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Office of Healthcare Inspections

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Comprehensive Healthcare Inspection Program Review of the Samuel S. Stratton VA Medical Center Albany, New York

March 29, 2018

Washington, DC 20420

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Glossary

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
EOC	environment of care
facility	Samuel S. Stratton VA Medical Center
FY	fiscal year
GE	geriatric evaluation
LIP	licensed independent practitioner
MH	mental health
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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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 Samuel S. Stratton VA Medical Center (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the Office of Inspector General's (OIG) overall efforts to ensure that our nation's veterans receive high-quality and timely VA health care services. The reviews are performed approximately every 3 years for each facility. OIG selects and evaluates specific areas of focus on a rotating basis each year. OIG's current areas of focus are:

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

This review was conducted during an unannounced visit made during the week of October 23, 2017. OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although 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, will potentially improve patient safety and health care quality.

Results and Review Impact

Leadership and Organizational Risks. At the Samuel S. Stratton VA Medical Center, the leadership team consists of the Interim Facility Director, Chief of Staff, Interim Associate Director for Patient Care Services (Nurse Executive), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure, with the Leadership Council having oversight for leadership groups such as the Health Systems Committee, Executive Committee Medical Staff, and Executive Committee Nursing Staff. The leaders are members of the Leadership Council through which they track, trend, and monitor quality of care and patient outcomes.

The Director and Nurse Executive have served in an interim capacity since June 26, 2017 and July 3, 2017, respectively. The Associate Director position had been covered with seven different interim staff from September 30, 2016, until the positon was filled October 15, 2017. The Chief of Staff was permanently assigned in January 2017 but had served as Acting Chief of Staff since July 2016.

In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted opportunities to improve employee satisfaction. Patient satisfaction scores were above the Veterans Health Administration (VHA) average. Facility leaders were actively engaged with employees and patients and were working to improve employee satisfaction scores. OIG also noted that facility leaders implemented processes and plans to maintain a committed workforce and positive patient experiences.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, Patient Safety Indicator data, and Strategic Analytics for Improvement and Learning (SAIL) data and identified the presence of organizational risk factors that may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored. OIG recognizes that the 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 VHA.[1]

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 3-star rating. In the review of key care processes, OIG issued 10 recommendations that are attributable to the Interim Facility Director, Chief of Staff, and Associate Director. Of the eight areas of clinical operations reviewed, OIG noted findings in five. These are briefly described below.

Credentialing and Privileging. OIG found general compliance with requirements for credentialing, privileging, and Focused Professional Practice Evaluations. However, OIG identified a deficiency in using the results of Ongoing Professional Practice Evaluations to determine whether to recommend continuation of current privileges.

[1] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. 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.

Quality, Safety, and Value. OIG found general compliance with requirements for protected peer reviews. However, OIG identified deficiencies with utilization management[2] and patient safety processes.

Environment of Care. OIG noted a safe environment of care with the exception of seven inpatient units that had dirty ventilation grills and stained or broken ceiling tiles and seven storage rooms that had supplies within 18 inches of a sprinkler. The representative community based outpatient clinic and Nutrition and Food Services generally met the performance indicators evaluated. OIG did not note any issues with construction safety. However, OIG identified deficiencies with EOC rounds frequency and attendance and storage of medical biohazardous waste.

Medication Management. OIG found general compliance with many of the requirements evaluated, such as for CSC reports, annual physical security surveys, ordering procedures, and the CSC and CSIs having no conflicts of interest and completing required training. Additionally, area and pharmacy inspections were generally completed as required. However, OIG identified deficiencies with verification of CS orders during area inspections and with frequency of prescription pad verifications.

Women's Health. OIG noted general compliance with many of the performance indicators reviewed, including electronically linking mammogram results to the order, scanning hard copy reports, and communication of results and any recommended course of action to the ordering provider. However, OIG identified a deficiency with communicating results to patients.

Summary

In the review of key care processes, OIG issued 10 recommendations that are attributable to the Interim Facility 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.

[2] VHA Directive 1117, *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

Comments

The Veterans Integrated Service Network Director and Interim Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 53–54, and the responses within the body of the report for the full text of the Directors' comments.) OIG will follow up on the planned actions until they are completed.

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

Purpose and Scope

Purpose

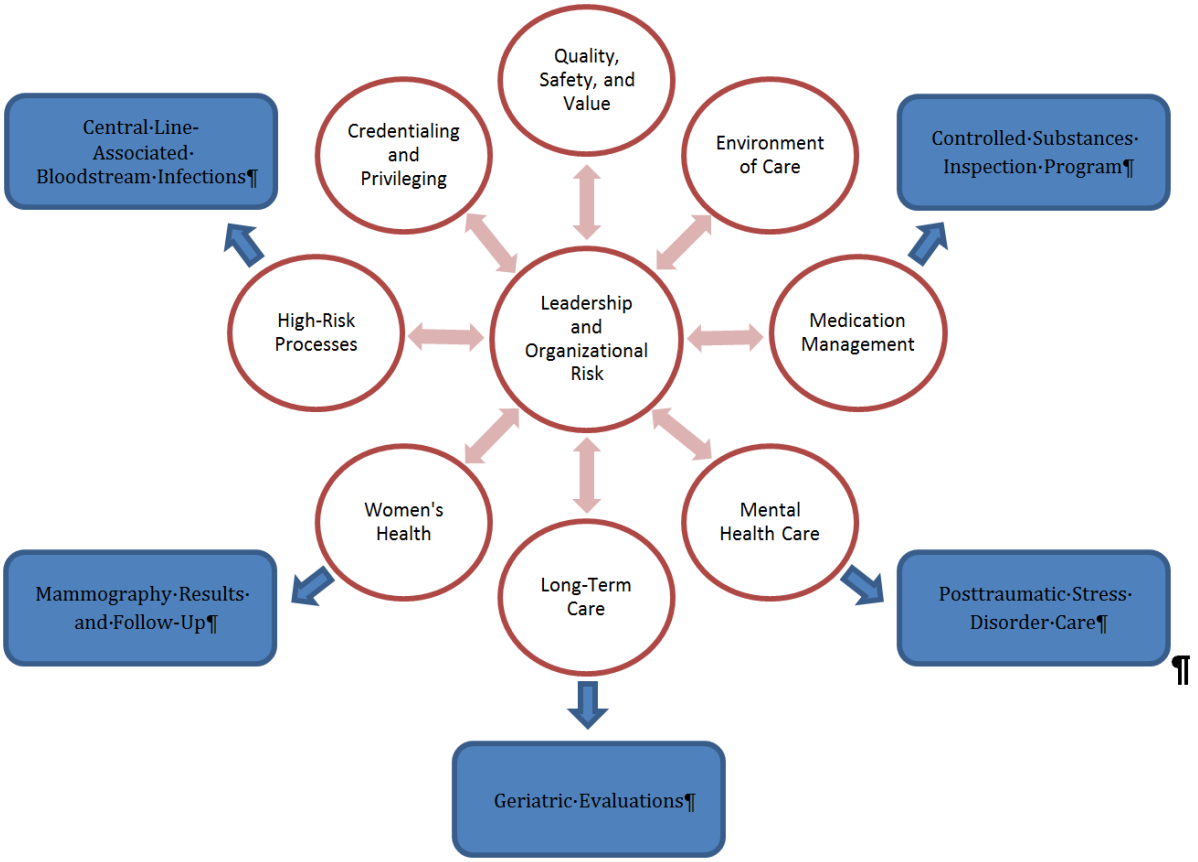
This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the Samuel S. Stratton VA Medical Center's (facility) inpatient and outpatient settings through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of health care services to veterans and to share findings with facility leaders so that informed decisions can be made to improve care.

Scope

CHIP reviews currently focus on the following nine areas: (1) Leadership and Organizational Risks; (2) Credentialing and Privileging; (3) Quality, Safety, and Value (QSV); (4) Environment of Care (EOC); (5) Medication Management; (6) Mental Health (MH) Care; (7) Long-Term Care; (8) Women's Health; and (9) High-Risk Processes. These were selected because of risks to patients and the organization when care is not performed well. For fiscal year (FY) 2018,[3] the Office of Inspector General (OIG) selected the following specific focus areas—Medication Management: Controlled Substances (CS) Inspection Program; MH Care: 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 1).

