eight [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of [root cause analyses] is driven by the events that occur and the [Safety Assessment Code] SAC score assigned to them. At least four analyses per fiscal year must be individual [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses]."

participation of all required members in the interdisciplinary review of UM data and the implementation of root cause analyses actions that warranted recommendations for improvement.

Specifically, VHA requires interdisciplinary review of UM data. This process must include, but not be limited to, participation by “representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR [chief business office revenue-utilization review].”⁵¹ From January 2018 through January 2019, the UM Committee lacked consistent representation from social work and the utilization review. Further, the OIG noted that Executive Leadership Board minutes for August 2018 documented the UM Committee was compliant with VHA Directive 1117(1)⁵² requirements although membership was not corrected until two months later. A social work representative was added to the committee in October 2018 and attended two meetings. The utilization review representative was added in January 2019 and attended one meeting. As a result, the committee reviewed and analyzed UM data without the perspectives of key social work and utilization review colleagues for the majority of the past thirteen months (prior to the OIG site visit). The UM coordinator stated they were unaware of the requirement and self-identified the deficiency after reviewing published OIG CHIP reports.

Recommendation 1

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

Facility concurred.

Target date for completion: July 31, 2020

Facility response: The Office of Care Coordination Chief will ensure compliance by adding a social worker and a utilization review representative to compliment the interdisciplinary team on the committee. Members have been notified they are required to send a designee if they are unable to attend. Negative attendance trends will be reported by the chair of the Utilization Management Committee to the Chief of Staff through the Medical Executive Board. Representatives from all disciplines attended both July and October meetings (quarterly meetings). Minutes are reported to the Medical Executive Board. Sustainability will be monitored based on a benchmark of 90% for two quarterly meetings or six consecutive months by the Medical Executive Board.

⁵¹ VHA Directive 1117(2).

⁵² VHA Directive 1117(2).

VHA requires that corrective actions identified through the root cause analysis process are “defined and implemented, to prevent future occurrences of similar events.”⁵³ For all five root cause analyses reviewed, the OIG did not find evidence of action plan implementation. This resulted in the potential for future occurrences of similar events. The director for Quality Improvement reported that the patient safety program staff’s workload is high, the assigned staff had difficulty keeping up with all responsibilities, and additional staff were assigned to assist with root cause analyses follow-up.

Recommendation 2

2. The facility director ensures that managers consistently implement corrective actions identified in root cause analyses and monitors compliance.

Facility concurred.

Target date for completion: September 30, 2020

Facility response: The Quality Improvement Director will ensure compliance by utilizing a SharePoint based program to support the sustained improvement of corrective actions identified in root cause analyses by tracking through to closure. This information will be reported to the Executive Leadership Board and documented in minutes to monitor for sustainability. A reduction in outstanding corrective actions will be monitored through the Executive Leadership Board to reach a benchmark of 100% completion within 6 consecutive months.

⁵³ VHA Handbook 1050.01.

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).⁵⁴

Clinical privileges need to be specific, based on the individual’s clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to their expiration.⁵⁵

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.”⁵⁶

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.⁵⁷ 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.⁵⁸

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:

⁵⁴ 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.)

⁵⁵ VHA Handbook 1100.19.

⁵⁶ VHA Handbook 1100.19.

⁵⁷ 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).

⁵⁸ VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. (This VHA Handbook was scheduled for recertification on or before the last working date of December 2014 and has not been recertified.)

- Four solo or few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months⁵⁹
- Six LIPs hired within 18 months before the site visit
- Twenty LIPs re-privileged within 12 months before the visit
- No providers 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-specific⁶⁰
 - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
 - Criteria defined in advance
 - Use of required criteria in FPPEs for selected specialty LIPs
 - Results and time frames clearly documented
 - Evaluation by another provider with similar training and privileges
 - Executive Committee of the Medical Staff consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
 - Criteria specific to the service or section
 - Use of required criteria in OPPEs for selected specialty LIPs

⁵⁹ The 18-month period was from December 24, 2017, through June 24, 2019. The 12-month review period covered June 24, 2018, through June 24, 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.

⁶⁰ According to VHA Handbook 1100.19, “facility-specific” means that privileges are granted only for procedures and types of services performed at the facility; “service-specific” refers to privileges being granted in a specific clinical service, such as neurology; and “provider-specific” means that the privileges should be granted to the individual provider based on their clinical competence and capabilities.

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

Medical Staff Privileging Conclusion

The OIG found general compliance with requirements for privileging. However, the OIG had a concern with the facility's process for recommending privileging actions to the director that warranted a recommendation for improvement.

Specifically, VHA requires that an appropriate executive level committee of the medical staff review and evaluate LIPs' initial and re-privileging requests prior to making recommendations to the facility director. This ensures that privileging recommendations are based on the practitioner's credentials and performance.⁶¹ The OIG found insufficient evidence in nine FPPE and 21 OPPE providers' profiles (four of which were solo providers) that the Medical Executive Board reviewed and recommended privileging actions to the director. The OIG noted that the facility's Professional Standards Board,⁶² which does not have the appropriate level of authority, was reviewing and recommending privileging actions to the director. The Medical Executive Board's lack of input to the director resulted in incomplete reviews to support the facility director's approval for granting or continuing privileges. The chief of staff reported an error in the committee structure as the reason for noncompliance.

⁶¹ VHA Handbook 1100.19.

⁶² According to *Bylaws and Rules of the Medical Staff of VHA*, Coatesville VA Medical Center, "the Professional Standards Board/Credentialing Committee acts on credentialing and clinical privileging matters of the Medical Staff, making recommendation on such matters to the Executive Committee of the Medical Staff (MEB) as defined in these Bylaws."

