DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the VA Hudson Valley Health Care System

Montrose, New York

CHIP REPORT | REPORT #17-05399-194 | JUNE 26, 2018

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Figure 1. *VA Hudson Valley Health Care System, Montrose, New York (Source: https://vaww.va.gov/directory/guide/, accessed on May 15, 2018)*

Abbreviations

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infection
CS	controlled substances
CSC	controlled substances coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
GE	geriatric evaluation
LIP	licensed independent practitioner
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
RCA	root cause analysis
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Hudson Valley Health Care System (Facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the overall efforts of the Office of Inspector General (OIG) to ensure that our nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year.

The OIG's current areas of focus are

1. Leadership and Organizational Risks;
2. Quality, Safety, and Value;
3. Credentialing and Privileging;
4. Environment of Care;
5. Medication Management;
6. Mental Health Care;
7. Long-Term Care;
8. Women's Health; and
9. High-Risk Processes.[1]

This review was conducted during an unannounced visit made during the week of October 23, 2017. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of Facility 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 facilities identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

[1] The OIG's review of central line-associated bloodstream infections focused on those that developed during care in intensive care units. This review was not performed for the VA Hudson Valley Health Care System because the Facility did not have an intensive care unit.

Results and Review Impact

Leadership and Organizational Risks

At the Facility, the leadership team consists of the Director, Chief of Staff, Associate Director Patient Care Services (ADPCS), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with the Executive Governance Board having oversight for leadership groups such as the Medical Staff Executive, Administrative Executive, and the Nurse Executive Councils. The leaders are members of the Executive Governance Board through which they track, trend, and monitor quality of care and patient outcomes.

Except for the Chief of Staff who was assigned to the position in August 2017, the executive leaders had been working together as a team since December 2015. In the review of selected employee and patient survey results regarding Facility senior leadership, the OIG noted satisfaction scores that reflected active engagement with employees and patients. The OIG also noted that Facility leaders implemented processes and plans to maintain a committed workforce and positive patient experiences.

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 the Veterans Health Administration (VHA).[2] Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current "4-Star" rating.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[3] disclosures of adverse patient events, and Patient Safety Indicator data, and did not identify any substantial organizational risk factors.

Of the seven applicable areas of clinical operations reviewed, the OIG noted findings in three and issued six recommendations that are attributable to the Director, Chief of Staff, and Associate Director. These are briefly described below.

[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" ranking system to designate a facility's performance in individual measures, domains, and overall quality.

[3] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

Credentialing and Privileging

The OIG found compliance with credentialing, privileging, and Ongoing Professional Practice Evaluations. However, the OIG identified deficiencies with initiation of Focused Professional Practice Evaluations and lack of evidence that these evaluations were completed by providers with similar training and privileges.

Environment of Care

The OIG noted a generally safe and clean environment of care. However, the OIG identified deficiencies with environment of care rounds attendance, damaged or soiled furnishings and equipment in patient care areas, and unsafe shower soap dispensers in the acute mental health unit that warranted recommendations for improvement.

Medication Management

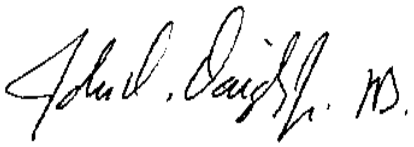
The OIG found general compliance with many of the requirements evaluated, including submission of monthly reports and assignment and training of Controlled Substance Inspectors without conflicts of interest. However, the OIG identified deficiencies with the initiation and completion of physical inventory inspections on the same day and corrective action follow-up for deficiencies identified in the annual physical security survey.

Summary

In the review of key care processes, the OIG issued six recommendations that are attributable to the Director, Chief of Staff, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this Facility. The intent is for Facility leadership 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 Comprehensive Healthcare Inspection Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 51–52, for the full text of the Directors' comments.) We consider recommendation 4 closed. We will follow up on the planned actions for the open recommendations until they are completed.



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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Hudson Valley Health Care System (Facility) through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of healthcare services to veterans and to share findings with Facility leaders so that informed decisions can be made to improve care.

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.[4,5] Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.[6] As noted in Figure 2, leadership and organizational risks can positively or negatively affect processes used to deliver care to veterans.

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management: Controlled Substances (CS) Inspection Program; Mental Health: Post-Traumatic Stress Disorder (PTSD) Care; Long-Term Care: Geriatric Evaluations; Women's Health: Mammography Results and Follow-up; and High-Risk Processes: Central Line-Associated Bloodstream Infections (CLABSI) (see Figure 2).[7] However, the CLABSI special focus area did not apply for the VA

[4] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

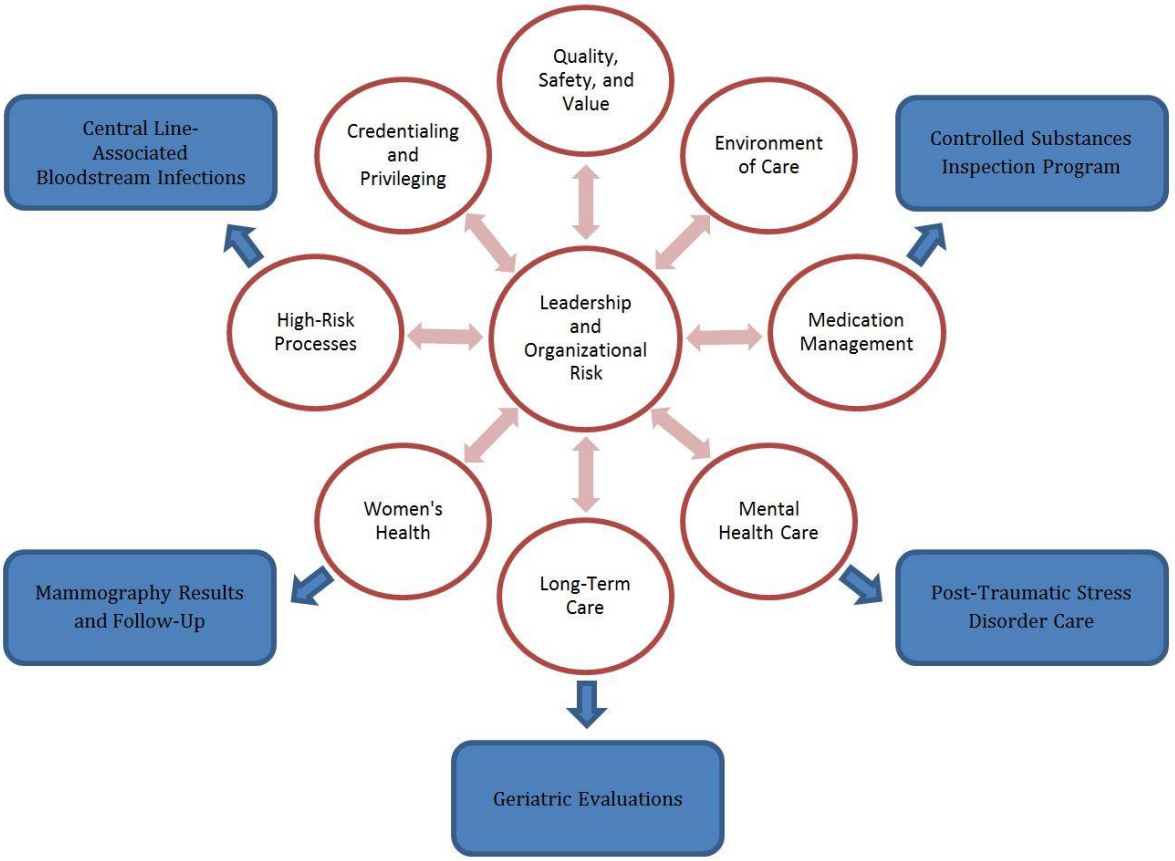
[5] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (Website accessed on March 1, 2018.)

[6] 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. (Website accessed March 1, 2018.)

[7] CHIP reviews address these processes during fiscal year (FY) 2018 (October 1, 2017, through September 30, 2018).

Hudson Valley Health Care System because the Facility did not have an intensive care unit. Thus, the OIG focused on the remaining seven areas of clinical operations.

Figure 2. FY 2018 Comprehensive Healthcare Inspection Program Review of Healthcare Operations and Services



Source: VA OIG

Additionally, OIG staff provided crime awareness briefings to increase Facility employees' understanding of the potential for VA program fraud and the requirement to report suspected criminal activity to the OIG.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the EOC, the OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[8] and discussed processes and validated findings with managers and employees. The OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for November 3, 2014,[9] through October 23, 2017, the date when an unannounced week-long site visit commenced. On November 1, 2017, the OIG presented crime awareness briefings to 107 of the Facility's 1,568 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

This report's recommendations for improvement target problems that can impact 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 recommendations in this report appear within each topic area.

While on site, the OIG did not receive any complaints beyond the scope of the CHIP review. The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and Q*uality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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

[9] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the Facility's ability to provide care in all of the selected clinical areas of focus.[10] To assess the Facility's risks, the OIG considered the following organizational elements

1. Executive leadership stability and engagement,
2. Employee satisfaction and patient experience,
3. Accreditation/for-cause surveys and oversight inspections,
4. Indicators for possible lapses in care, and
5. VHA performance data.