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

Figure 1. Fiscal Year 2018[4] Comprehensive Healthcare Inspection Program Review of Health Care Operations and Services



Source: VA OIG.

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

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements[5] related to patient care quality, clinical functions, and the EOC, OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[6] and discussed processes and validated findings

[4] October 1, 2017 through September 30, 2018.
[5] Appendix C lists policies that had expired recertification dates but were considered in effect as they had not been superseded by more recent policy or guidance.
[6] OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.

with managers and employees. OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for October 6, 2014[7] through October 23, 2017, the date when an unannounced week-long site visit commenced. On November 13, 2017, OIG presented crime awareness briefings to 64 of the facility's 1,415 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Recommendations for improvement in this report 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 onsite, OIG did not receive any concerns beyond the scope of a CHIP review. OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[7] 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 risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus.[8] The factors OIG considered in assessing the facility's risks and strengths were:

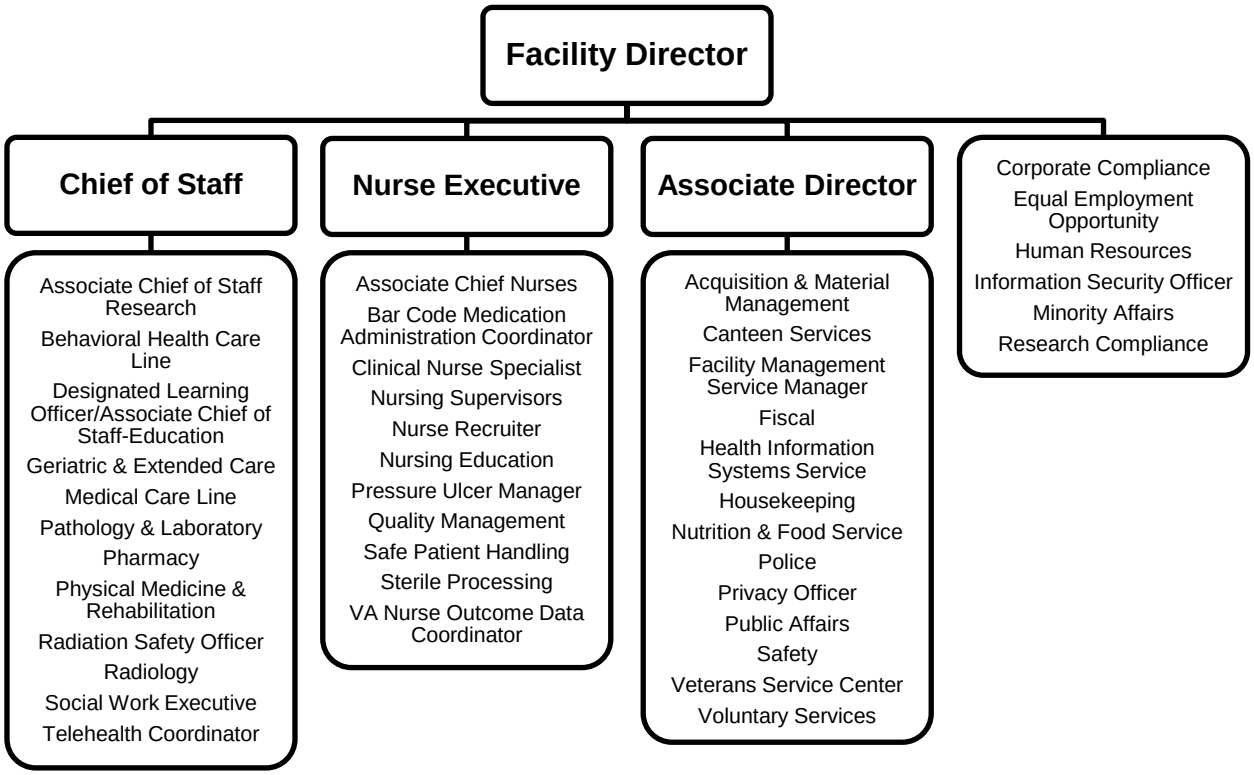
1. Executive leadership stability and engagement
2. Employee satisfaction and patient experience
3. Accreditation/for-cause surveys and oversight inspections
4. Indicators for possible lapses in care
5. VHA performance data

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, the leadership organizational chart may differ between facilities. Figure 2 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the Interim Director, Chief of Staff, Interim Associate Director for Patient Care Services (Nurse Executive), and Associate Director. The Chief of Staff, Nurse Executive, and Associate Director are responsible for overseeing patient care and service directors and program and practice chiefs.

It is important to note that the Interim Director and Interim Nurse Executive were assigned on June 26, 2017 and July 3, 2017, respectively. The Associate Director was permanently assigned effective October 15, 2017. Prior to this, the position had been vacant since September 30, 2016 and was filled by seven different interim appointees. The Chief of Staff, after having served as Acting Chief of Staff since July 2016, was permanently assigned in January 2017.

[8] Botwinick, L., Bisognano, M., and Haraden, C., 2006. *Leadership Guide to Patient Safety*. Institute for Healthcare Improvement, Innovation Series white paper. Retrieved February 2, 2017 from http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx.

Figure 2. Facility Organizational Chart



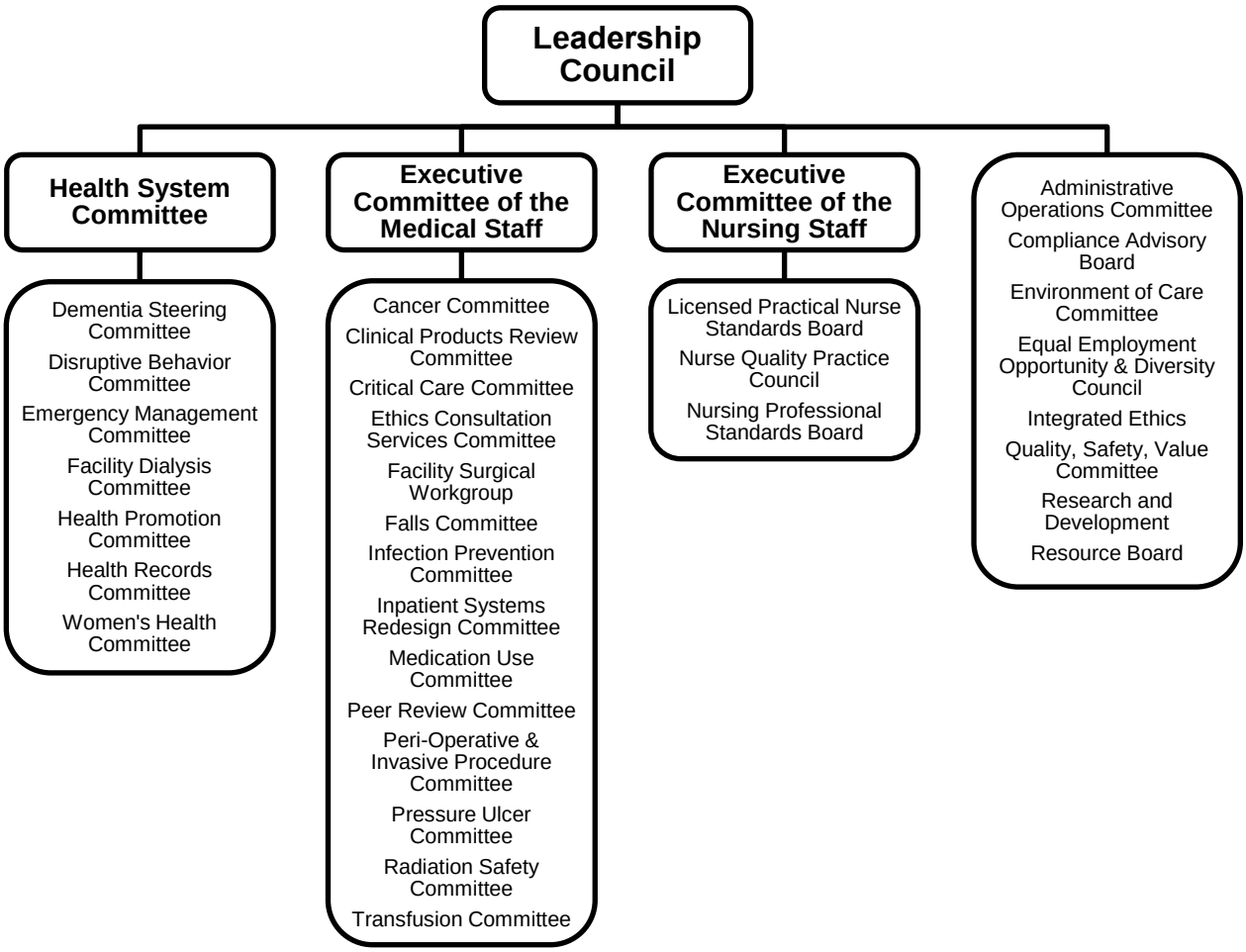
Source: Samuel S. Stratton VA Medical Center (received October 23, 2017).