Recommendation 3

3. The chief of staff ensures that the Medical Executive Board reviews and evaluates licensed independent practitioners' initial and re-privileging requests prior to making recommendations to the facility director.

Facility concurred.

Target date for completion: July 31, 2020

Facility response: The governance structure for the Medical Executive Board and Professional Standards Board are two separate committees with individual memberships. The Chief of Staff will ensure compliance by revising the Medical Executive Board agenda to now include credentialing as a standing agenda item. Approval of privileges is recommended to the Medical Executive Board and recorded in the minutes. Sustainability will be monitored based on a benchmark of 100% for six consecutive months as evidenced by the Medical Executive Board meeting minutes.

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.⁶³

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.⁶⁴

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.⁶⁵

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.⁶⁶ Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,⁶⁷

⁶³ VHA Directive 1608, *Comprehensive Environment of Care (CEOC Program)*, February 1, 2016.

⁶⁴ 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).

⁶⁵ 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.)

⁶⁶ VHA Directive 0320.01.

⁶⁷ 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,⁶⁸ and National Fire Protection Association standards.⁶⁹ The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.⁷⁰

In all, the OIG team inspected five areas—CLC (building 59-B/2nd floor and building 138-east/hospice), inpatient mental health (building 59-A), UCC (building 3-ground floor), and outpatient specialty clinic (building 3-A). The team also inspected the Spring City VA Clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

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

⁶⁸ 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.)

⁶⁹ 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.)

⁷⁰ TJC. Environment of Care standard EC.02.05.07.

- 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 Spring City VA Clinic generally met performance indicators evaluated for safety and privacy. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG team noted improvement opportunities with maintaining environmental cleanliness, annually reviewing the facility's inventory of emergency resources and assets, and testing and documenting emergency generators.

Specifically, TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices,⁷¹ and to “keep furnishings and equipment safe and in good repair”.⁷² Of the five patient care areas inspected at the parent facility, all had dusty heating, ventilation, and air conditioning grills;⁷³ two units had dirty floors,⁷⁴ dirty light fixtures⁷⁵ and stained/damaged ceiling tiles;⁷⁶ and one unit had cleanliness issues with spider/cobwebs in rooms corners.⁷⁷ These findings may affect the safety and physical well-being of patients, staff, and visitors. The chief engineer reported five leadership vacancies which hindered effective supervisory oversight. The chief of Environmental Management reported the service had been without an assistant chief for over 11 months and had vacancies for seven housekeeping aides and one work leader.

Recommendation 4

4. The associate director ensures managers maintain a safe and clean environment in patient care areas and monitors managers' compliance.

⁷¹ TJC. Environment of Care standard EC.04.01.01.

⁷² TJC. Environment of Care standard EC.02.06.01.

⁷³ CLC (building 59-B, building 138-east-hospice), UCC (building 3-A), outpatient specialty clinic (building 3-A), inpatient mental health (building 59-A).

⁷⁴ CLC (building 59-B), UCC (building 3-A).

⁷⁵ CLC (building 59-B and building 138-east-hospice).

⁷⁶ CLC (building 59-B and building 138-east-hospice).

⁷⁷ CLC (building 138-east-hospice).

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Housekeeping Supervisors with direction from the Chief and Assistant Chief of Environmental Management will ensure compliance with maintaining a clean and safe environment by conducting weekly inspections of patient care areas. The Housekeeping Supervisors are required to meet with their teams monthly to provide refresher training. Documentation of attendance for the weekly supervisory inspections and monthly training meetings is recorded and submitted to the Environment of Care Committee of which the Associate Director is a member. Inspection documentation will meet a benchmark of 90% for six consecutive months.

For emergency management, VHA⁷⁸ and TJC⁷⁹ require facilities to have a comprehensive emergency management plan that includes a documented inventory of resources and assets that may be needed during emergencies. This inventory must be evaluated by the Emergency Management Committee and approved by the executive leadership team annually.⁸⁰

The OIG found no evidence of a comprehensive inventory of resources and assets for emergency equipment, resources, and supplies, despite program staff reporting in June 2018 to the Executive Leadership Board that the facility was in compliance.⁸¹ This resulted in a lack of assurance that the facility was prepared for contingency operations during emergencies. The emergency manager reported a comprehensive inventory of emergency resources and assets was not documented and reviewed annually due to a lack of awareness of the requirement.

Recommendation 5

5. The associate director verifies that the inventory of resources and assets that may be needed during an emergency is documented and reviewed annually and monitors compliance.

⁷⁸ VHA Directive 0320.01.

⁷⁹ TJC. Emergency Management standard EM.03.01.01.

⁸⁰ VHA Directive 0320.01.

⁸¹ VHA Directive 0320.01.

Facility concurred.

Target date for completion: August 31, 2020

Facility response: The annual inventory review of the Emergency Management Cache and Nutrition and Food Cache was completed by the Fire Chief. The Emergency Management Committee approved the annual inventory review on July 11, 2019. To ensure all the Emergency Cache annual reviews are completed, a reporting schedule will be created and reported to the Emergency Management Committee. The Associate Director will ensure compliance.

Additionally, VHA⁸² and TJC⁸³ require facilities to test generators monthly and triennially. When the monthly generator testing does not reach the minimum required 30 percent dynamic load, TJC requires a facility test a generator once every 12 months at load (dynamic or static) of 50 percent for 30 minutes, followed by 75 percent load for 60 minutes for a total of 90 continuous minutes.⁸⁴ The OIG found no evidence of testing to reach the minimum load either monthly or annually in 2017 for the generators reviewed. This could have resulted in a lack of assurance of operational readiness and reliability of the generators when needed during emergency conditions. The chief engineer reported that due to a staffing change, the 2017 generator testing documentation could not be located.