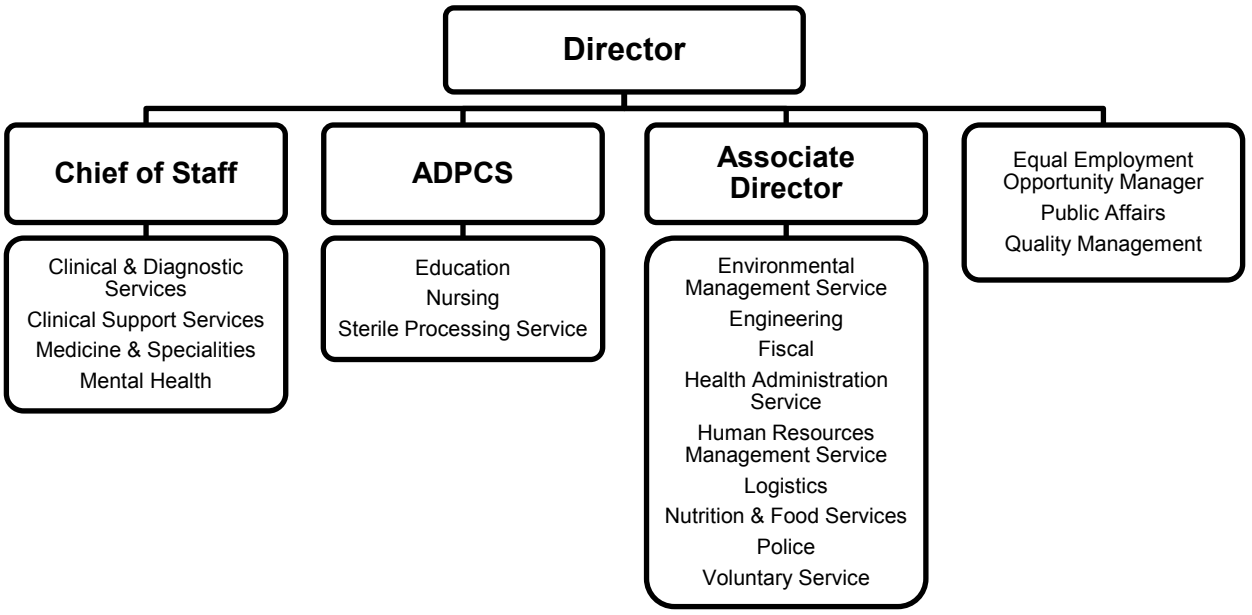
Executive Leadership Stability and Engagement

Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ among facilities. Figure 3 illustrates the 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. The Chief of Staff and ADPCS are responsible for overseeing patient care and service and program directors.

It is important to note that prior to December 2015, the Facility had multiple leaders in acting roles for the Associate Director, ADPCS, and Chief of Staff positions. The Chief of Staff was permanently assigned in August 2017 and had been serving in an acting capacity since November 2016. With that one exception, the executive leaders had been working together as a team since December 2015.

[10] L. Botwinick, M. Bisognano, and C. Haraden. "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx. (Website accessed February 2, 2017.)

Figure 3. Facility Organizational Chart



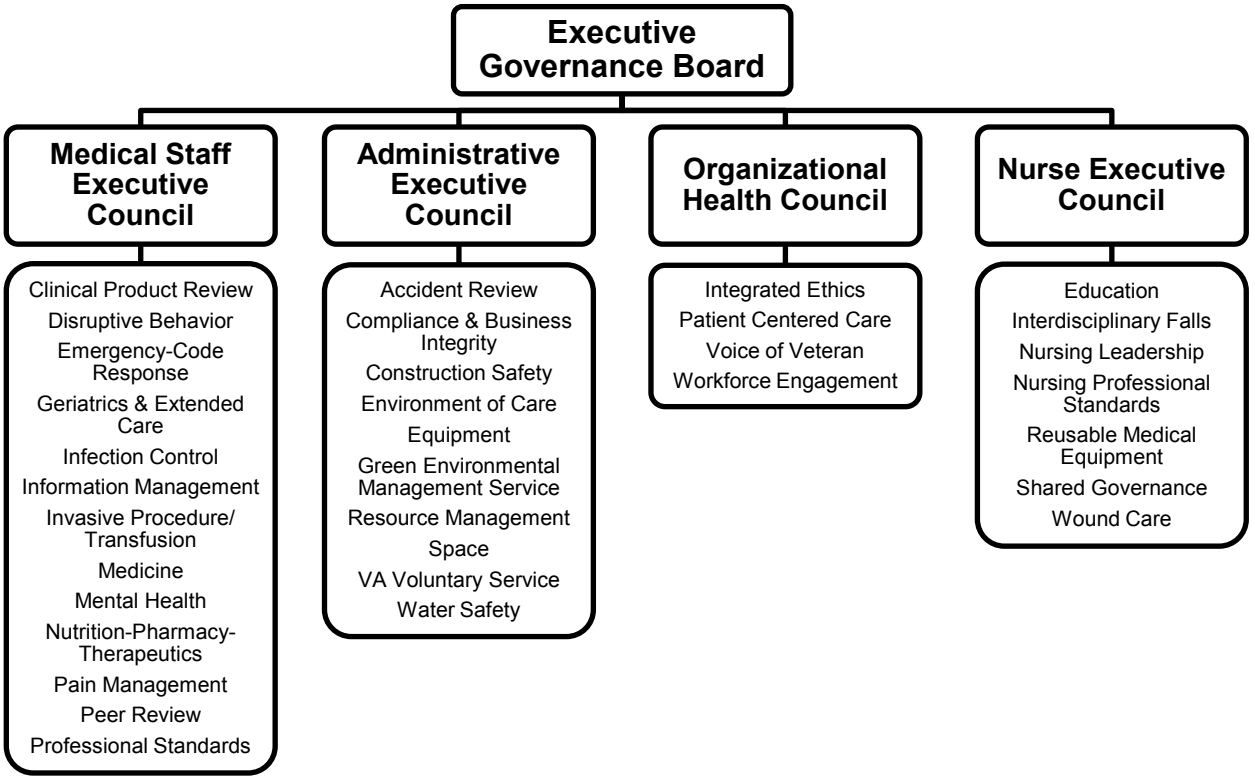
Source: VA Hudson Valley Health Care System (received October 23, 2017)

To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various metrics and involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leaders generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Facility's Executive Governance Board, which tracks, trends, and monitors quality of care and patient outcomes. The Director serves as the Chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Governance Board also oversees various working committees, such as the Medical Staff Executive, Administrative Executive, and the Nurse Executive Councils. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: VA Hudson Valley Health Care System (received October 23, 2017)

Employee Satisfaction and Patient Experience

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 at several points in response to VA leadership inquiries on VA culture and organizational health. To assess employee and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2016, through September 30, 2017, and patient experience survey results that relate to the period of October 1, 2016, through June 30, 2017.

Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on Facility leadership. Tables 1 and 2 provide relevant survey results for VHA and the Facility.

As Table 1 indicates, the Facility leaders' results (Director's office average) from the employee survey were markedly higher than both the Facility and VHA averages.[11] Overall, employees appear generally satisfied with the leaders.

Table 1. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions/Survey Items	Scoring	VHA Average	Facility Average	Director's Office Average[12]
All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?*	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	3.1	4.7
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	65.5	92.5

Source: VA All Employee Survey (accessed October 4, 2017)

VHA's Patient Experiences Survey Reports provide results from surveys administered by the Survey of Healthcare Experience of Patients (SHEP) program. VHA utilizes industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences of their health care and to support the goal of benchmarking its performance against the private sector.

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes towards Facility leaders. For this Facility, three of the four patient survey results also reflected higher care ratings than the VHA average. The Facility's leadership team noted that the reasons for the lower score to the question regarding recommending the hospital to friends and family resulted from a history of nurse turnover and difficulty discharging patients from the medical unit at the Castle Point campus. The leaders implemented several initiatives to assist with improving patient experiences, including staffing changes and increased visibility and availability of the Patient Advocate. The nurse managers also provide patients a business card so that they can make contact if they have any issues while on the unit. Overall, patients appear generally satisfied with care provided.

[11] 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.

[12] Rating is based on responses by employees who report to or are aligned under the Director.

Table 2. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2016, through June 30, 2017)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.9	65.5
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	83.3	87.8
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	74.6	84.1
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	75.0	87.2

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 4, 2017)

Accreditation/For-Cause Surveys[13] and Oversight Inspections

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 3 summarizes the relevant Facility inspections most recently performed by the OIG and The Joint Commission (TJC). Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 3.[14]

[13] 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 reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

[14] 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.

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[15] and College of American Pathologists,[16] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute conducted an inspection of the Facility's Community Living Center.[17]

Table 3. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG (Combined Assessment Program Review of the VA Hudson Valley Health Care System, Montrose, New York, February 4, 2015)	November 2014	19	0
OIG (Review of Community Based Outpatient Clinic and Other Outpatient Clinics of VA Hudson Valley Health Care System, Montrose, New York, February 5, 2015)	November 2014	7	0
OIG (Healthcare Inspection – Alleged Unsafe Patient Transportation Practices, VA Hudson Valley Health Care System, Montrose, New York, January 13, 2016)	April 2015	1	0
TJC[18]	May 2015		
• Hospital Accreditation		20	0
• Nursing Care Center Accreditation		3	0
• Behavioral Health Care Accreditation		3	0
• Home Care Accreditation		1	0

[15] 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.