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

In individual interviews, these executive leadership team leaders, with the exception of the newly appointed Associate Director, 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 Leadership Council, which tracks, trends, and monitors quality of care and patient outcomes. The Interim Facility 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 Leadership Council also oversees various working groups, such as the Health System Committee, Executive Committee of the Medical Staff, and Executive Committee Nursing Service. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: Samuel S. Stratton VA Medical Center (received October 23, 2017).

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, 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 OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership. Tables 1 and 2 provide relevant survey results for VHA and the facility. The facility leaders' results (Director's office average) were rated above the VHA and facility average; however, the facility averages were below the VHA average.[9] All four patient survey results reflected higher care ratings than the VHA average. Opportunities appear to exist to improve employee satisfaction, and patients appear generally satisfied with the leadership and care provided. Facility leaders were actively engaged with employees and patients and were working to improve employee satisfaction scores.

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

Questions	Scoring	VHA Average	Facility Average	Director's Office Average[10]
All Employee Survey[11] 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	3.0	3.6
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	67.7	65.7	77.6

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

[9] 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.
[10] Rating is based on responses by employees who report to the Director.
[11] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

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[12] (inpatient): Would you recommend this hospital to your friends and family?	The response average is the percent of "Definitely Yes" responses.	66.9	67.7
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	85.7
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		74.6	79.5
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		75.0	82.3

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

Accreditation/For-Cause[13] Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, 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 VA OIG and The Joint Commission (TJC). Indicative of effective leadership, the facility has closed[14] all recommendations for improvement as listed in Table 3.

[12] VHA's Patient Experiences Survey Reports provide results from surveys administered by the Survey of Healthcare Experience of Patients (SHEP) program. Industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program are utilized to evaluate patients' experiences of their health care and to support the goal of benchmarking VHA performance against the private sector. VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys.

[13] 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 accreditation organization or inspecting agency.

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[17] conducted an inspection of the facility's Community Living Center.

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
VA OIG (*Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York, January 14, 2015)*	October 2014	23	0
VA OIG (Review of *Community Based Outpatient Clinic and Other Outpatient Clinics of Samuel S. Stratton VA Medical Center, Albany, New York, January 6, 2015)*	October 2014	6	0
TJC[18]			
• Hospital Accreditation	April 2015	29	0
• Nursing Care Center Accreditation		1	0
• Behavioral Health Care Accreditation		3	0
• Home Care Accreditation		5	0

Sources: VA OIG and TJC (inspection/survey results verified with Facility Director on October 24, 2017).

[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 health care 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 more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

Indicators for Possible Lapses in Care. Within the health care 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 OIG's previous October 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of October 23, 2017.

Table 4. Summary of Selected Organizational Risk Factors[19] (October 2014 to October 23, 2017)

Factor	Number of Occurrences
Sentinel Events[20]	2
Institutional Disclosures[21]	19
Large-Scale Disclosures[22]	0

Source: Samuel S. Stratton VA Medical Center's *Patient Safety Manager (received October 26, 2017).*

[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 Samuel S. Stratton VA Medical Center is a mid-high complexity (1c) affiliated facility as described in Appendix B.)
[20] A sentinel event is a patient safety event that involves a patient and results in death, permanent harm, or severe temporary harm and 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 the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.
[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.

OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[23] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 5 summarizes the Patient Safety Indicator data from October 1, 2015 through June 30, 2017.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 2	Facility
Pressure Ulcers	0.60	0.82	0
Death among surgical inpatients with serious treatable conditions	103.19	136.99	40.00
Iatrogenic Pneumothorax	0.18	0.41	0.26
Central Venous Catheter-Related Bloodstream Infection	0.14	0.09	0
In Hospital Fall with Hip Fracture	0.08	0.09	0.31
Perioperative Hemorrhage or Hematoma	2.00	2.61	3.56
Postoperative Acute Kidney Injury Requiring Dialysis	0.98	1.29	0
Postoperative Respiratory Failure	5.98	9.25	14.74
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.33	3.45	2.25
Postoperative Sepsis	4.04	4.87	11.83
Postoperative Wound Dehiscence	0.50	0	0
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.53	1.23	1.69

Source: VHA Support Service Center.

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

The Patient Safety Indicator measure for iatrogenic pneumothorax shows a higher observed rate than VHA while five other Patient Safety Indicator measures (in hospital fall with hip fracture, perioperative hemorrhage or hematoma, postoperative respiratory failure, postoperative sepsis, and unrecognized abdominopelvic accidental puncture/laceration) show a higher observed rate than Veterans Integrated Service Network (VISN) 2 and VHA.

A single patient developed a pneumothorax following a lung biopsy. This case was reviewed at a morbidity and mortality conference, and it was determined that there were no opportunities for improvement.

One patient sustained a hip fracture after an in hospital fall. A root cause analysis was completed, and as a result of the review, actions were taken to prevent future reoccurrences.

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

Three patients experienced perioperative hemorrhage or hematoma. All three cases were reviewed at a morbidity and mortality conference, and it was determined that there were no opportunities for improvement.

Six patients had postoperative respiratory failure. Of these, one patient required prolonged ventilator support after surgery. The other five patients were removed from the ventilator after surgery; however, during their postoperative period, they required further ventilator support due to difficulty with breathing. Six patients had postoperative sepsis. All of the cases were reviewed at morbidity and mortality conferences, and no further actions were needed.

Additionally, OIG noted that the number of occurrences with postoperative respiratory failure and sepsis did not trigger the facility to conduct a more in depth review of all of the cases for tracking, and trending, and identification of opportunities for improvement.

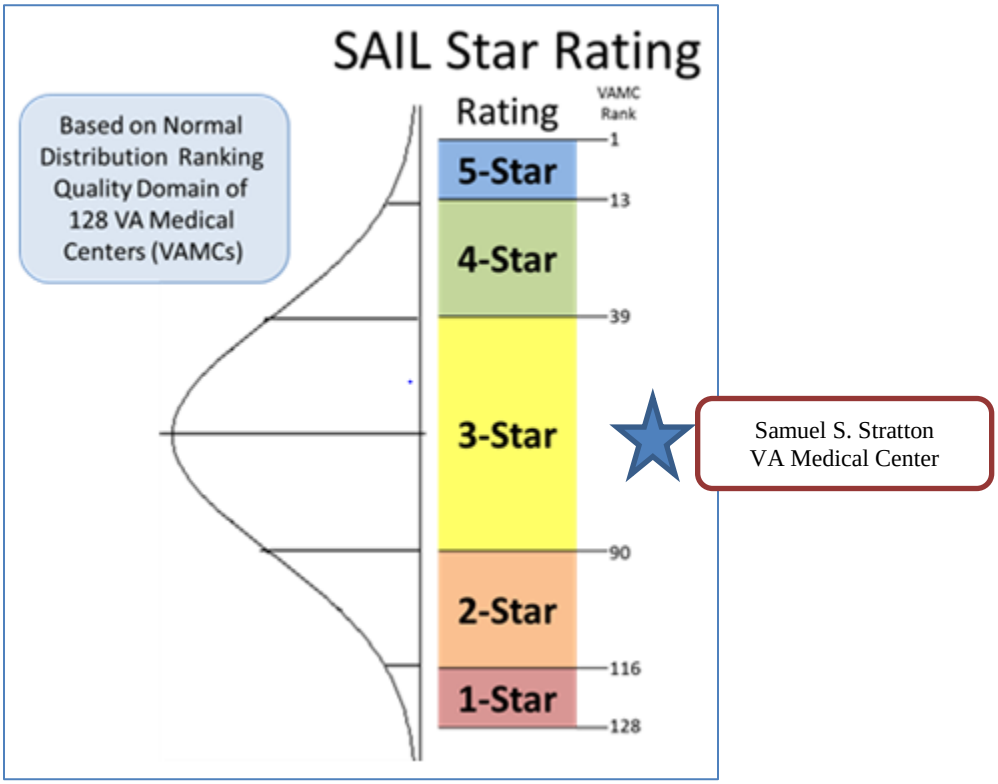
One patient had an unrecognized abdominopelvic accidental puncture/laceration; however, the injury was identified during surgery and repaired.