Recommendation 6

6. The associate director ensures that emergency generators are tested in accordance with required standards and results are documented and monitors compliance.

Facility concurred.

Target date for completion: July 31, 2020

Facility response: Coatesville VA Medical Center completed a full load bank test for all campus generators on 3/26/2019 and 4/10/2019 and currently has a service contract in place to continue this testing on an annual basis. Full and complete records will be filed for each individual generator and saved as a hard copy for all future inspections in the Facility and Engineering Service Department. Reports will be submitted to the Environment of Care Committee which is chaired by the Associate Director. This issue will be added as an annual standing agenda item. Compliance will be monitored by a Facilities Engineering Supervisor.

⁸² VHA Directive 1028, *Electrical Power Distribution Systems*, July 25, 2014.

⁸³ TJC. Environment of Care standard EC.02.05.07.

⁸⁴ TJC. Environment of Care standard EC.02.05.07.

Medication Management: Controlled Substances Inspections

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

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

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

- Controlled substances coordinator reports
 - Monthly summary of findings to the director
 - Quarterly trend reports to the director
 - Quality Management Committee's review of monthly and quarterly trend reports
 - Actions taken to resolve identified problems
- Pharmacy operations
 - Staff restrictions for monthly review of balance adjustments⁸⁹
- Requirements for controlled substances inspectors

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

⁸⁶ American Society of Health-System Pharmacists, "ASHP Guidelines on Preventing Diversion of Controlled Substances," *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

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

⁸⁸ The two quarters were from October 1, 2019, through March 31, 2019.

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

- No conflicts of interest
- Appointed in writing by the director for a term not to exceed three years
- Hiatus of one year between any reappointment
- Completion of required annual competency assessment
- Controlled substances area inspections
 - Completion of monthly inspections
 - Rotations of controlled substances inspectors
 - Patterns of inspections
 - Completion of inspections on day initiated
 - Reconciliation of dispensing between pharmacy and each dispensing area
 - Verification of controlled substances orders
 - Performance of routine controlled substances inspections
- Pharmacy inspections
 - Monthly physical counts of the controlled substances in the pharmacy
 - Completion of inspections on day initiated
 - Security and verification of drugs held for destruction⁹⁰
 - Accountability for all prescription pads in pharmacy
 - Verification of hard copy controlled substances prescriptions
 - Verification of twice a week (three days apart) inventories of the main vault⁹¹
 - Quarterly inspections of emergency drugs
 - Monthly checks of locks and verification of lock numbers
- Facility review of override reports⁹²

⁹⁰ According to VHA Directive 1108.02(1), the Destructions File Holding Report “lists all drugs awaiting local destruction or turn-over to a reverse distributor.” Controlled substances inspectors “must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.”

⁹¹ 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*.)

⁹² 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

The OIG found general compliance with requirements for most of the performance indicators evaluated. The OIG team noted that the staff responsible for conducting the monthly review of balance adjustments also had the security key to perform and document the balance adjustments; however, this was corrected while the OIG team was still on site. The OIG identified deficiencies in appointments and competencies of controlled substance inspectors and verification of controlled substances orders that warranted recommendations for improvement.

VHA requires that the facility director appoint an adequate number of controlled substances inspectors, in writing, to a term not to exceed three years and that the controlled substances coordinator complete an annual competency assessment for the inspectors.⁹³

The OIG found that 3 of 10 controlled substances inspectors did not have an appointment in writing by the facility director or have a competency assessment. This resulted in instances where controlled substances inspectors conducted inspections without written authorization or formal evaluation of their knowledge, skills, and abilities to fulfill their duties and responsibilities. The controlled substances coordinator, who was assigned this role in February 2019, was not aware of the requirements until receiving training in March 2019 and, due to competing priorities, was unable to address all requirements prior to the OIG site visit.

Recommendation 7

7. The facility director makes certain that controlled substances inspectors are appointed in writing and monitors compliance.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: There are a total of 20 Controlled Substance Inspectors appointed, to which all have appointment letters filed with the Controlled Substance Inspector. To ensure continued compliance with this expectation, the Controlled Substance Coordinator will add appointment letter compliance information to the quarterly report that is submitted to the Medical Executive Board. The Quality Improvement Director is a member of the Medical Executive Board and will ensure compliance. The Medical Center Director reviews and signs the Medical Executive Board minutes. Sustainability will be monitored based on a benchmark of 100% for six consecutive months.

⁹³ VHA Directive 1108.02(1).

Recommendation 8

8. The facility director makes certain that the controlled substances coordinators complete annual competency assessment of inspectors and monitors coordinators' compliance.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: Out of 20 Controlled Substance Inspectors, there are 5 who have been recently appointed and are currently in training. The remaining 15 have completed their annual competencies and this is documented in the records maintained by the Controlled Substance Coordinator. The Controlled Substance Coordinator will add this annual competency compliance information to the quarterly report that is submitted to the Medical Executive Board of which the Quality Improvement Director is a member. The Quality Improvement Director will ensure compliance. The Medical Center Director reviews and signs the Medical Executive Board minutes. Sustainability will be monitored based on a benchmark of 100% for six consecutive months.

VHA requires that during controlled substances area inspections, controlled substances inspectors verify that there is evidence of a written or electronic controlled substances order for five randomly selected dispensing activities.⁹⁴ The OIG reviewers found that during October 2018 through March 2019, controlled substances inspectors did not consistently verify five random dispensing activities in all 10 non-pharmacy areas reviewed. Failure to verify orders may result in missed opportunities to identify potential drug diversion activities and any discrepancies related to controlled substances. The controlled substance coordinator explained that some inspectors were unaware of the number of required reviews per dispensing area for random order verifications.