[16] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

[17] Since 1999, the Long Term Care Institute has been to over 3,500 healthcare facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

[18] TJC is 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 VHA facilities for over 30 years. Compliance with Joint Commission standards and accreditation processes facilitates risk reduction and performance improvement by standardizing critical procedures and processes.

Sources: OIG and TJC (Inspection/survey results verified with the Director on October 24, 2017)

Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 4 summarizes key indicators of risk since the OIG's previous November 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of October 23, 2017.[19]

Table 4. Summary of Selected Organizational Risk Factors (November 2014 to October 23, 2017)

Factor	Number of Occurrences
Sentinel Events[20]	2
Institutional Disclosures[21]	2
Large-Scale Disclosures[22]	0

Source: VA Hudson Valley Health Care System (received October 24, 2017)

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and

[19] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events 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 VA Hudson Valley Health Care System is a low complexity (3) affiliated Facility as described in Appendix B.)

[20] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

[21] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which 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 course of 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.

[22] Large-scale disclosure of adverse events (sometimes referred to as "notification") is 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.

procedures.[23] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 5 summarizes Patient Safety Indicator data from October 1, 2015, through June 30, 2017.

Table 5. Patient Safety Indicator Data (October 1, 2015, through June 30, 2017)

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 2	Facility
Pressure ulcers	0.60	0.82	0.00
Death among surgical inpatients with serious treatable conditions	103.19	136.99	n/a
Iatrogenic pneumothorax	0.18	0.41	0.00
Central venous catheter-related bloodstream infection	0.14	0.09	0.00
In-hospital fall with hip fracture	0.08	0.09	0.00
Perioperative hemorrhage or hematoma	2.00	2.61	n/a
Postoperative acute kidney injury requiring dialysis	0.98	1.29	n/a
Postoperative respiratory failure	5.98	9.25	n/a
Perioperative pulmonary embolism or deep vein thrombosis	3.33	3.45	n/a
Postoperative sepsis	4.04	4.87	n/a
Postoperative wound dehiscence	0.50	0.00	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	1.23	0.00

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

None of the six applicable Patient Safety Indicator measures show an observed rate in excess of the observed rates for Veterans Integrated Service Network (VISN) 2 or VHA.

Veterans Health Administration Performance Data

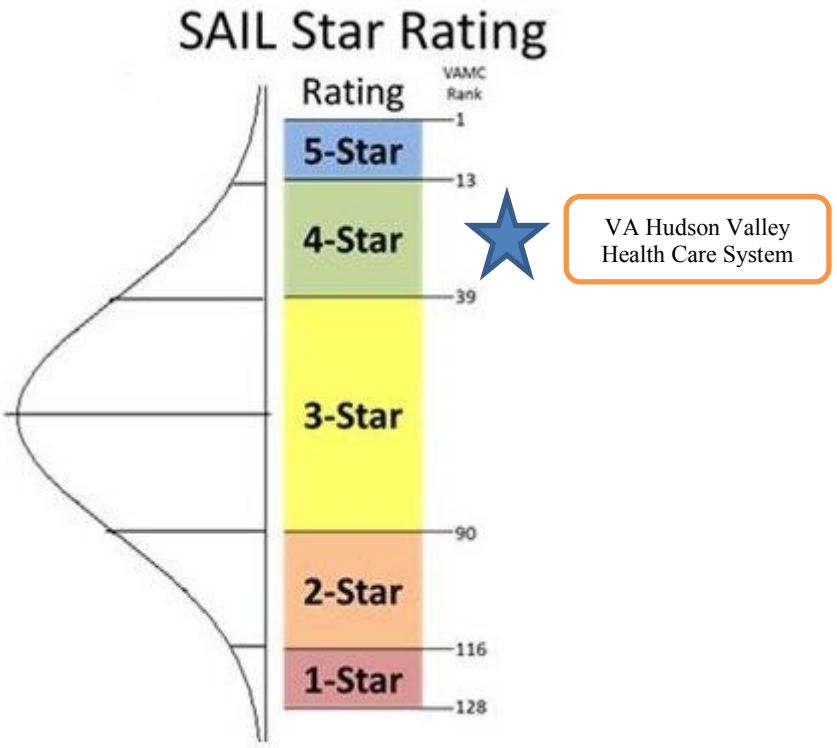
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for

[23] Agency for Healthcare Research and Quality website. https://www.qualityindicators.ahrq.gov/. (Website accessed on March 8, 2017.)

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.

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.[24] As of June 30, 2017, the Facility was rated at "4 Stars" for overall quality.

Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2017)



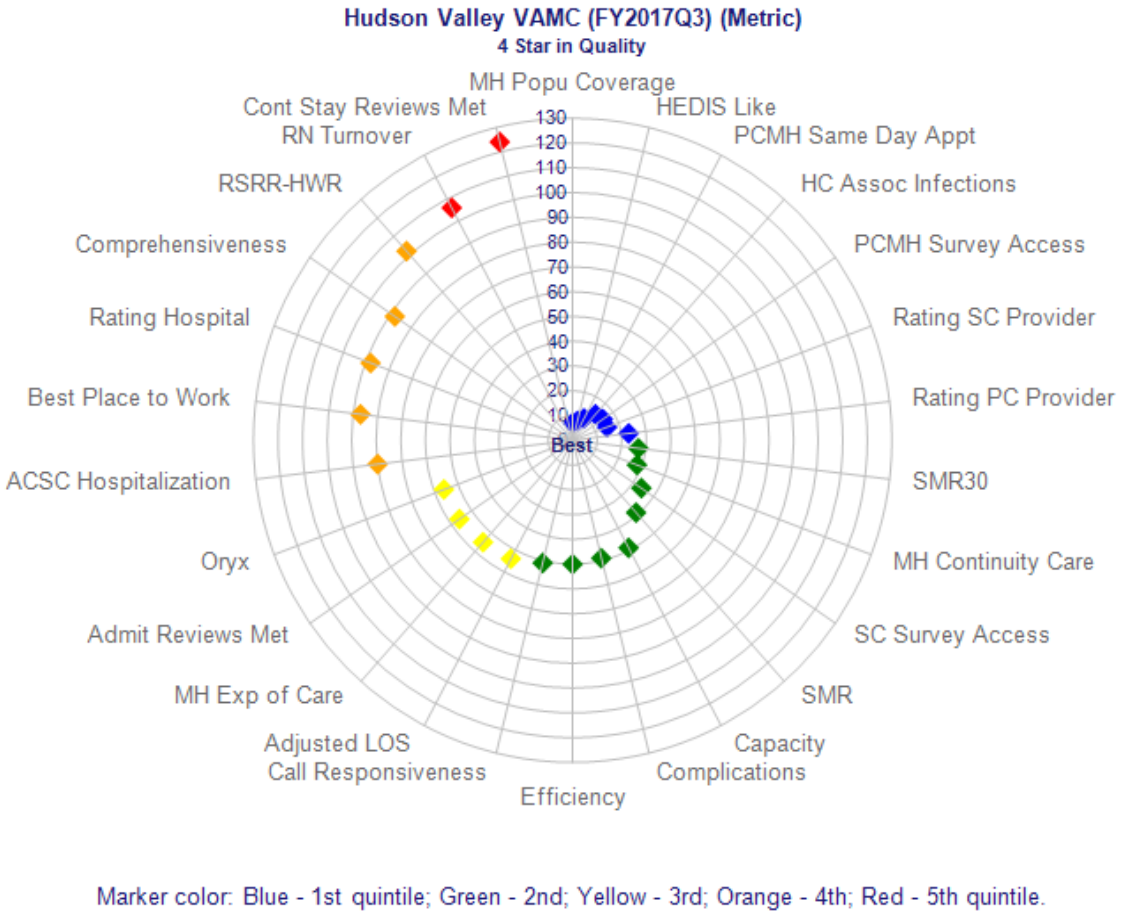
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed October 4, 2017)

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of June 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example in the areas of Mental Health (MH) Population Coverage, Healthcare (HC) Associated (Assoc) Infections, Standardized

[24] Based on normal distribution ranking quality domain of 128 VA Medical Centers.

Mortality Ratio (SMR), and Call Responsiveness).[25] Metrics that need improvement are denoted in orange and red (for example, Best Place to Work), Rating [of] Hospital, and Registered Nurse (RN) Turnover).

Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of June 30, 2017)



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

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). For data definitions, see Appendix D.

[25] For data definitions of acronyms in the SAIL metrics, please see Appendix D.

Conclusion

The Facility has generally stable executive leadership and active engagement with employees and patients as evidenced by employee and patient satisfaction scores. Organizational leadership supports patient safety, quality care, and other positive outcomes (such as enacting processes and plans to maintain positive perceptions of the Facility through active stakeholder engagement and proactive communication with the VISN). The OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors. Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve care and performance of selected Quality of Care and Efficiency metrics likely contributing to the most current "4-Star" rating.