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.[24] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[25]

[24] The model is derived from the Thomson Reuters Top Health Systems Study.
[25] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146

VA also uses a star-rating system that is designed to make model results more accessible for the average user. Facilities with a 5-star rating are performing within the top 10 percent of facilities, whereas 1-star facilities are performing within the bottom 10 percent of facilities. Figure 4 describes the distribution of facilities by star rating. As of June 30, 2017, the Samuel S. Stratton VA Medical Center received a rating of 3 stars for overall quality. This means the facility is in the 3rd quintile (30–70 percent range).

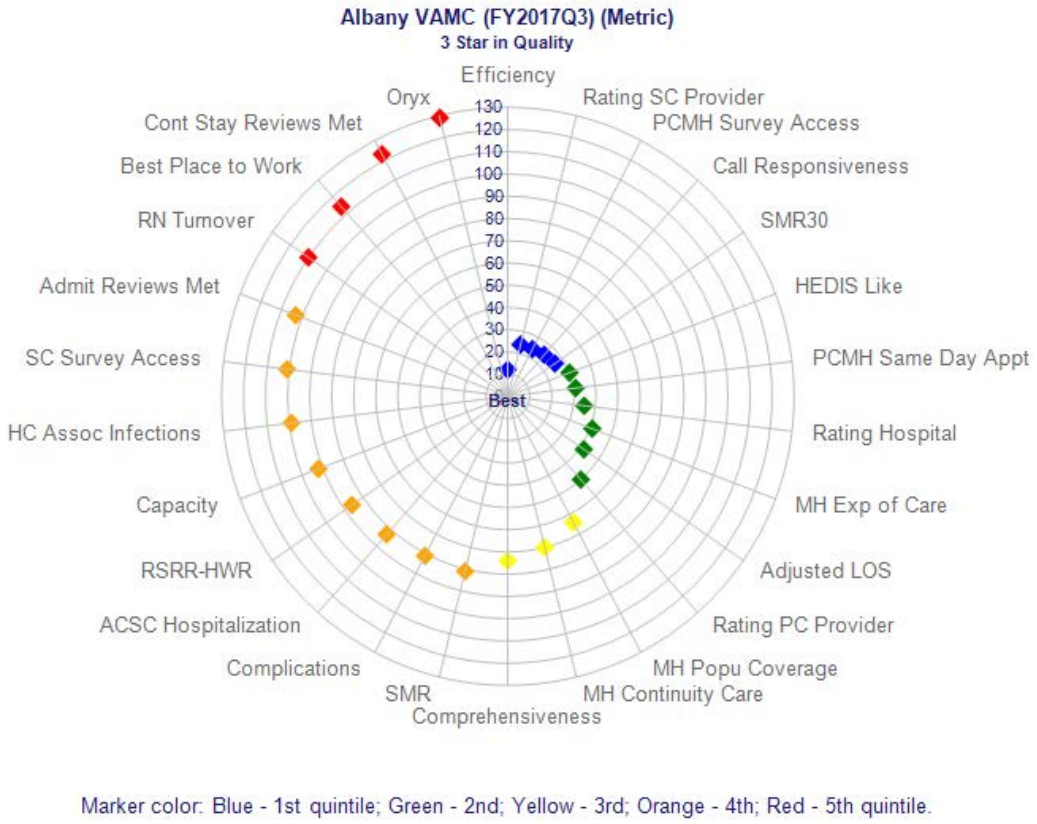
Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2017)



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

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of June 30, 2017. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, Efficiency, Rating [of] Specialty Care [SC] Provider, Call Responsiveness, and Rating [of] Hospital). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Complications, Capacity, Registered Nurse [RN] Turnover, and Best Place to Work).

Figure 5. Facility Quality of Care and Efficiency Metric Rankings (as of June 30, 2017)



Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness. Also, see Appendix D 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 E.

Conclusions. Three of four facility leadership positions had been filled by interim staff for at least a year prior to our onsite visit. The Director and Nurse Executive positions were both filled with interim staff. The Associate Director was permanently assigned; however, prior to this, the position was vacant for over 12 months and had been filled by seven different interim appointees. OIG noted that facility leaders were actively engaged with employees and patients and were working to improve employee satisfaction scores (such as initiating processes and plans to maintain positive perceptions of the facility through active stakeholder engagement). Organizational leadership appears to support patient safety and quality care. 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 3-star rating.

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all health care 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 health care professionals are also referred to as licensed independent practitioners (LIP).[26]

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, mental and physical health, and skill to fulfill the requirements of the position and to support the requested clinical privileges.[27]

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 Facility Director. Clinical privileges are granted for a period not to exceed 2 years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.[28]

The purpose of this review was to determine whether the facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. OIG interviewed key managers and reviewed the credentialing and privileging folders of 10 LIPs who were hired within the previous 18 months prior to OIG's onsite visit.[29] OIG also reviewed the credentialing and privileging folders of 20 LIPs who were re-privileged within the 12 months prior to the onsite visit.[30] OIG reviewed the following performance indicators.

- Credentialing
  - At least one current license
  - Evidence of primary source verification for all medical licenses
- Privileging
  - Two efforts made to obtain verification of clinical privileges currently or most recently held at other institutions
  - Requested privileges:
    - Facility-specific
    - Service-specific
    - Provider-specific

[26] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)
[27] Ibid.
[28] Ibid.
[29] April 23, 2016 through October 23, 2017.
[30] October 23, 2016 through October 23, 2017.

  - Documentation of service chief recommendation of approval for requested privileges
  - Medical Staff Executive Committee documentation of decision to recommend the requested privileges
  - Approval of privileges for a period of ≤2 years
- Focused Professional Practice Evaluation (initial or new privileges)
  - Evaluation initiated:
    - Timeframe clearly documented
    - Criteria developed
    - Results documented and based upon evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee documentation of decision to recommend continuing initially-granted privileges based on results
- Ongoing Professional Practice Evaluation (OPPE) (re-privileging)
  - Evidence determination to continue current privileges based in part on results of OPPE activities
    - Criteria specific to the service/section
    - Results based on evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee documentation of decision to recommend continuing privileges based on results

Conclusions. OIG found general compliance with requirements for credentialing, privileging, and Focused Professional Practice Evaluations. However, OIG identified a deficiency in using evidence from OPPEs to determine continuation of current privileges.

Re-Privileging. VHA requires that the determination to continue LIP privileges be based in part on the results of OPPE activities, such as results of EHR reviews, outcome data, and direct observation.[31] These activities allow the facility to identify professional practice trends that impact patient care, safety, and quality of care. For 8 of 20 LIPs who were re-privileged, EHRs reviews were not consistently done; therefore the Executive Committee of the Medical Staff lacked adequate data from EHR reviews to recommend continuation of privileges. As a result, providers continued delivering care without a thorough evaluation of their practice. Service chiefs had inconsistent methods of reporting OPPE results to the Executive Committee of the Medical Staff, and the committee granted privileges without corroborating documentation.

[31] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)

Recommendation

1. The Chief of Staff ensures the Executive Committee of the Medical Staff uses the results of Ongoing Professional Practice Evaluations in the determination of whether to recommend continuation of licensed independent practitioners' privileges and monitors compliance.

Facility Concurred.

Target date for completion: June 1, 2018

Facility response: A process was established at the Executive Committee of the Medical Staff meeting, by the Chief of Staff, to review the results of the Ongoing Professional Practice Evaluation reviews. At the time of re-credentialing and re-privileging, there is a full review of the previous two year period. Monitoring will occur through Executive Committee of the Medical Staff committee minutes for three months to ensure 90 percent compliance is achieved.