Recommendation 9

9. The facility director makes certain that the controlled substances inspectors verify controlled substance orders for five randomly selected dispensing activities and monitors coordinators' compliance.

⁹⁴ VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The 15 established Controlled Substance Inspectors have been retrained and the 5 newly appointed Controlled Substance Inspectors have received this information in their training, but completion of their training program is still ongoing. To ensure ongoing compliance with this expectation, the Controlled Substance Coordinator will add information to the quarterly report regarding compliance that controlled substance orders for five randomly selected dispensing activities have been completed and submit compliance rate to the Medical Executive Board of which the Quality Improvement Director is a member. The Quality Improvement Director will ensure compliance. The Medical Center Director reviews and signs the Medical Executive Board minutes. Sustainability will be monitored based on a benchmark of 90% for six consecutive months.

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.”⁹⁵ 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.⁹⁶

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.⁹⁷ Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.⁹⁸

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.⁹⁹ Those who screen positive must have access to appropriate MST-related care.¹⁰⁰ 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.¹⁰¹

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.¹⁰² All mental health and primary care providers must complete MST mandatory

⁹⁵ VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

⁹⁶ Military Sexual Trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on November 17, 2017.)

⁹⁷ VHA Directive 1115.

⁹⁸ 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.)

⁹⁹ 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.”

¹⁰⁰ VHA Directive 1115.

¹⁰¹ VHA Handbook 1160.01.

¹⁰² 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.¹⁰³

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 30 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. The OIG noted a concern, however, with providers completing the MST mandatory training that warranted a recommendation for improvement.

VHA requires that all primary care and mental health providers hired after July 1, 2012, must complete MST mandatory training no later than 90 days after assuming their position.¹⁰⁴ The OIG found that 3 of 13 providers did not complete the required training within 90 days after

¹⁰³ 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.

¹⁰⁴ VHA Directive 1115.01; 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.

entering their positions. This could prevent clinicians from providing appropriate counseling, care, and service to veterans who experienced MST. The associate chief of staff for Mental Health stated that due to reassignments, supervisors may not have been alerted via the electronic education system regarding when their employees' training requirements were due and therefore were not able to provide adequate oversight.

Recommendation 10

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

Facility concurred.

Target date for completion: June 30, 2020

Facility response: A new process was developed at Coatesville VA Medical Center. When new providers begin, they are automatically assigned the required MST training for their position, and it is automatically due within 90 days. To ensure compliance, assignment and timely completion of the required MST training for new providers will be monitored by the MST Coordinator until 90% compliance is reached and maintained for six consecutive months. This information will be reported through the Women Veterans Health Committee meetings on a bi-monthly basis whose minutes are reviewed at the Ambulatory Care/Primary Care Executive Committee.

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."¹⁰⁵ 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.¹⁰⁶

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 antidepressant drugs, psychotherapy, or a combination of both."¹⁰⁷

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.¹⁰⁸ 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."¹⁰⁹ In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.¹¹⁰ 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.¹¹¹ The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

¹⁰⁵ 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.)

¹⁰⁶ 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.)

¹⁰⁷ 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.)

¹⁰⁸ 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.sgot.org/allegato_docs/1057_Beers-Criteria.pdf. (The website was accessed on March 22, 2018.)

¹⁰⁹ TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

¹¹⁰ VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

¹¹¹ 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.¹¹²

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 27 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.¹¹³ 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 found compliance with providers justifying the reason for medication initiation, providing patient/caregiver education, and medication reconciliation. However, the OIG identified that clinicians did not evaluate patient/caregiver understanding when education was provided that warranted a recommendation for improvement.

TJC requires that clinicians educate patients and families about “safe and effective use of medications” as well as evaluate “the patient’s understanding of the education and training [that was] provided.”¹¹⁴ The OIG determined that clinicians assessed understanding of education provided for 58 percent of the patients at the facility, based on the electronic health records reviewed.¹¹⁵ Providing medication education and confirming patients’ understanding are critical steps to ensure that patients or their caregivers have the information they need to manage their own health at home.¹¹⁶ The chief of Psychiatry believed the requirement was being met because the providers documented that the patient did not have any questions.

¹¹² VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

¹¹³ The seven selected antidepressant medications are Amitriptyline, Clomipramine, Desipramine, Doxepin (>6mg/day), Imipramine, Nortriptyline, and Paroxetine.

¹¹⁴ TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

¹¹⁵ Confidence intervals are not included because the data represents every patient in the study population.

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

Recommendation 11

11. The chief of staff makes certain that clinicians document patient and/or caregiver understanding of the education provided about the safe and effective use of newly prescribed medications and monitors the clinicians' compliance.

Facility concurred.

Target date for completion: September 30, 2020

Facility response: Coatesville's medication reconciliation clinical reminder was revised in early 2019 to include the patient and/or caregiver's verbalized understanding to the medication education provided for all prescribed medications but not all clinicians were using this clinical reminder. As of July 7, 2019, all clinicians were re-educated to use the required medication reconciliation clinical reminder. Medication reconciliation documentation compliance will be monitored by Quality Improvement Staff with a benchmark of 90% for six consecutive months. This information will be reported through service line committees to the Medical Executive Board which is chaired by the Chief of Staff.

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.¹¹⁷ Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.¹¹⁸ In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.¹¹⁹ Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.¹²⁰

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.¹²¹

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.¹²²

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

¹¹⁷ 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.)

¹¹⁸ Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

¹¹⁹ 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.)

¹²⁰ 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.)

¹²¹ VHA Directive 1330.01(2).