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 using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.[26] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[27]

VHA requires that its facilities operate a Quality, Safety, and Value (QSV) program to monitor the quality of patient care and performance improvement activities. The purpose of the OIG review was to determine whether the Facility implemented and incorporated selected key functions of VHA's Enterprise Framework for QSV into local activities. To assess this area of focus, the OIG evaluated the following: protected peer reviews of clinical care,[28] utilization management (UM) reviews,[29] and patient safety incident reporting with related root cause analyses (RCAs).[30]

VHA has implemented approaches to improving patient safety, including the reporting of patient safety incidents to its National Center of Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required RCAs help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the organization.[31]

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[26] VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

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

[28] According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff. (Due for recertification June 30, 2015, but has not been updated.)

[29] According to VHA Directive 1117, UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

[30] According to VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011, VHA has implemented approaches to improve patient safety, including the reporting of patient safety incidents to VHA National Center of Patient Safety, in order for VHA to learn about system vulnerabilities and how to address them as well as the requirement to implement RCA (a widely-used methodology for dealing with safety-related issues) to allow for more accurate and rapid communication throughout an organization of potential and actual causes of harm to patients.

[31] VHA Handbook 1050.01.

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[32]

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Entry of all reported patient incidents into WebSPOT[33]
  - Annual completion of a minimum of eight RCAs[34]
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

Conclusion

The OIG found general compliance with the above performance indicators. The OIG made no recommendations.

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

[33] WebSPOT is the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database.

[34] According to VHA Handbook 1050.01, March 4, 2011, the requirement for a total of eight RCAs and aggregated reviews is a minimum number, as the total number of RCAs 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 RCAs with the balance being aggregated reviews or additional individual RCAs.

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIP).[35]

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This systematic process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.[36]

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges need to be specific, based on the individual's clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.[37]

The purpose of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of 5 LIPs who were hired within 18 months prior to the on-site visit,[38] and 25 LIPs who were re-privileged within 12 months prior to the visit.[39] The OIG evaluated the following performance indicators:

- Credentialing
  - Current licensure
  - Primary source verification
- Privileging
  - Verification of clinical privileges
  - Requested privileges

[35] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)
[36] VHA Handbook 1100.19.
[37] VHA Handbook 1100.19.
[38] The 18-month period was from March 2016 through September 2017.
[39] The 12-month review period was from September 2016 through September 2017.

    - Facility-specific
    - Service-specific
    - Provider-specific
  - Service chief recommendation of approval for requested privileges
  - Medical Staff Executive Committee decision to recommend requested privileges
  - Approval of privileges for a period of less than, or equal to, two years
- Focused Professional Practice Evaluation (FPPE)
  - Evaluation initiated
    - Timeframe clearly documented
    - Criteria developed
    - Evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee decision to recommend continuing initially granted privileges
- Ongoing Professional Practice Evaluation (OPPE)
  - Determination to continue privileges
    - Criteria specific to the service or section
    - Evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee decision to recommend continuing privileges

Conclusions

The OIG found general compliance with requirements for credentialing, privileging, and Ongoing Professional Practice Evaluations. However, the OIG identified deficiencies with initiation of Focused Professional Practice Evaluations and completion of professional practice evaluations by providers with similar training and privileges.

Focused Professional Practice Evaluations

VHA requires that all LIPs new to the Facility have FPPEs completed and documented in the practitioner's provider profile and reported to an appropriate committee of the Medical Staff.[40] The process involves the evaluation of privilege-specific competence of the practitioners new to

[40] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

the Facility; this may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.[41]

FPPEs were not initiated for three of five recently hired LIPs. Further, the OIG did not find evidence that the two initiated FPPEs were completed by providers with similar training and privileges. This resulted in inadequate data to support the decisions to grant clinical privileges to these LIPs. Clinical managers indicated that staffing issues (collateral duty) and lack of attention to detail during completion of FPPEs were the reasons for noncompliance.

Recommendation 1

1. The Chief of Staff ensures that Facility clinical managers consistently initiate Focused Professional Practice Evaluations and that they are completed by providers with similar training and privileges and monitors compliance.

Facility Concurred.

Target date for completion: September 30, 2018.

Facility response: Associate Chiefs of Staff (ACOS), and Service Chiefs agreed that all Licensed Independent Practitioners (LIPs) new to the facility have FPPEs completed by providers with similar training and privileges, and documented in the practitioner's provider profile within 6 months of being onboarded, and the FPPEs are reported to the Professional Standard Board (PSB), then reported to the Medical Staff Committee and monitored for compliance by Credentialing and Privileging (C&P) staff. This will be monitored until 90% compliance is maintained for 3 consecutive months.

[41] VHA Handbook 1100.19.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC 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.[42]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements.[43] The OIG also determined whether the Facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case, with a special emphasis on construction safety[44] and Nutrition and Food Services processes.[45]

VHA requires a safe and healthy worksite for staff, patients, and the general public during construction and renovation-related activities. The implementation of a proactive and comprehensive construction safety program reduces the potential for injury, illness, accidents, or exposures.[46]

The Nutrition and Food Services Program must provide quality meals that meet the regulatory requirements for food safety in accordance with the U.S. Food and Drug Administration's Food Code and VHA's food safety program. Facilities must have annual hazard analysis critical control point food safety plan, food services inspections, food service emergency operations plan, and safe food transportation and storage practices.[47]

In all, the OIG inspected four inpatient units (community living centers 1 and 2, acute MH, and chronic MH); the urgent care, primary care, and physical therapy clinics; two construction sites; and Nutrition and Food Services at the Montrose campus. At the Castle Point campus, the OIG inspected two inpatient units (community living center and medical unit); the urgent care and primary care clinics; the day surgery unit; and Nutrition and Food Services. The OIG also

[42] VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

[43] Applicable requirements include 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).

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

[45] VHA Handbook 1109.04, *Food Service Management Program*, October 11, 2013.

[46] VHA Directive 7715.

[47] VHA Handbook 1109.04.

inspected the Poughkeepsie CBOC.[48] Additionally, the OIG reviewed the most recent Infection Prevention Risk Assessment, Infection Control Committee minutes for the past 6 months, and other relevant documents, and the OIG interviewed key employees and managers. The OIG reviewed the following location-specific performance indicators:

- Parent Facility
  - EOC rounds
  - EOC deficiency tracking
  - Infection prevention
  - General safety
  - Environmental cleanliness
  - General privacy
  - Women veterans' exam room privacy
  - Availability of medical equipment and supplies
- Community Based Outpatient Clinic
  - General safety
  - Medication safety and security
  - Infection prevention
  - Environmental cleanliness
  - General privacy
  - Exam room privacy
  - Availability of medical equipment and supplies
- Construction Safety
  - Completion of infection control risk assessment for all sites
  - Infection Prevention/Infection Control Committee discussions on construction activities
  - Dust control

[48] Each outpatient site selected for physical inspection was randomized from all PC CBOCs, multi-specialty CBOCs, and health care centers reporting to the parent Facility and was operational and classified as such in VA's Site Tracking Database by August 15, 2017.

  - Safety and security
  - Selected requirements based on project type and class[49]
- Nutrition and Food Services
  - Annual Hazard Analysis Critical Control Point Food Safety System plan
  - Food Services inspections
  - Emergency operations plan for food service
  - Safe transportation of prepared food
  - Environmental safety
  - Infection prevention
  - Storage areas

Conclusions

General safety, infection prevention, and privacy measures were in place at the parent Facility and representative CBOC areas with the exception of dusty ventilation ducts in two units and stained ceiling tiles in two units. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified the following deficiencies that warranted recommendations for improvement.

Parent Facility's Environment of Care Rounds Attendance

VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.[50] From October 1, 2016, through September 30, 2017, 2 of 13 required EOC team members did not consistently attend rounds. This resulted in lack of subject matter experts on EOC rounds. Facility managers were aware of requirements but had not monitored participation. Facility

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

[50] According to VHA, core membership is composed of representatives from programmatic areas such as nursing, infection control, patient safety, and medical equipment management to ensure adherence to various program requirements.

managers also stated that attendance data was not entered correctly in the comprehensive EOC tool software; however, the attendance data was not provided for OIG review.[51]

Recommendation 2

2. The Associate Director ensures all required team members consistently participate on environment of care rounds and monitors compliance.

Facility concurred.

Target date for completion: November 1, 2018.

Facility response: Attendance will be monitored/reported at the monthly Environment of Care (EOC) Committee meetings for 6 months. EOC Committee members required to participate in rounds will achieve and maintain 90% attendance for 3 consecutive months. A memo will be sent to the Service Chiefs of recurring non-compliant EOC round members by the Associate Director.

Furnishings and Equipment

TJC requires hospitals to continually monitor environmental conditions in order to identify opportunities to resolve environmental safety and infection prevention issues. This ensures a clean and safe health care environment and minimizes the spread of infection and reduces or eliminates potential safety hazards. Six of 12 patient care areas[52] inspected had damaged or soiled furnishings, equipment with old tape residue, damaged wheelchairs, torn stretcher mattresses, and/or torn patient recliner chairs repaired with medical tape. These findings posed safety hazards and/or infection control issues since the surfaces could not be sanitized. Managers and staff knew the requirements but were unaware of the damaged furnishings.