Quality, Safety, and Value

One of VA's strategies is to deliver high-quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, and efficiency.[32] VHA set the goal of serving as the Nation's leader in delivering high-quality, safe, and reliable care, centered on the veteran, while promoting population health throughout the coordinated care continuum. To meet this goal, VHA must foster a culture that acts with integrity to achieve accountability; that is vigilant and mindful, proactively risk aware, highly reliable, and predictable; and that seeks to continuously improve.[33]

VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities. The purpose of this review was to determine whether the facility implemented and incorporated selected key functions of the Enterprise Framework for QSV into local activities. To assess this area of focus, OIG evaluated: (1) protected peer review[34] of clinical care, (2) utilization management (UM) reviews,[35] and (3) patient safety incident reporting and root cause analyses.[36]

OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. OIG reviewed the following performance indicators.

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, timely 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

[32] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[33] VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
[34] 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.)*
[35] According to VHA Directive 1117, UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.
[36] According to VHA Handbook 1050.01 (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 root cause analysis (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.

- Patient safety
  - Entry of all reported patient incidents into WebSPOT database[37]
  - Completion of required minimum of eight root cause analyses
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report

Conclusions. OIG found general compliance with requirements for protected peer reviews. However, OIG identified the following deficiencies with UM documentation and data review and with patient safety that warranted recommendations for improvement.

Utilization Management: Documentation of Decisions. VHA requires that Physician UM Advisors document their decisions in the National UM Integration database regarding appropriateness of patient admission and continued stays. This ensures a process for communicating all UM data within the facility and to the VISN, as a component of the Quality Management System, and facilitates the use of UM data to assist with identification of initiatives to improve efficiency.[38] In 9 of 30 cases (30 percent) referred to the physician advisors from August 1 2017 through September 30, 2017, there was no evidence that advisors documented their decisions in the database, resulting in incomplete reviews. Reasons provided for the assigned advisors not completing the reviews were position vacancies, clinical responsibilities, and lack of assigned alternate Physician UM Advisors.

Recommendation

2. The Chief of Staff ensures Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and monitors the advisors' compliance.

Facility Concurred.

Target date for completion: May 1, 2018

Facility response: The Chief of Staff ensured that there are Physician Utilization Management Advisors now in place for all services. The Utilization Management nurses collaborate with the Physician Utilization Management Advisors when cases are assigned. The PUMA's and UM nurses attend the interdisciplinary daily discharge rounds. PUMA compliance will be reported to the facility Quality, Safety, Value Committee monthly then quarterly after compliance is attained. Monitoring will occur through the Quality Committee minutes until 90 percent compliance is maintained for three consecutive months.

[37] WebSPOT is the software application used for reporting and documenting adverse events in the VHA Patient Safety Information System.
[38] VHA Directive 1117.

Utilization Management: Review of Data. VHA requires that an interdisciplinary facility group review UM data. This group should include, but not be limited to, representatives from UM, medicine, nursing, social work, case management, MH, and Chief Business Office revenue utilization review.[39] This ensures that an interdisciplinary team reviews UM data to identify initiatives to improve efficiency. From October 1, 2016 through September 30, 2017, the interdisciplinary group that reviewed UM data did not include representation from case management or Chief Business Office revenue utilization review. This resulted in a lack of expertise in the review and analysis of UM data. Facility managers were not aware of the membership requirements.

Recommendation

3. The Chief of Staff ensures the interdisciplinary group or committee that reviews utilization management data includes representatives from the Chief, Business Office Revenue-Utilization Review.

Facility Concurred.

Target date for completion: June 1, 2018

Facility response: The Chief of Staff/designee developed a process to report Utilization Management data through the Quality Committee monthly. This will include all the required members including the Chief Business Officer/designee. Monitoring of attendance will be conducted monthly through the Quality, Safety, Value Committee minutes until 80 percent compliance is achieved.

Patient Safety: Root Cause Analyses. VHA requires that the Patient Safety Manager provides timely feedback to staff who submit close call and adverse event reports that result in a root cause analysis.[40] This establishes trust in the system and ensures staff are aware that their report was taken seriously. For three of five root cause analyses conducted during FY 2017, there was no evidence that the individual or department reporting the incident received feedback about actions taken. The Patient Safety Manager reported not meeting the requirement due to a lack of follow up and receipt of supporting documentation that actions were implemented.

[39] Ibid.
[40] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

Recommendation

4. The Facility Director ensures the Patient Safety Manager or designee provides feedback about root cause analysis actions to the reporting individuals or departments and monitors the Patient Safety Manager's compliance.

Facility Concurred.

Target date for completion: June 1, 2018

Facility response: The Patient Safety Manager will report Root Cause Analysis findings to the Nursing Quality Practice Council and Executive Committee of the Medical staff. It is the service chief/manager responsibility of the department where the Root Cause Analysis originated from to relay the action plan/findings of the Root Cause Analysis to the front line staff. The service chief/manager will report completion at the following Nursing Quality Practice Council and Executive Committee of the Medical staff meeting. This will be monitored for three consecutive months in the Nursing Quality Practice Council and/or Executive Committee of the Medical staff committee meeting minutes until 90 percent compliance is achieved.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the health care environment. VHA requires managers to conduct EOC inspection rounds and resolve EOC issues in a timely manner.[41] 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 health care organization must not only be functional but should also promote healing.

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.[42] 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[43] and Nutrition and Food Services.[44]

The implementation of a proactive and comprehensive construction safety program reduces the potential for injury and illness from unsafe and unhealthy construction activities. Construction safety programs reduce the potential for construction-related accidents, injuries, or exposures.[45]

The Nutrition and Food Services Program must provide quality meals that meet the regulatory requirements for food safety. The highest standard of quality and safety must be maintained in accordance with the Food and Drug Administration Food Code and the VHA-established food safety program.[46]

In all, OIG inspected seven inpatient units (critical care, 9B-Community Living Center, 9C-Community Living Center, 8B-medicine, 10B-inpatient MH, 7B-surgical, and post-anesthesia care), the Emergency Department, the Outpatient Women's Health Center, and Nutrition and Food Service. OIG also inspected the Troy CBOC and selected construction sites.[47] Additionally, OIG reviewed the most recent Infection Prevention Risk Assessment, Infection Prevention/Control Committee minutes for the

[41] VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.
[42] Applicable requirements also include VHA Directive 1116(2) (March 23, 2016), VHA Directive 1131 (November 7, 2017), VHA Directive 1229 (July 7, 2017), VHA Directive 1330.01 (amended September 8, 2017), VHA Directive 1761(1) (October 24, 2016), VHA Directive 2012-026 (September 27, 2012), Joint Commission hospital accreditation standards (Environment of Care, Infection Prevention and Control, Information Management, Leadership, Life Safety, Medication Management, and Rights and Responsibilities of the Individual), Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).
[43] VHA Directive 7715, *Safety and Health during Construction*, April 6, 2017.
[44] VHA Handbook 1109.04, *Food Service Management Program*, October 11, 2013.
[45] VHA Directive 7715.
[46] VHA Handbook 1109.04.
[47] 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.

past 6 months, and other relevant documents, and OIG interviewed key employees and managers. 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
- 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
- Emergency operations plan for food service
- Safe transportation of prepared food
- Environmental safety
- Infection prevention
- Storage areas

Conclusions. General safety and privacy measures were in place at the parent facility. The representative CBOC generally met the performance indicators evaluated. Nutrition and Food Services met most of the performance indicators reviewed. OIG did not note any issues with construction safety or with the availability of medical equipment and supplies. However, seven inpatient units had dirty ventilation grills and stained or

broken ceiling tiles.[48] OIG identified the following deficiencies in EOC rounds and infection prevention that warranted recommendations for improvement.

Parent Facility: Environment of Care Rounds. VHA requires facilities to conduct EOC rounds at a minimum of once per FY in non-patient care areas and twice per FY in patient care areas and to document completion of such rounds in the Performance Logic database.[49] This ensures a safe, clean, and functional health care environment. From October 1, 2016 through September 30, 2017, the facility did not complete 19 of 128 required inspections (15 percent). The facility's Performance Logic database reflected a requirement to conduct two inspections of all areas, including non-patient care areas that required only one inspection per FY. This resulted in missed inspections, under-inspection of patient care areas, and over-inspection of non-patient care areas. OIG determined that facility managers lacked proper knowledge on use of the database.