¹²² 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.¹²³

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 four women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

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

Women's Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including requirements for a designated women veterans program manager, clinical oversight of the women's health program, tracking of data related to cervical cancer screenings, and follow-up care when indicated. The OIG determined that ordering providers notified patients of abnormal results within seven calendar days in three of the four electronic health records reviewed. However, the OIG noted noncompliance with the Women Veterans Health Committee membership that warranted a recommendation for improvement.

¹²³ VHA Directive 1330.01(2).

Specifically, VHA requires that the core membership of the Women Veterans Health Committee includes a women veterans program manager; a women's health medical director; and "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 the executive leadership."¹²⁴ Despite an assessment by the woman veterans program manager reporting program compliance to the Executive Leadership Board in November 2018, the OIG team noted that the membership of the Women Veterans Advisory Council, formally, the Women Veterans Health Committee, lacked representation from the radiology and laboratory departments. This resulted in a lack of expertise and oversight in the review and analysis of data to ensure appropriate clinical services are available to women veterans. The quality coordinator believed the facility was in compliance because the radiology department was not performing mammograms at the parent facility but stated the lack of a laboratory representative was an error.

Recommendation 12

12. The chief of staff makes certain the Women Veterans Health Committee is comprised of the required core members and monitors committee's compliance.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The Women Veterans Health Committee charter will be updated to include all required members as per the Directive. The Women's Health Committee membership has been expanded to include laboratory and radiology department representatives. Attendance will be recorded and monitored in the minutes. Negative attendance trends will be reported by the chair of the Women Veterans Health Committee to the Chief of Staff to ensure compliance through the Medical Executive Board. Sustainability will be monitored based on a benchmark of 90% for two quarterly meetings or six consecutive months.

¹²⁴ VHA Directive 1330.01(2).

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

VHA defines an emergency department as a “unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations.” An urgent care center (UCC) “provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries.”¹²⁵ 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.¹²⁶

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.”¹²⁷

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.”¹²⁸

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.¹²⁹

¹²⁵ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016 (amended March 7, 2017).

¹²⁶ VHA Directive 1101.05(2).

¹²⁷ VHA Directive 1101.05(2).

¹²⁸ TJC. Leadership standard LD.04.03.11.

¹²⁹ 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.¹³⁰ Managers must ensure medications are securely stored,¹³¹ a psychiatric intervention room is available,¹³² 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.¹³³

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

¹³⁰ VHA Directive 1101.05(2).

¹³¹ TJC. Medication Management standard MM.03.01.01.

¹³² A psychiatric intervention room is where individuals experiencing a behavioral health crisis, including serious disturbances, agitation, or intoxication may be taken immediately on arrival.

¹³³ 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 tracks¹³⁴
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
 - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

The facility complied with some of the performance indicators used by the OIG team to assess the operations and management of the UCC. However, the OIG found the following areas of noncompliance that warranted recommendations for improvement: around-the-clock UCC operations without a waiver and required staffing with registered nurses and availability of support services during all hours of operation.

VHA requires that VA medical facilities operating a UCC 24 hours a day, seven days a week, must request and receive approval for a “waiver from the national director of Emergency

¹³⁴ The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated.

Medicine to ensure safe patient care with proper staffing and support.”¹³⁵ The OIG review team found the facility did not have a waiver to operate the UCC with continuous hours. This hindered VHA leadership’s awareness and ability to ensure that all facilities provide safe UCC care during all hours of operation. Facility leadership was aware of the need for a waiver and had submitted a request to the VISN in February 2019, as required, before submitting a formal waiver to the national director; however, no action had been taken by the VISN prior to the OIG team’s arrival.

Recommendation 13

13. The facility director makes certain that if the urgent care center operates 24 hours a day, seven days a week, that the national director of Emergency Medicine has approved a waiver.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The facility director is ensuring compliance by approving a phased reduction in operational hours that began on Monday, October 28, 2019. The phased approach will reduce hours gradually to reach a closing hour of 5 pm by March 2, 2020 and there will be no federal holiday and weekend operational hours for the Urgent Care. All employees were notified of the phased reduction.

As previously mentioned, VHA requires that a UCC has appropriately educated and qualified emergency care professionals physically present in the UCC during all hours of operation. This includes a licensed physician and a minimum of two registered nurses.¹³⁶ The OIG found that the UCC is open 24 hours a day, seven days a week, and was staffed by at least one licensed physician, but was not staffed with two registered nurses between 7 p.m. and 8 a.m. each day. One UCC registered nurse and the physician also respond to emergencies outside of the UCC. This could result in potentially unsafe situations in the UCC when a single clinical staff member—a licensed practical nurse—is the only one present in the UCC.¹³⁷ The assistant nurse manager for the UCC and director of Ambulatory Care Service stated awareness of the requirement to have two registered nurses staff the UCC at all times, however, they had made no changes to the nurse staffing.

¹³⁵ VHA Directive 1101.05(2).

¹³⁶ VHA Directive 1101.05(2).

¹³⁷ VHA Directive 1101.05(2).

Recommendation 14

14. The facility director makes certain that the urgent care center is staffed with at least two registered nurses at all times of operation and monitors the center's compliance.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: As of October 28, 2019, a minimum of two Registered Nurses were scheduled during all hours of operation. Registered Nurse staffing compliance will be adjusted to meet the Directive.

Additionally, VHA requires that necessary resources, including support services, are provided to the UCC to ensure timely access to care for patients.¹³⁸ The OIG reviewers found that the facility does not have laboratory, pharmacy, radiology, or social work available, or on call, during all hours of UCC operation. This resulted in delays and inconsistent delivery of care. The assistant manager of ambulatory services believed practices met requirements and stated that, when support services were not available for laboratory and radiology, the UCC staff used the station ambulance to transport blood specimens for local community hospital analysis and to send patients for x-rays. The assistant manager also stated that, for pharmacy, the facility used a virtual pharmacist if needed. The social work supervisor stated an unawareness of the requirement for social work support for the UCC.