Recommendation 3

3. The Associate Director ensures damaged or soiled furnishings and equipment in patient care areas are sanitized, repaired, or removed from service and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2018.

[51] Attendance is tracked and trended with the Comprehensive EOC Assessment and Compliance Tool.

[52] Community living centers 1 and 2, chronic MH and urgent care clinic at Montrose campus, community living center, and medical unit at Castle Point campus.

Facility response: Response: Re-education will be provided to 95% of Chiefs, ACOS and Associate Chiefs Nursing Service (ACNS) to notify Engineering Service when they observe any damaged furniture in their areas. Performance Standards will be established by facility leadership for 95% of Chiefs, ACOS, and ACNS regarding accountability for regularly monitoring their areas and maintaining furniture/equipment in good condition.

Acute Mental Health Unit

VHA requires facilities with inpatient psychiatric units treating currently suicidal patients to perform systematic environmental assessments using the Mental Health Environment of Care Checklist (MHEOCC)[53] for the purpose of eliminating environmental factors that could facilitate suicide attempts and completion or harm to staff members. The OIG noted that plastic wall-mounted soap dispensers in all of the showers were not compliant with MHEOCC requirements. The dispensers presented hanging points or could be broken off the wall and used to create a sharp-edged weapon. The Facility managers had identified the problem but had not yet corrected it, citing a delay in obtaining compliant equipment.

Recommendation 4

4. The Associate Director ensures that shower soap dispensers in the acute Mental Health Unit are replaced as required by the Mental Health Environment of Care Checklist and monitors compliance.

Facility concurred.

Target date for completion: Installation took place from January 26 - February 8, 2018.

Facility response: New shower soap dispensers were ordered by Logistics and installed. All new shower soap dispensers have been installed by Environmental Management Service (EMS).

[53] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.[54] Diversion by healthcare workers—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—remains a serious problem that can increase serious patient safety issues, causes harm to the diverter, and elevates the liability risk to healthcare organizations.[55]

VHA requires that facility managers implement and maintain a CS inspection program to minimize the risk for loss and diversion and to enhance patient safety.[56] Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSI), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.

The OIG review of these issues was conducted to determine whether the Facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.[57] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[58] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[59] CS inspection quarterly trend reports for the prior four quarters;[60] and other relevant documents. The OIG evaluated the following performance indicators:

- CSC reports
  - Monthly summary of findings to the Director
  - Quarterly trend report to the Director
  - Actions taken to resolve identified problems

[54] Drug Enforcement Agency Controlled Substance Schedules.-https://www.deadiversion.usdoj.gov/schedules/. (Website accessed on August 21, 2017.)

[55] American Society of Health-System Pharmacists, "ASHP Publishes Controlled Substances Diversion Prevention Guidelines," October 2016. https://www.ashp.org/news/2017/03/10/19/22/ashp-publishes-controlled-substances-diversion-prevention-guidelines. (Website accessed on August 21, 2017.)

[56] VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (*Due for recertification November 30, 2015, but has not been updated*); VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

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

[58] The review period was April 1, 2017, through September 30, 2017.

[59] The review period was October 1, 2016, through September 30, 2017.

[60] The four quarters were from October 1, 2016, through September 30, 2017.

- Pharmacy operations
  - Annual physical security survey of the pharmacy/pharmacies by VA Police
  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transition
  - Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from 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 CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSIs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated

- Security and documentation of drugs held for destruction[61]
- Accountability for all prescription pads in pharmacy
- Verification of hard copy outpatient pharmacy CS prescriptions
- Verification of 72-hour inventories of the main vault
- Quarterly inspections of emergency drugs
- Monthly CSI checks of locks and verification of lock numbers

Conclusions

The OIG found general compliance with requirements for most of the performance indicators evaluated, including CSI reports and CSC and CSIs having no conflicts of interest and completing required training. However, the OIG identified the following deficiencies that warranted recommendations for improvement.

Inspections Completed on the Day Initiated

VHA requires that the physical inventory of the CS storage areas be completed on the day initiated.[62] This helps to ensure accountability for all CS. For 3 of 10 areas, the OIG did not find evidence that monthly inspections were completed on the same day the inspections were initiated. This resulted in a potential lack of accountability for all CSIs. The CSC and Facility managers told us that the date on the checklist is the date the inspection was initiated and completed which meets VHA requirements. However, the OIG could not determine when the inspections were initiated or completed because a date was not consistently found on the checklists.

Recommendation 5

5. The Facility Director ensures that all Controlled Substance Inspectors complete the physical inventory of the controlled substance storage areas on the same day initiated and monitors compliance.

Facility concurred.

Target date for completion: November 1, 2018.

[61] The "Destructions File Holding Report" lists all drugs awaiting local destruction or turn-over to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

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

Facility response: Controlled Substance Inspectors will continue to complete/document the physical inventory on the same day initiated and monitor compliance until there is 100% compliance for 3 months. Report of compliance will be presented to Performance Improvement Committee (PIC) on a monthly basis.

Annual Physical Security Survey

VHA requires the Chief, Police and Security Unit, follow up with the pharmacy to ensure that identified deficiencies from the annual physical security survey have been corrected.[63] This ensures the security of medications stored in the pharmacy. The VA Police identified three deficiencies at the Montrose Campus during the June 2017 annual physical security survey. Deficiencies identified during the physical security survey that are not corrected or mitigated leave the Facility vulnerable to loss and theft. The VA Police provided evidence that work orders were placed on August 22 and August 27, 2017, and at the time of our visit, these work orders were pending completion.

Recommendation 6

6. The Facility Director ensures that all deficiencies identified on the Annual Physical Security Survey are corrected and monitors compliance.

Facility concurred.

Target date for completion: December 1, 2018.

Facility response: The door will be replaced with a solid metal door. During the interim, a metal plate was installed on March 22 to cover the glass window pane on the inside door. Additionally, a metal security screening was installed on April 19 to cover the glass window pane on the outside door.

[63]VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.

Mental Health Care: Post-Traumatic Stress Disorder Care

Post-Traumatic Stress Disorder (PTSD) may occur "following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury, or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."[64] For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. Non-war zone military experiences, such as the crash of a military aircraft, may also contribute to the development of PTSD.[65]

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed.[66] VHA requires that

1. PTSD screening is performed for every new patient and then is repeated every year for the first five years post-separation and every five years thereafter, unless there is a clinical need to re-screen earlier;
2. If the patient's PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.[67]

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG team reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 41 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Completion of suicide risk assessment by acceptable provider within required timeframe
- Offer to patient of further diagnostic evaluation

[64] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010. (Due for recertification March 31, 2015, and revised December 8, 2015, but has not been updated.)

[65] VHA Handbook 1160.03.

[66] A PTSD screen is not required if the patient received a PTSD diagnosis in outpatient setting in the past year; has a life expectancy of 6 months or less; has severe cognitive impairment, including dementia; is enrolled in a VHA or community-based hospice program; or has a diagnosis of cancer of the liver, pancreas, or esophagus.

[67] VHA Handbook 1160.03.

- Referral for diagnostic evaluation
- Completion of diagnostic evaluation within required timeframe

Conclusion

The OIG found general compliance with the above performance indicators. The OIG made no recommendations.

Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.[68] As a group, veterans experience more chronic disease and disability than their non-veteran peers. VA must plan for the growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.[69] Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.[70]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[71] This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. The healthcare team would then manage the patient with treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.[72] Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.[73]

In determining whether the Facility provided an effective geriatric evaluation, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of 44 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Program oversight and evaluation
  - Evidence of GE program evaluation
  - Evidence of performance improvement activities through leadership board
- Provision of clinical care
  - Medical evaluation by GE provider
  - Assessment by GE nurse

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

[69] VHA Directive 1140.04.

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

[71] Public Law 106-117.

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

[73] VHA Directive 1140.04.

  - Comprehensive psychosocial assessment by GE social worker
  - Patient or family education
  - Plan of care based on GE
- Geriatric management
  - Implementation of interventions noted in plan of care

Conclusion

The OIG found general compliance with the above performance indicators. The OIG made no recommendations.

Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.[74] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veterans Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.[75] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services, including mammography services to eligible women veterans.[76]

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Verbal communication with patients must be documented.[77]

The OIG team examined whether the Facility complied with selected VHA requirements for the reporting of mammography results by again reviewing relevant documents and interviewing relevant employees and managers. The team also reviewed the EHRs of 48 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Electronic linking of mammogram results to radiology order
- Scanning of hard copy mammography reports, if outsourced
- Inclusion of required components in mammography reports
- Communication of results and any recommended course of action to ordering provider
- Communication of results and any recommended course of action to patient
- Performance of follow-up mammogram if indicated

[74] U.S. Breast Cancer Statistics. http://www.BreastCancer.org. (Website accessed on May 18, 2017.)

[75] Veterans Health Care Amendments of 1983, Pub. L. 98-160 (1983).