Recommendation

5. The Associate Director ensures environment of care rounds are conducted in all areas of the facility at the required frequency and monitors compliance.

Facility Concurred.

Target date for completion: May 1, 2018

Facility Response: The Facility Safety Manager has reviewed and updated the Environment of Care rounding schedule to ensure that all areas are inspected at the required frequency. The facility Environment of Care rounds memorandum was updated. The compliance reports will be reported to the Environment of Care Committee. This will be monitored for three consecutive months in the Environment of Care committee until 90 percent compliance is achieved.

Parent Facility: 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, 10 of 13 required EOC team members did not attend rounds consistently. This resulted in a lack of subject matter experts on EOC rounds. Facility managers were not monitoring attendance and were unaware that team attendance could be tracked and trended through the Performance Logic software.

[48] Critical care, 9B-Community Living Center, 9C-Community Living Center, 8B-medicine, 10B-inpatient MH, 7B-surgical, and post-anesthesia care units.
[49] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
[50] Ibid. According to VHA Directive 1608, 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.

Recommendation

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

Facility Concurred.

Target date for completion. May 1, 2018

Facility Response: The facility Environment of Care rounds memorandum was updated by the Facility Safety Manager to ensure the required members consistently participated. The attendance will be reported to the Environment of Care Committee meeting monthly to ensure compliance. This will be monitored for three consecutive months in the Environment of Care Committee with 90 percent compliance.

Infection Prevention/Control: Goals and Identification of Risks. TJC requires hospitals to minimize the risk of infection when storing and disposing of infectious waste.[51] This decreases the risk of patients, visitors, and employees being exposed to infectious materials. OIG noted two medical biohazardous waste storage rooms (on unit 8B-medicine and the post-anesthesia care unit) with unsecured doors. This resulted in a potential for patient and visitor exposure to contaminated materials. The reason provided for unsecured waste storage rooms was a lack of attention to detail.

Recommendation

7. The Associate Director ensures medical biohazardous waste storage rooms are secured and monitors compliance.

Facility Concurred.

Target date for completion: April 1, 2018

Facility response: For the PACU and ED biohazardous waste storage rooms that needed to be secured, work orders were entered to have keypad locks placed. The biohazardous waste storage room located on unit 8B currently has a traditional key lock; a work order was entered to have the key lock removed and a keypad lock installed.

[51] TJC. Infection Prevention and Control standard IC.02.01.01, EP 6. July 2017.

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 use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused.[52] Diversion—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—by health care workers remains a serious problem that increases the potential for serious patient safety issues, causes harm to the diverter, and elevates the liability risk to health care organizations.[53]

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.[54,55] 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 purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.[56] OIG interviewed key managers and reviewed CS inspection reports for the past 2 completed quarters;[57] monthly summaries of findings, including discrepancies, provided to the Facility Director for the past 12 months; CS inspection quarterly trend reports for the last 4 quarters;[58] and other relevant documents. OIG reviewed the following performance indicators.

- CSC reports
  - Monthly summary of findings to the Facility Director
  - Quarterly trend report to the Facility Director
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Annual physical security survey of the pharmacy/pharmacies by VA Police
  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transitions
  - Staff restrictions for monthly review of balance adjustments

[52] Drug Enforcement Agency Controlled Substance Schedules. Retrieved August 21, 2017, from https://www.deadiversion.usdoj.gov/schedules/.
[53] American Society of Health-System Pharmacists. October 2016. *ASHP Publishes Controlled Substances Diversion Prevention Guidelines*. Retrieved August 21, 2017, from https://www.ashp.org/news/2017/03/10/19/22/ashp-publishes-controlled-substances-diversion-prevention-guidelines.
[54] VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (*Due for recertification November 30, 2015, but has not been updated*.)
[55] VHA Directive 1108.02, *Inspection of Controlled Substances*, November 28, 2016.
[56] VA OIG, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, June 10, 2014.
[57] April 1, 2017 through September 30, 2017.
[58] October 1, 2016 through September 30, 2017.

- 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 Facility 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 performed
  - Rotation 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 CSCs
- Pharmacy inspections
  - Monthly physical counts of the pharmacy by CSIs
  - Completion of inspection on day initiated
  - Security and documentation of drugs held for destruction[59]
  - 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. OIG found general compliance with requirements for most of the performance indicators evaluated, including CSC reports, annual physical security surveys, ordering procedures, and the CSC and CSIs having no conflicts of interest and completing required training. Additionally, area and pharmacy inspections were generally completed as required. However, OIG identified deficiencies in verification of CS orders and accountability for prescription pads that warranted recommendations for improvement.

Controlled Substances Area Inspections: Verification of Orders. VHA requires that CSIs verify during CS area inspections that there is evidence of a written or electronic CS order for a prescribed number of randomly selected patients.[60] This ensures accountability for all CS. Although OIG found that CS order verification was being done,

[59] 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.
[60] VHA Directive 1108.02, *Inspection of Controlled Substances*, November 28, 2016.

the CSC, rather than the CSIs, performed the verifications. This resulted in the CSC's involvement in consecutive monthly area inspections. The reason that the CSC did not require CSIs to perform this function was that it may be too difficult for non-clinical CSIs.

Recommendation

8. The Facility Director ensures that controlled substances inspectors perform controlled substances order verification as required and monitors inspectors' compliance.

Facility Concurred.

Target date for completion: June 1, 2018

Facility Response: The Controlled Substance Inspectors are randomly selecting and documenting orders from a list provided by the Pharmacy Automated Data Processing Application Coordinator. The Controlled Substance Coordinator is then verifying the Controlled Substance Inspectors documentation for accuracy. This will be reported to Quality, Safety, Value Committee for three consecutive months with 90 percent compliance achieved.

Pharmacy Inspections: Prescription Pad Accountability. VHA requires CSIs to verify the inventory count of prescription pads monthly on the day of the pharmacy inspection to ensure correct prescription pad accountability.[61] CSIs conducted quarterly inventories of prescription pads in the inpatient pharmacy or emergency cache rather than the required monthly inventories. This resulted in vulnerability and risk for drug loss, diversion, or potential diversion. The reason for noncompliance centered on differences in forms used for inpatient, emergency cache, and outpatient pharmacy inspections.

Recommendation

9. The Facility Director ensures controlled substances inspectors complete monthly pharmacy prescription pad inventories and monitors inspectors' compliance.

Facility Concurred.

Target date for completion: May 1, 2018

Facility Response: The Prescription pad inventory has been added to Controlled Substance Inspector checklist. The inspection forms now include a section to specifically count prescription pads every month. This will be monitored by the Controlled Substance Coordinator. It will then be reported to the Quality Steering, Safety, Value Committee for three consecutive months to ensure 100 percent compliance.

[61] VHA Directive 1108.02.

Mental Health Care: Post-Traumatic Stress Disorder Care

Post-Traumatic Stress Disorder (PTSD) is a disorder that 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."[62] 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.[63]

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.[64] VHA requires that:

1. PTSD screening is performed for every new patient and then is repeated every year for the first 5 years post-separation and every 5 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.
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.

The purpose of this review was to assess whether the facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care. OIG reviewed relevant documents and interviewed key employees and managers. Additionally, OIG reviewed the electronic health records of 35 randomly selected outpatients who had a positive PTSD screen from July 1, 2016 through June 30, 2017. OIG reviewed the following performance indicators.

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

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

[62] 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.)*
[63] VHA Handbook 1160.03.
[64] 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.

Long-Term Care: Geriatric Evaluations

In 2016, more than 42 percent of the nearly 22 million veterans were age 65 and over, and 5.5 percent of veterans (1.25 million) were over age 85. More than 9 million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.[65]

As a group, veterans experience more chronic disease and disability than age-matched, non-veterans, requiring VA to plan for growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.[66] Participants in geriatric evaluation and management (GE) programs have been shown to be significantly less likely to lose functional ability, experience increased health-related restrictions in their daily activities, have possible depression, or use home health care services.[67]

In 1999, Public Law 106-117, the Veterans Millennium Benefits and Healthcare Act, mandated that the veterans' standard benefits package include access to geriatric evaluation. This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. Management of the patient would then include treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.[68] From a facility standpoint, the GE program must be evaluated through a review of program objectives, procedures for monitoring care processes and outcomes, and analysis of findings.[69]

The purpose of this review was to determine whether the facility provided effective GE. OIG reviewed relevant documents and interviewed key employees and managers. Additionally, OIG reviewed the electronic health records of 47 randomly selected patients who received a geriatric evaluation from July 1, 2016 through June 30, 2017. OIG reviewed the following performance indicators.