Recommendation 15

15. The facility director ensures that support services are available to the urgent care center during all hours of operation and monitors compliance.

Facility concurred.

Target date for completion: April 1, 2020

Facility response: The facility director is ensuring compliance by approving a phased reduction in operational hours that began on Monday, October 28, 2019. The phased approach will reduce hours gradually to reach a closing hour of 5 pm by March 2, 2020 and there will be no federal holiday and weekend operational hours for the Urgent Care. All employees were notified of the phased reduction. The Urgent Care hours will ultimately only be open during the same operational hours of the ancillary services. The social work supervisors are available after hours to be contacted for any urgent care concerns during the hours of operation.

¹³⁸ VHA Directive 1101.05(2).

Incidental Finding

Facility Ambulance

VHA requires UCCs to not accept ambulances.¹³⁹ The OIG team found that patients or visitors who had a medical emergency while on facility grounds had been transported by facility ambulance to the UCC following an evaluation by the code team. The OIG also noted that the facility did not have a policy or guideline on the use of the station ambulance for transfers, and per the UCC medical director, the medical officer of the day makes the decision to transport patients to the UCC. As noted above, the facility was operating without support services during most hours of operation and transporting a patient with a medical emergency to the UCC instead of a local emergency room could result in the delay of appropriate evaluation and care. Despite the requirements, the medical director for the UCC believed that this was appropriate and did not provide a reason for noncompliance.

Recommendation 16

16. The facility director makes certain the urgent care center does not receive patients via ambulance and monitors compliance.

Facility concurred.

Target date for completion: May 30, 2020

Facility response: As of November 8, 2019, Coatesville VA Medical Center has discontinued ambulance transportation of Veterans to Urgent Care following medical emergency responses. Fire Department ambulance responders have been educated regarding discontinuation of ambulance transfers to Urgent Care. A policy is being developed by the Medical Emergency Response Team (MERT) Committee to define a supportive and safe procedure to meet this recommendation. After approval of the policy, training of 90% staff will be completed by March 31, 2020. Implementation of the emergency response patient transfer procedure will be monitored by the MERT Committee. MERT Committee emergency response documentation will be audited for the appropriate transfers of patients as per policy to meet compliance with a benchmark of 90% for six consecutive months. The MERT Committee minutes are reviewed at the Medical Executive Board meetings with roll-up to the Executive Leadership Board which is chaired by the facility director.

¹³⁹ VHA Directive 1101.05(2).

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	<ul style="list-style-type: none"> Executive leadership position stability and engagement Employee satisfaction Patient experience Accreditation and/or for-cause surveys and oversight inspections Factors related to possible lapses in care VHA performance data 	Sixteen OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director, associate director, and chief of staff. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> Protected peer reviews UM reviews Patient safety Resuscitation episode review 	<ul style="list-style-type: none"> Managers consistently implement corrective actions identified in root cause analyses. 	<ul style="list-style-type: none"> All required members consistently participate in interdisciplinary reviews of UM data.
Medical Staff Privileging	<ul style="list-style-type: none"> Privileging FPPEs OPPEs FPPEs for cause Reporting of privileging actions to National Practitioner Data Bank 	<ul style="list-style-type: none"> The Medical Executive Board reviews and evaluates licensed independent practitioners' initial and re-privileging requests prior to making recommendations to the facility director. 	<ul style="list-style-type: none"> None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	<ul style="list-style-type: none"> • Parent facility <ul style="list-style-type: none"> ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Community based outpatient clinic <ul style="list-style-type: none"> ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Locked inpatient mental health unit <ul style="list-style-type: none"> ○ 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 <ul style="list-style-type: none"> ○ Hazard vulnerability analysis (HVA) ○ Emergency operations plan (EOP) ○ Emergency power testing and availability 	<ul style="list-style-type: none"> • Emergency generators are tested, and results are documented in accordance with required standards. 	<ul style="list-style-type: none"> • A safe and clean environment is maintained throughout the facility. • The inventory of resources and assets is reviewed annually.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	<ul style="list-style-type: none"> Controlled substances coordinator reports Pharmacy operations Controlled substances inspector requirements Controlled substances area inspections Pharmacy inspections Facility review of override reports 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Controlled substances inspectors are appointed in writing. Controlled substances coordinator completes and documents annual competency assessments of the inspectors. Controlled substances inspectors verify controlled substance orders for five randomly selected dispensing activities.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Primary care and mental health providers complete MST mandatory training within the required time frame.
Geriatric Care: Antidepressant Use among the Elderly	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Clinicians evaluate and document patient and/or caregiver understanding of the education provided about the safe and effective use of newly prescribed medications.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • The Women Veterans Health Committee is comprised of the required core members.
High-Risk Processes: Operations and Management of Emergency Departments and UCCs	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • A waiver is in place when operating the UCC 24 hours a day, seven days a week. • The UCC is staffed with at least two registered nurses at all times of operation. • Support services are available to the UCC during all hours of operation. 	<ul style="list-style-type: none"> • None
Incidental Finding	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • The UCC does not receive patients via ambulance (except in disaster situations). 	<ul style="list-style-type: none"> • None

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) facility reporting to VISN 4.¹⁴⁰

**Table B.1. Facility Profile for Coatesville VA Medical Center (542)
(October 1, 2015, through September 30, 2018)**

Profile Element	Facility Data FY 2016 ¹⁴¹	Facility Data FY 2017 ¹⁴²	Facility Data FY 2018 ¹⁴³
Total medical care budget in dollars	\$184,502,974	\$199,111,670	\$201,945,910
Number of:			
• Unique patients	19,318	19,533	19,250
• Outpatient visits	237,225	234,606	234,350
• Unique employees ¹⁴⁴	939	966	946
Type and number of operating beds:			
• Community living center	169	169	126
• Domiciliary	148	148	148
• Mental health	28	28	28
Average daily census:			
• Community living center	119	122	103
• Domiciliary	107	117	114
• Mental health	20	22	20

Source: VHA Support Service Center and VA Corporate Data Warehouse

Note: The OIG did not assess VA's data for accuracy or completeness.