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

[77] VHA Directive 1330.01, *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017); VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011. (Due for recertification April 30, 2016, but has not been updated.)

- Performance of follow-up study[78]

Conclusion

The OIG found general compliance with the above performance indicators. The OIG made no recommendations.

[78] This performance indicator did not apply to this Facility.

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

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Six OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Director, Chief of Staff, and Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs	• None	• None
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• FPPEs are initiated and completed by providers with similar training and privileges.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	• Parent Facility ○ EOC rounds and deficiency tracking ○ Infection prevention ○ General safety ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies • CBOC ○ General safety ○ Medication safety and security ○ Infection prevention ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies • Construction Safety ○ Infection control risk assessment ○ Infection Prevention/ Infection Control Committee discussions ○ Dust control ○ Safety/security ○ Selected requirements based on project type and class • Nutrition and Food Services ○ Annual Hazard Analysis Critical control Point Food Safety System plan ○ Food Services inspections ○ Safe transportation of prepared food ○ Environmental safety ○ Infection prevention ○ Storage areas	• Shower soap dispensers in the acute MH unit are replaced as required by the MHEOCC.	• Required team members participate on EOC rounds. • Damaged or soiled furnishings and equipment in patient care areas are sanitized, repaired, or removed from service.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	• CSC reports • Pharmacy operations • Annual physical security survey • CS ordering processes • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections	• None	• CSIs complete the physical inventory of the CS storage areas on the same day initiated. • Deficiencies identified on the annual physical security survey are corrected.
Mental Health Care: Post-Traumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• None	• None
Long-Term Care: Geriatric Evaluations	• Program oversight and evaluation • Provision of clinical care • Geriatric management	• None	• None
Women's Health: Mammography Results and Follow-Up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• 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)[79] affiliated[80] Facility reporting to VISN 2.

Table 6. Facility Profile for Montrose (620)
(October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[81]	Facility Data FY 2016[82]	Facility Data FY 2017[83]
Total Medical Care Budget in Millions	$252.5	$237.1	$247.6
Number of:			
• Unique Patients	24,307	24,591	24,047
• Outpatient Visits	371,423	381,622	363,101
• Unique Employees[84]	1,100	1,072	1,048
Type and Number of Operating Beds:			
• Community Living Center	297	297	297
• Domiciliary	148	148	148
• Intermediate	12	12	12
• Medicine	15	15	15
• Mental Health	105	105	105
Average Daily Census:			
• Community Living Center	95	88	89
• Domiciliary	100	96	89
• Intermediate	0	0	0

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

[80] Associated with a medical residency program.

[81] October 1, 2014, through September 30, 2015.

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

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

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

Profile Element	Facility Data FY 2015[81]	Facility Data FY 2016[82]	Facility Data FY 2017[83]
• Medicine	7	5	4
• Mental Health	50	46	36

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

VA Outpatient Clinic Profiles[85]

The VA outpatient clinics in communities within the catchment area of the Facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 7 provides information relative to each of the clinics.

Table 7. VA Outpatient Clinic Workload/Encounters[86] and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[87] Provided	Diagnostic Services[88] Provided	Ancillary Services[89] Provided
New City, NY	620GA	5,133	2,079	Dermatology Endocrinology Hematology/Oncology Nephrology Neurology Pulmonary/ Respiratory Disease Rheumatology Poly-Trauma Rehab Physician Anesthesia Eye Podiatry	EKG	Nutrition Pharmacy Prosthetics Social Work Weight Management

[85] Includes all outpatient clinics in the community that were in operation as of August 15, 2017.

[86] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

[87] Specialty care services refer to non-PC and non-MH services provided by a physician.

[88] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

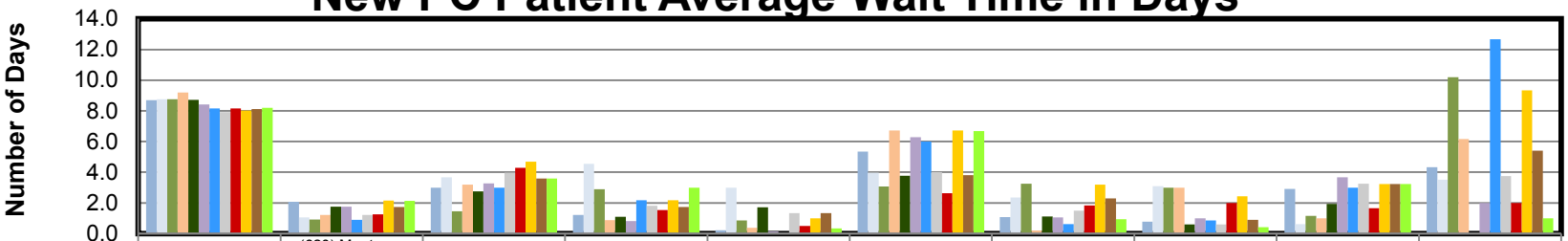
[89] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[87] Provided	Diagnostic Services[88] Provided	Ancillary Services[89] Provided
Carmel, NY	620GB	2,844	1,544	Dermatology Endocrinology Hematology/Oncology Neurology Rehab Physician Eye Podiatry	EKG	Nutrition Social Work Weight Management
Goshen, NY	620GD	4,978	2,491	Dermatology Endocrinology Hematology/Oncology Nephrology Neurology Poly-Trauma Rehab Physician Eye Podiatry	EKG	Nutrition Pharmacy Social Work Weight Management
Port Jarvis, NY	620GE	4,126	1,221	Endocrinology Neurology Pulmonary/ Respiratory Disease Poly-Trauma Anesthesia Eye Podiatry	EKG	Nutrition Pharmacy Prosthetics Social Work Weight Management

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[87] Provided	Diagnostic Services[88] Provided	Ancillary Services[89] Provided
Monticello, NY	620GF	2,507	303	Dermatology Endocrinology Neurology Pulmonary Rheumatology Poly-Trauma Rehab Physician Anesthesia Eye Podiatry	EKG	Nutrition Pharmacy Social Work Weight Management
Poughkeepsie, NY	620GG	2,996	674	Dermatology Eye Podiatry	EKG	Nutrition Pharmacy Social Work
Pine Plains, NY	620GH	1,075	137	Hematology/Oncology Eye Podiatry	EKG	Pharmacy Social Work

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

Appendix C: Patient Aligned Care Team Compass Metrics[90]



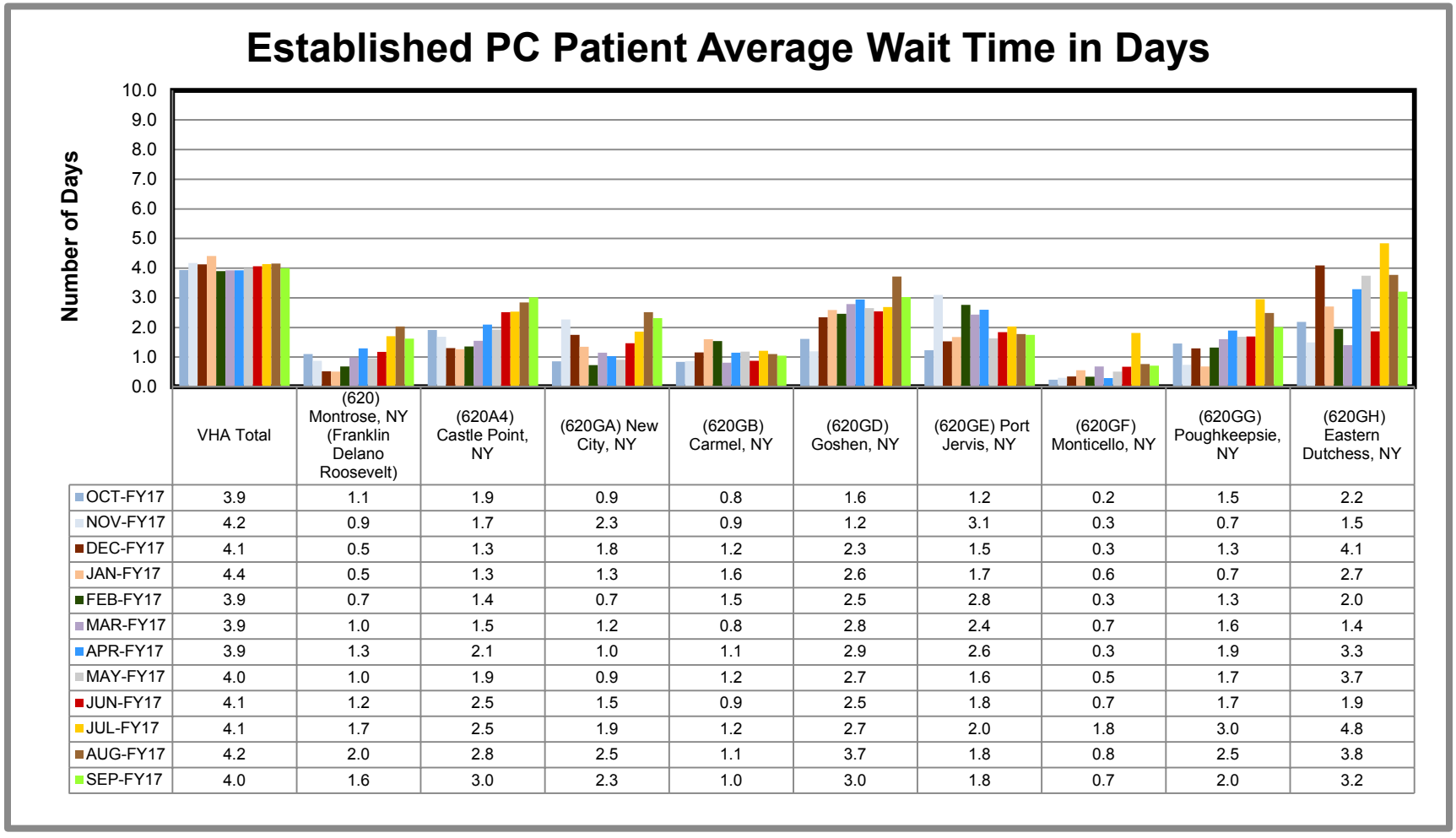
	VHA Total	(620) Montrose, NY (Franklin Delano Roosevelt)	(620A4) Castle Point, NY	(620GA) New City, NY	(620GB) Carmel, NY	(620GD) Goshen, NY	(620GE) Port Jervis, NY	(620GF) Monticello, NY	(620GG) Poughkeepsie, NY	(620GH) Eastern Dutchess, NY
OCT-FY17	8.7	2.1	3.0	1.2	0.2	5.3	1.1	0.8	2.9	4.3
NOV-FY17	8.8	1.1	3.7	4.6	3.0	4.0	2.4	3.1	0.6	3.5
DEC-FY17	8.8	0.9	1.5	2.9	0.9	3.1	3.3	3.0	1.2	10.2
JAN-FY17	9.2	1.2	3.2	0.9	0.4	6.7	0.2	3.0	1.0	6.2
FEB-FY17	8.7	1.8	2.8	1.1	1.7	3.8	1.1	0.6	1.9	0.0
MAR-FY17	8.4	1.8	3.3	0.8	0.1	6.3	1.1	1.0	3.7	2.0
APR-FY17	8.2	0.9	3.0	2.2	0.0	6.0	0.6	0.9	3.0	12.7
MAY-FY17	7.9	1.2	4.0	1.8	1.3	4.0	1.5	0.6	3.3	3.8
JUN-FY17	8.2	1.3	4.3	1.5	0.5	2.6	1.8	2.0	1.7	2.0
JUL-FY17	8.0	2.2	4.7	2.2	1.0	6.7	3.2	2.4	3.2	9.3
AUG-FY17	8.1	1.7	3.6	1.7	1.3	3.8	2.3	0.9	3.2	5.4
SEP-FY17	8.2	2.1	3.6	3.0	0.3	6.7	0.9	0.4	3.2	1.0