- Provision of or access to geriatric evaluation
- Program oversight and evaluation
  - Evidence of GE program evaluation
  - Evidence of performance improvement activities through leadership board

[65] VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.
[66] Ibid.
[67] Boult C, et al. A randomized clinical trial of outpatient geriatric evaluation and management. *J Am Geriatric Soc*. 2001; 49:351–9.
[68] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.
[69] VHA Handbook 1140.04.

- Geriatric evaluation
  - Medical evaluation by GE provider
  - Assessment by GE nurse
  - Comprehensive psychosocial assessment by GE social worker
  - Evidence of patient or family education
  - Development of plan of care based on geriatric evaluation
- Geriatric management
  - Evidence of implementation of interventions noted in plan of care

Conclusions. Generally, the facility met requirements with the above performance indicators. 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 United States' women.[70] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

Public Law 98-160, The Veteran's Health Care Amendments of 1983, mandated VA to provide veterans with preventive care, including breast cancer screening.[71] Public Law 102-585, Veterans Health Care Act of 1992, Title I, authorized VA to provide gender-specific services, including mammography services to eligible women veterans.

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 practitioner within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering practitioner. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering practitioner within 3 business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with 7 calendar days representing the outer acceptable limit. Verbal communication with patients must be documented.[72]

The purpose of this review was to determine whether the facility complied with selected VHA requirements for the reporting of mammography results. OIG reviewed relevant documents and interviewed key employees and managers. Additionally, OIG reviewed the electronic health records of 44 randomly selected women veteran patients who received a mammogram from July 1, 2016 through June 30, 2017. OIG reviewed the following performance indicators.

- Electronic linking of mammogram results to radiology order
- Scanning of hardcopy 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

The performance indicator below did not apply to this facility.

- Performance of follow-up study if indicated

[70] U.S. Breast Cancer Statistics, http://www.BreastCancer.org website, accessed May 18, 2017.
[71] VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011. (Due for recertification April 30, 2016, but has not been updated.)
[72] VHA Directive 1330.01, *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).

Conclusions. Generally, OIG noted compliance with requirements for electronic linking of mammogram results, scanning hard copy reports if outsourced, inclusion of required components in reports, communication of results and any recommended course of action to the ordering provider, and performance of follow-up mammograms and studies if indicated. However, OIG identified the following deficiency with communication of results to patients.

Communication of Results to Patients. VHA requires that providers notify patients of their mammography results.[73] This ensures appropriate and timely follow-up, tracking, and reporting. OIG estimated that providers communicated results to patients in 68.2 percent[74] of the electronic health records reviewed. The lack of patient notification of results could lead to delays in treatment. OIG was told that providers had inconsistent processes for patient notification of results.

Recommendation

10. The Chief of Staff ensures providers communicate mammogram results to patients and monitors providers' compliance.

Facility Concurred. Target date for completion: June 1, 2018 Facility Response: A template was created in CPRS titled "Letter of communication of test results for Mammography." The letter automatically is generated when the note is signed for all mammogram results and is sent within two business days. A monitoring process was established to review all abnormal results and randomly select normal results for compliance monthly. This will be reported to Quality, Safety, Value Committee for three consecutive months to ensure 90 percent compliance.

[73] VHA Directive 1330.01, *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).
[74] OIG is 95 percent confident that the true rate is somewhere between 54.48 and 81.75 percent, which OIG determined is statistically significantly below the 90 percent benchmark.

High Risk Processes: Central Line-Associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[75] Central lines "refer to a broad category of intravascular (within blood vessels) devices used to administer fluids, medications, blood and blood products, and parenteral nutrition. Unlike the short, temporary catheters inserted into the peripheral vasculature,"[76] central lines are threaded through a vein in the arm, chest, neck, or groin and advanced so that the furthest tip terminates at or close to the heart or in one of the great vessels.[77]

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a CLABSI as a primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site.[78]

An infection is considered to be health care-associated if it occurs on or after the 3rd calendar day of admission to an inpatient location where the day of admission is calendar day 1.[79] The patient's age, underlying conditions, and gender are basic risk factors, but external risk factors such as prolonged hospitalization, multi-lumen central lines, and central line duration far outnumber the basic ones. Central lines are associated with an increased risk for mortality and increased health care costs.[80]

The purpose of this review was to determine whether the facility established and maintained programs to reduce the incidence of health care-associated bloodstream infections in intensive care unit patients with indwelling central venous catheters. OIG reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents, and OIG interviewed key employees and managers. Additionally, OIG reviewed the training records of 21 clinical employees involved in inserting and/or managing central lines. OIG reviewed the following performance indicators.

[75] TJC. Infection Control and National Patient Safety Goals. IC.01.03.01, EP 4, 5. July 2017.
[76] Association for Professionals in Infection Control and Epidemiology. *Guide to Preventing Central Line-Associated Bloodstream Infections*. 2015.
[77] These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.
[78] The Centers for Disease Control and Prevention. *Guidelines for the Prevention of Intravascular Catheter-Related Infections*. 2011.
[79] The Centers for Disease Control and Prevention National Healthcare Safety Network. *Bloodstream Infection Event: Central Line-Associated Bloodstream Infection and non-central line-associated Bloodstream Infection*. January 2017.
[80] Association for Professionals in Infection Control and Epidemiology, 2015.

- Presence of facility policy on the use and care of central lines
- Performance of annual infection prevention risk assessment
- Evidence of routine discussion of CLABSI data and prevention outcome measures in committee minutes
- Provision of infection incidence data on CLABSI
- Education on reducing the risk of CLABSI for staff involved in inserting and/or managing central lines
- Educational materials about CLABSI prevention for patients/families
- Use of checklist for central line insertion and maintenance

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

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	Ten OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Interim Facility Director, Chief of Staff, and Associate Director. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[81] for Improvement**	**Recommendations for Improvement**
Credentialing and Privileging	• Medical licenses • Privileges • Focused Professional Practice Evaluations • OPPEs	• The Executive Committee of the Medical Staff uses the results of OPPEs in the determination of whether to recommend continuation of LIPs privileges.	None
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and root cause analyses	None	• Physician UM Advisors consistently document their decisions in the National UM Integration database. • The interdisciplinary group or committee that reviews UM data includes representatives from case management and Chief Business Office revenue utilization review. • The Patient Safety Manager or designee provides feedback about root cause analysis actions to the reporting individuals or departments.

[81] OIG defines "critical recommendations" as those that rise above others and address vulnerabilities and risks that could cause exceptionally grave health care outcomes and/or significant impact to quality of care.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	• Parent facility o EOC rounds and deficiency tracking o Infection prevention o General Safety o Environmental cleanliness o General and exam room privacy o Availability of medical equipment and supplies • CBOC o General safety o Medication safety and security o Infection prevention o Environmental cleanliness o General and exam room privacy o Availability of medical equipment and supplies • Construction Safety o Infection control risk assessment o Infection Prevention/ Infection Control Committee discussions o Dust control o Safety/security o Type C – Class III specific requirements • Nutrition and Food Services o Annual Hazard Analysis Critical control Point Food Safety System plan o Food Services inspections o Safe transportation of prepared food o Environmental safety o Infection prevention o Storage areas	None	• Parent facility: o EOC rounds are conducted in all areas of the facility at the required frequency. o Required team members consistently participate on EOC rounds. o Medical biohazardous waste storage rooms are secured.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	• CSC reports • Pharmacy operations • Annual physical security survey • CS ordering • Processes with permanent change in Chief of Pharmacy • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections	None	• CSIs perform CS order verification as required. • CSIs complete monthly pharmacy prescription pad inventories.
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	• Provision of or access to geriatric evaluation • Program oversight and evaluation requirements • Geriatric evaluation requirements • Geriatric management requirements	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	• Providers communicate mammogram results to patients.
High-Risk Processes: Central Line-Associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data • Education and educational materials • Checklist	None	None

Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this mid-high complexity (1c)[82] affiliated[83] facility reporting to VISN 2.