¹⁴⁰ The VHA medical centers are classified according to a facility complexity model; a designation of “3” indicates a facility with “low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs.”

¹⁴¹ October 1, 2015, through September 30, 2016.

¹⁴² October 1, 2016, through September 30, 2017.

¹⁴³ October 1, 2017, through September 30, 2018.

¹⁴⁴ Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles¹⁴⁵

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)¹⁴⁶

Location	Station No.	Primary Care Workload/Encounters	Mental Health Workload/Encounters	Specialty Care Services ¹⁴⁷ Provided	Diagnostic Services ¹⁴⁸ Provided	Ancillary Services ¹⁴⁹ Provided
Newtown Square, PA	542GA	5,079	3,239	Dermatology	EKG	Pharmacy Social work Weight management Nutrition
Spring City, PA	542GE	4,279	1,912	Dermatology	EKG Laboratory & Pathology	Pharmacy Social work Weight management Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse

Note: The OIG did not assess VA's data for accuracy or completeness.

¹⁴⁵ Includes all outpatient clinics in the community that were in operation as of February 8, 2019.

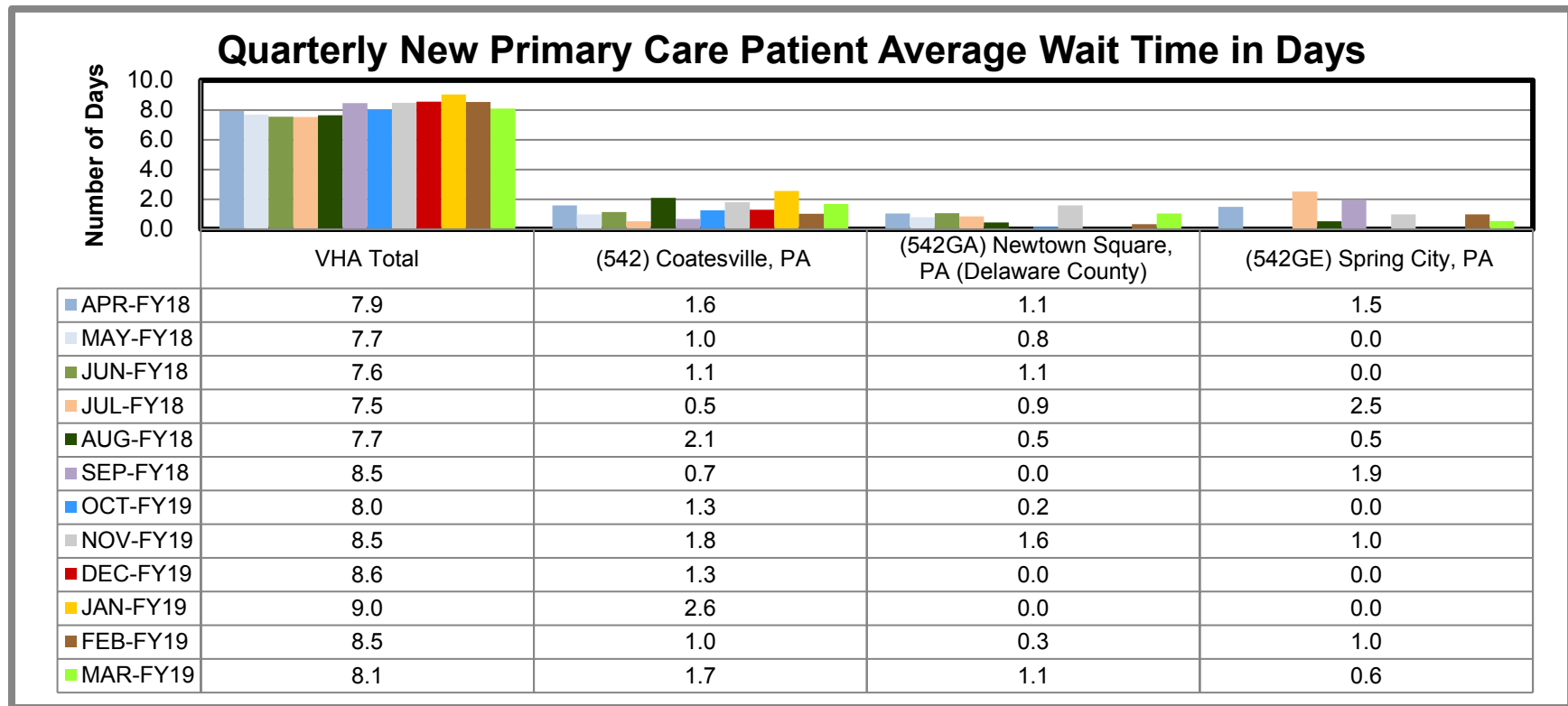
¹⁴⁶ The definition of an "encounter" can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015, and has not been updated.) An encounter is a "professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

¹⁴⁷ Specialty care services refer to non-primary care and non-mental health services provided by a physician.