Source: VHA Support Service Center

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

***Data Definition**: The average number of calendar days between a new patient's PC 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 FY 2015, this metric was calculated using the earliest possible create date.*

[90] Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.

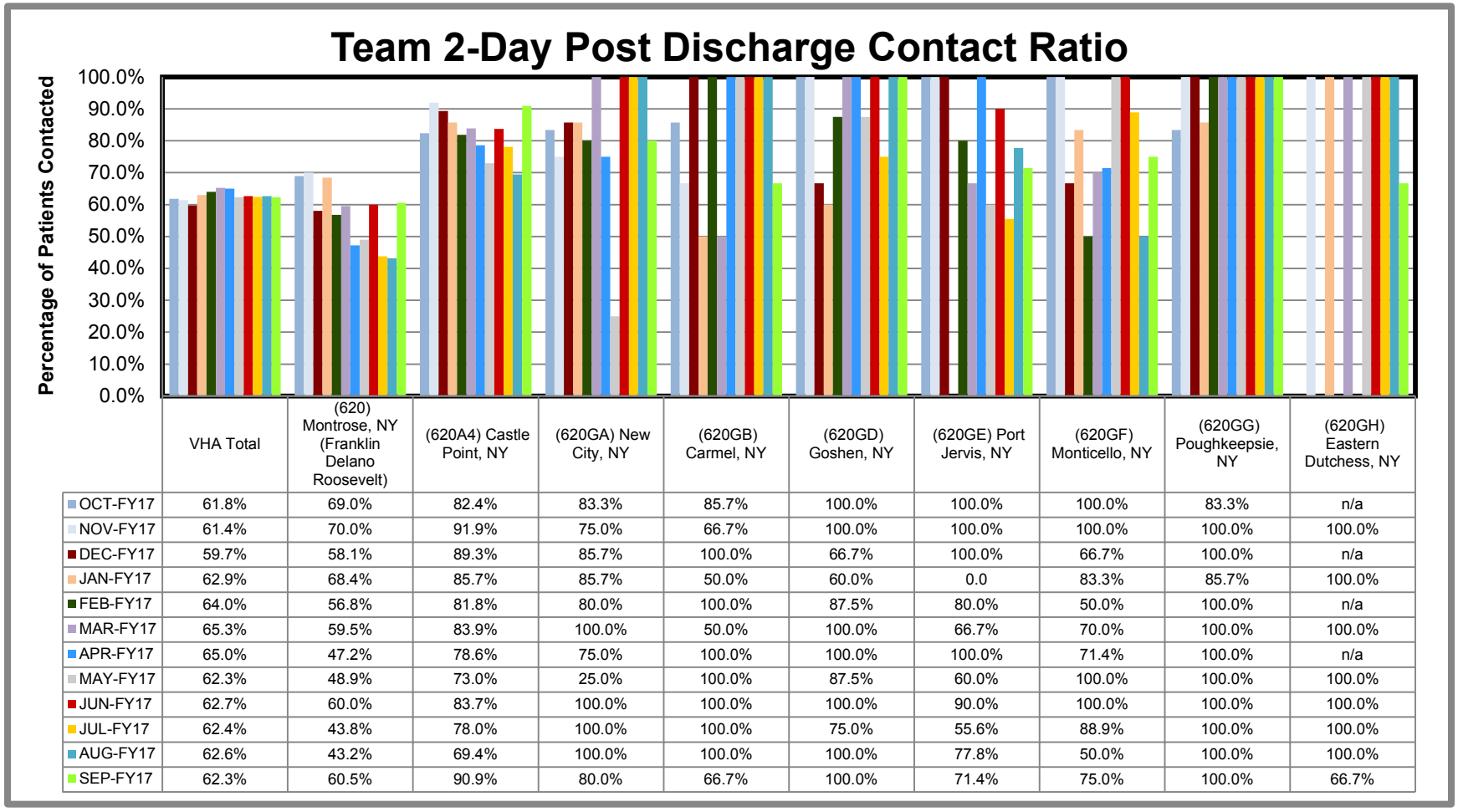


	VHA Total	(620) Montrose, NY (Franklin Delano Roosevelt)	(620A4) Castle Point, NY	(620GA) New City, NY	(620GB) Carmel, NY	(620GD) Goshen, NY	(620GE) Port Jervis, NY	(620GF) Monticello, NY	(620GG) Poughkeepsie, NY	(620GH) Eastern Dutchess, NY
OCT-FY17	3.9	1.1	1.9	0.9	0.8	1.6	1.2	0.2	1.5	2.2
NOV-FY17	4.2	0.9	1.7	2.3	0.9	1.2	3.1	0.3	0.7	1.5
DEC-FY17	4.1	0.5	1.3	1.8	1.2	2.3	1.5	0.3	1.3	4.1
JAN-FY17	4.4	0.5	1.3	1.3	1.6	2.6	1.7	0.6	0.7	2.7
FEB-FY17	3.9	0.7	1.4	0.7	1.5	2.5	2.8	0.3	1.3	2.0
MAR-FY17	3.9	1.0	1.5	1.2	0.8	2.8	2.4	0.7	1.6	1.4
APR-FY17	3.9	1.3	2.1	1.0	1.1	2.9	2.6	0.3	1.9	3.3
MAY-FY17	4.0	1.0	1.9	0.9	1.2	2.7	1.6	0.5	1.7	3.7
JUN-FY17	4.1	1.2	2.5	1.5	0.9	2.5	1.8	0.7	1.7	1.9
JUL-FY17	4.1	1.7	2.5	1.9	1.2	2.7	2.0	1.8	3.0	4.8
AUG-FY17	4.2	2.0	2.8	2.5	1.1	3.7	1.8	0.8	2.5	3.8
SEP-FY17	4.0	1.6	3.0	2.3	1.0	3.0	1.8	0.7	2.0	3.2

Source: VHA Support Service Center

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

Data Definition: *The average number of calendar days between an established patient's PC 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.*

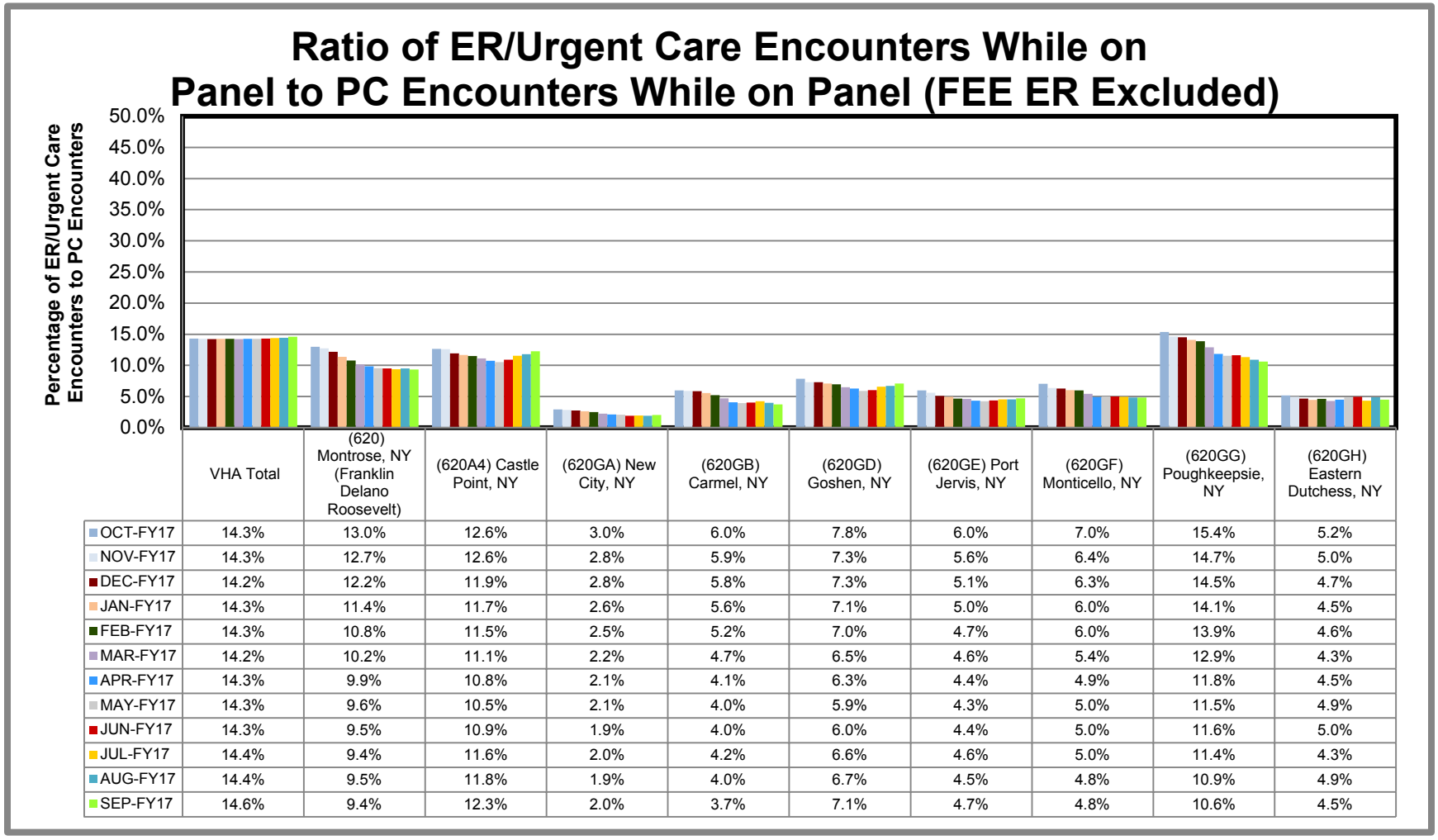


	VHA Total	(620) Montrose, NY (Franklin Delano Roosevelt)	(620A4) Castle Point, NY	(620GA) New City, NY	(620GB) Carmel, NY	(620GD) Goshen, NY	(620GE) Port Jervis, NY	(620GF) Monticello, NY	(620GG) Poughkeepsie, NY	(620GH) Eastern Dutchess, NY
OCT-FY17	61.8%	69.0%	82.4%	83.3%	85.7%	100.0%	100.0%	100.0%	83.3%	n/a
NOV-FY17	61.4%	70.0%	91.9%	75.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%
DEC-FY17	59.7%	58.1%	89.3%	85.7%	100.0%	66.7%	100.0%	66.7%	100.0%	n/a
JAN-FY17	62.9%	68.4%	85.7%	85.7%	50.0%	60.0%	0.0	83.3%	85.7%	100.0%
FEB-FY17	64.0%	56.8%	81.8%	80.0%	100.0%	87.5%	80.0%	50.0%	100.0%	n/a
MAR-FY17	65.3%	59.5%	83.9%	100.0%	50.0%	100.0%	66.7%	70.0%	100.0%	100.0%
APR-FY17	65.0%	47.2%	78.6%	75.0%	100.0%	100.0%	100.0%	71.4%	100.0%	n/a
MAY-FY17	62.3%	48.9%	73.0%	25.0%	100.0%	87.5%	60.0%	100.0%	100.0%	100.0%
JUN-FY17	62.7%	60.0%	83.7%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%
JUL-FY17	62.4%	43.8%	78.0%	100.0%	100.0%	75.0%	55.6%	88.9%	100.0%	100.0%
AUG-FY17	62.6%	43.2%	69.4%	100.0%	100.0%	100.0%	77.8%	50.0%	100.0%	100.0%
SEP-FY17	62.3%	60.5%	90.9%	80.0%	66.7%	100.0%	71.4%	75.0%	100.0%	66.7%

Source: VHA Support Service Center

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

Data Definition: *The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17."*



	VHA Total	(620) Montrose, NY (Franklin Delano Roosevelt)	(620A4) Castle Point, NY	(620GA) New City, NY	(620GB) Carmel, NY	(620GD) Goshen, NY	(620GE) Port Jervis, NY	(620GF) Monticello, NY	(620GG) Poughkeepsie, NY	(620GH) Eastern Dutchess, NY
OCT-FY17	14.3%	13.0%	12.6%	3.0%	6.0%	7.8%	6.0%	7.0%	15.4%	5.2%
NOV-FY17	14.3%	12.7%	12.6%	2.8%	5.9%	7.3%	5.6%	6.4%	14.7%	5.0%
DEC-FY17	14.2%	12.2%	11.9%	2.8%	5.8%	7.3%	5.1%	6.3%	14.5%	4.7%
JAN-FY17	14.3%	11.4%	11.7%	2.6%	5.6%	7.1%	5.0%	6.0%	14.1%	4.5%
FEB-FY17	14.3%	10.8%	11.5%	2.5%	5.2%	7.0%	4.7%	6.0%	13.9%	4.6%
MAR-FY17	14.2%	10.2%	11.1%	2.2%	4.7%	6.5%	4.6%	5.4%	12.9%	4.3%
APR-FY17	14.3%	9.9%	10.8%	2.1%	4.1%	6.3%	4.4%	4.9%	11.8%	4.5%
MAY-FY17	14.3%	9.6%	10.5%	2.1%	4.0%	5.9%	4.3%	5.0%	11.5%	4.9%
JUN-FY17	14.3%	9.5%	10.9%	1.9%	4.0%	6.0%	4.4%	5.0%	11.6%	5.0%
JUL-FY17	14.4%	9.4%	11.6%	2.0%	4.2%	6.6%	4.6%	5.0%	11.4%	4.3%
AUG-FY17	14.4%	9.5%	11.8%	1.9%	4.0%	6.7%	4.5%	4.8%	10.9%	4.9%
SEP-FY17	14.6%	9.4%	12.3%	2.0%	3.7%	7.1%	4.7%	4.8%	10.6%	4.5%

Source: VHA Support Service Center

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

Data Definition: *This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a LIP divided by the number of PC Team Encounters WOT with an LIP* ***plus*** *the total number of VHA ER/Urgent Care Encounters WOT with an LIP.*

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[91]

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	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	All Employee Survey Best Places to Work score	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Capacity	Physician Capacity	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	% 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

[91] VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: February 14, 2018.

Measure	Definition	Desired Direction
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Healthcare 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	MH 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	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (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 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
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
Rating Hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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
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

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: May 9, 2018

From: Director, New York/New Jersey VA Health Care Network (10N2)

Subj: CHIP Review of the VA Hudson Valley Health Care System, Montrose, NY

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review the draft OIG Comprehensive Healthcare Inspection Program (CHIP) Review of the VA Hudson Valley Health Care System at Montrose, New York. I concur with the report findings and recommendations.
2. I have reviewed the VAMC's action plan and concur with the submitted plan.

(Original signed by:)

Joan E. McInerney, MD, MBA, MA FACEP

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Americans with Disabilities Act.

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: May 9, 2018

From: Director, VA Hudson Valley Health Care System (620/00)

Subj: CHIP Review of the VA Hudson Valley Health Care System, Montrose, NY

To: Director, New York/New Jersey VA Health Care Network (10N2)

I have reviewed the attached draft report for the CHIP Review of the VA Hudson Valley Health Care System, Montrose, New York and concur with this report.

I have reviewed the action plans and concur with them as submitted. VA Hudson Valley Health Care System will continue to monitor and report as required.

(Original signed by:)

MARGARET B. CAPLAN
Medical Center Director
VA Hudson Valley Health Care System

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Americans with Disabilities Act.

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