¹⁴⁸ Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

¹⁴⁹ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Appendix C: Patient Aligned Care Team Compass Metrics¹⁵⁰

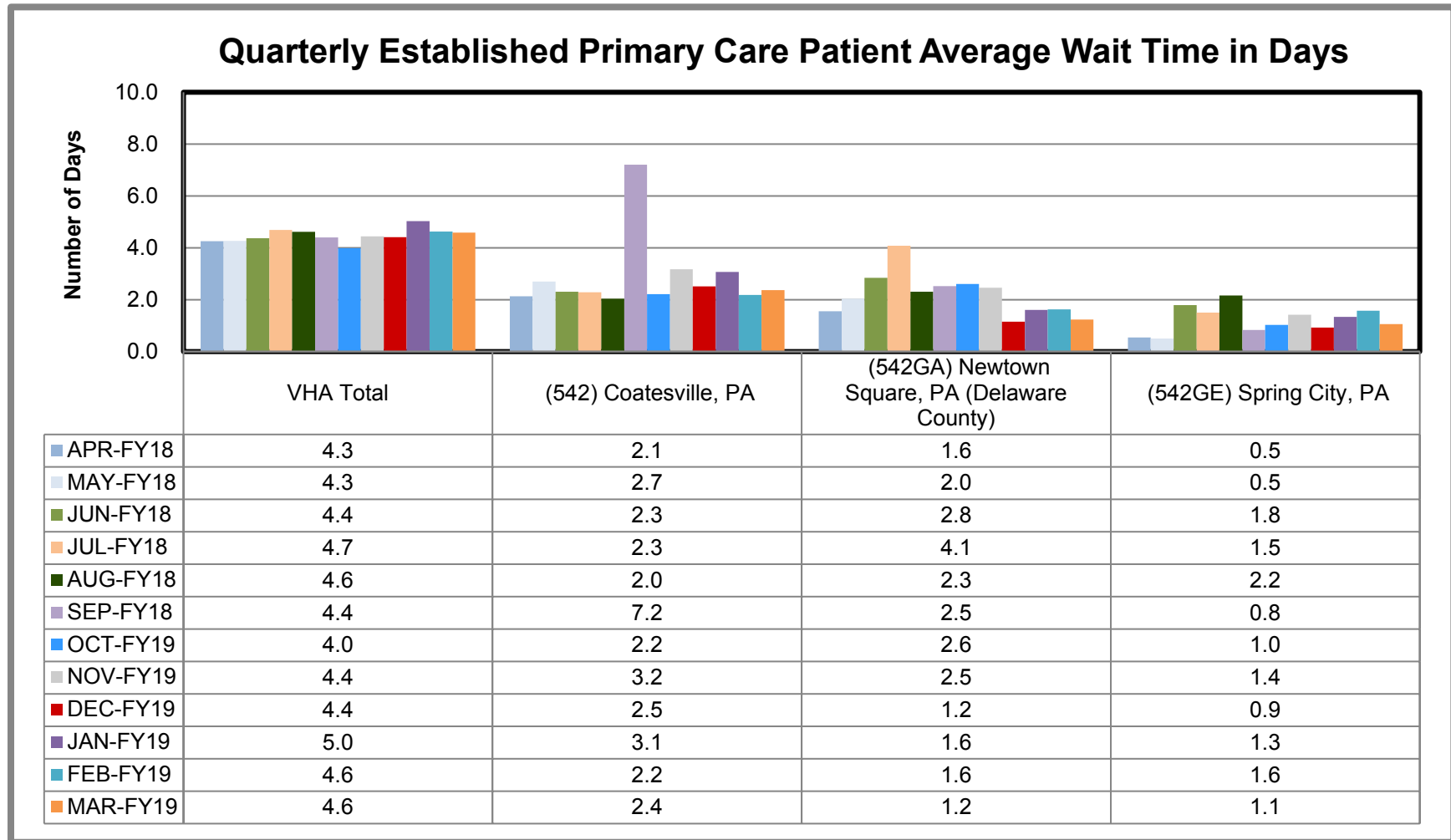


Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness.

Data Definition: "The average number of calendar days between a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Note that prior to FY15, this metric was calculated using the earliest possible create date.

¹⁵⁰ Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 13, 2018.



Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness

Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions¹⁵¹

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

¹⁵¹ 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 Definitions¹⁵²

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.

¹⁵² *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: November 13, 2019

From: Director, VA Healthcare – VISN 4 (10N4)

Subj: Comprehensive Healthcare Inspection of the Coatesville VA Medical Center, PA

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

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

I have reviewed the responses provided by the Comprehensive Healthcare Inspection of the Coatesville VA Medical Center, PA and I am submitting to your office as requested. I concur with their response.

(Original signed by:)

Charles R. Thilges for Timothy W. Liezert

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: November 8, 2019

From: Director, Coatesville VA Medical Center (542/00)

Subj: Comprehensive Healthcare Inspection of the Coatesville VA Medical Center, PA

To: Director, VA Healthcare – VISN 4 (10N4)

1. I have reviewed the draft report of the Inspector General Comprehensive Healthcare Inspection of Coatesville VA Medical Center. I concur with the findings in this report and have included the corrective action plan.
2. I appreciate the opportunity for this review as a continuing process to improve care to our Veterans.

(Original signed by:)

Carla A. Sivek

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

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Inspection Team	Kristie Van Gaalen, BSN, RN, Team Leader Myra Brazell, LCSW Charles Cook, MHA Elizabeth Whidden, MS, ARNP Michelle Wilt, MBA, BSN
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Other Contributors	Limin Clegg, PhD Justin Hanlon, BS LaFonda Henry, MSN, RN-BC Gayle Karamanos, MS, PA-C Yoonhee Kim, PharmD Susan Lott, MSA, RN Scott McGrath, BS Larry Ross, Jr., MS Marilyn Stones, BS Erin Stott, MSN, RN April Terenzi, BA, BS Mary Toy, MSN, RN Robert Wallace, ScD, MPH
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