Table 6. Facility Profile for Albany (528A8) for October 1, 2014 through September 30, 2017

Profile Element	Facility Data FY 2015[84]	Facility Data FY 2016[85]	Facility Data FY 2017[86]
Total Medical Care Budget in Millions	$249.4	$249.8	$249.5
Number of:			
• **Unique Patients**	36,338	35,979	35,816
• **Outpatient Visits**	398,765	391,691	375,313
• **Unique Employees**[87]	1,123	1,111	1,172
Type and Number of Operating Beds:			
• **Acute**	38	38	44
• **Mental Health**	15	12	12
• **Community Living Center**	50	50	50
• **Domiciliary**	12	12	12
Average Daily Census:			
• **Acute**	32	36	37
• **Mental Health**	9	10	8
• **Community Living Center**	46	43	42
• **Domiciliary**	10	9	9

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse.

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

[82] VHA medical centers are classified according to a facility complexity model; 1c designation indicates a facility with medium-high volume, medium-risk patients, some complex clinical programs, and medium-sized research and teaching programs. Retrieved October 24, 2017, from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx.
[83] Associated with a medical residency program.
[84] October 1, 2014 through September 30, 2015.
[85] October 1, 2015 through September 30, 2016.
[86] October 1, 2016 through September 30, 2017.
[87] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[88]

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[89] and Specialty Care, Diagnostic, and Ancillary Services Provided for October 1, 2016 through September 30, 2017

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[90] Provided	Diagnostic Services[91] Provided	Ancillary Services[92] Provided
Westport, NY	528G2	2,557	529	Dermatology Endocrinology Gastroenterology Nephrology Neurology Rheumatology Poly-Trauma Plastic	n/a	Pharmacy Nutrition
Bainbridge, NY	528G3	2,847	1,028	Dermatology Endocrinology Gastroenterology Nephrology Neurology Poly-Trauma Rehab Physician	n/a	Pharmacy Social Work
Fonda, NY	528G6	2,834	722	Dermatology Nephrology Neurology	n/a	Social Work Weight Management Nutrition
Catskill, NY	528G7	3,786	564	Dermatology Gastroenterology Nephrology Neurology	n/a	Social Work
Glens Falls, NY	528GT	6,711	1,280	Dermatology Endocrinology Gastroenterology Nephrology Neurology Rheumatology Poly-Trauma Plastic	n/a	Pharmacy Social Work

[88] Includes all outpatient clinics in the community that were in operation as of August 15, 2017.
[89] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[90] Specialty care services refer to non-PC and non-MH services provided by a physician.
[91] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[92] 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 Provided	Diagnostic Services Provided	Ancillary Services Provided
Plattsburgh, NY	528GV	4,988	1,894	Dermatology Endocrinology Gastroenterology Nephrology Neurology Rheumatology Poly-Trauma Rehab Physician Anesthesia Plastic	n/a	Pharmacy Nutrition
Schenectady, NY	528GW	3,917	82	Dermatology Endocrinology Neurology	n/a	Pharmacy
Troy, NY	528GX	3,246	82	Dermatology Endocrinology	n/a	Pharmacy
Clifton Park, NY	528GY	3,552	186	Dermatology Endocrinology Gastroenterology Nephrology Neurology	n/a	Pharmacy
Kingston, NY	528GZ	3,558	1,246	Dermatology Endocrinology Gastroenterology Nephrology Neurology Rheumatology	n/a	Pharmacy Nutrition
Saranac Lake, NY	528QK	389	52	Dermatology Endocrinology Nephrology Neurology	n/a	Pharmacy Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

n/a = not applicable

VHA Policies Beyond Recertification Dates

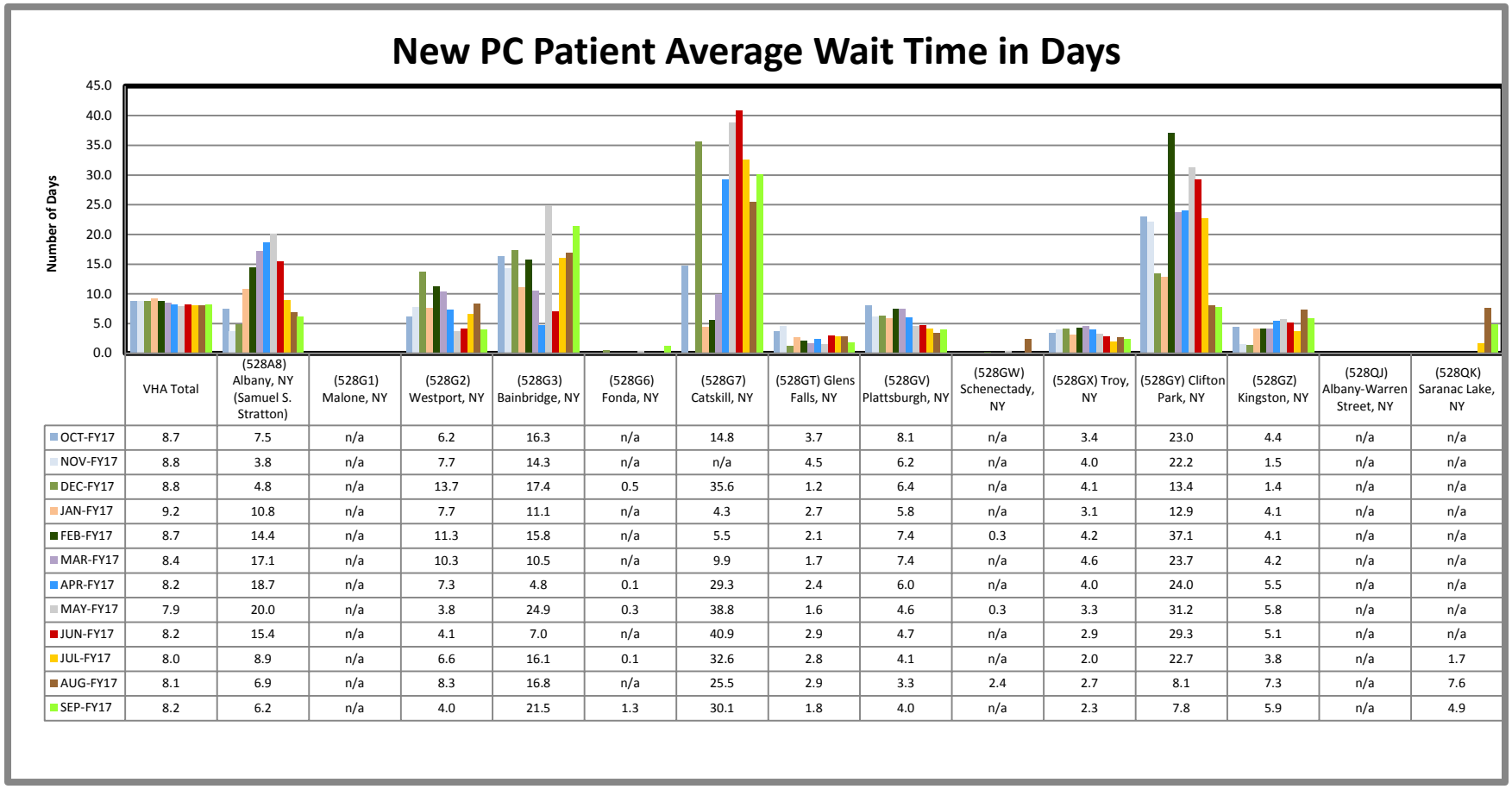
In this report, OIG cited seven policies that were beyond the recertification date:

1. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due date March 31, 2016).
2. VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012 (recertification due date October 31, 2017).
3. VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011 (recertification due date April 30, 2016).
4. VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010 (recertification due date November 30, 2015).
5. VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD),* March 12, 2010 (recertification due date March 31, 2015), revised December 8, 2015.[93]
6. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
7. VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012 (recertification due date September 30, 2017).

OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[94] the VA Under Secretary for Health mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[95] The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[96]

[93] This handbook was in effect during the review period for this report; it was rescinded and replaced by VHA Directive 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, November 16, 2017.
[94] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[95] VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.
[96] Ibid.

Patient Aligned Care Team Compass Metrics[97]



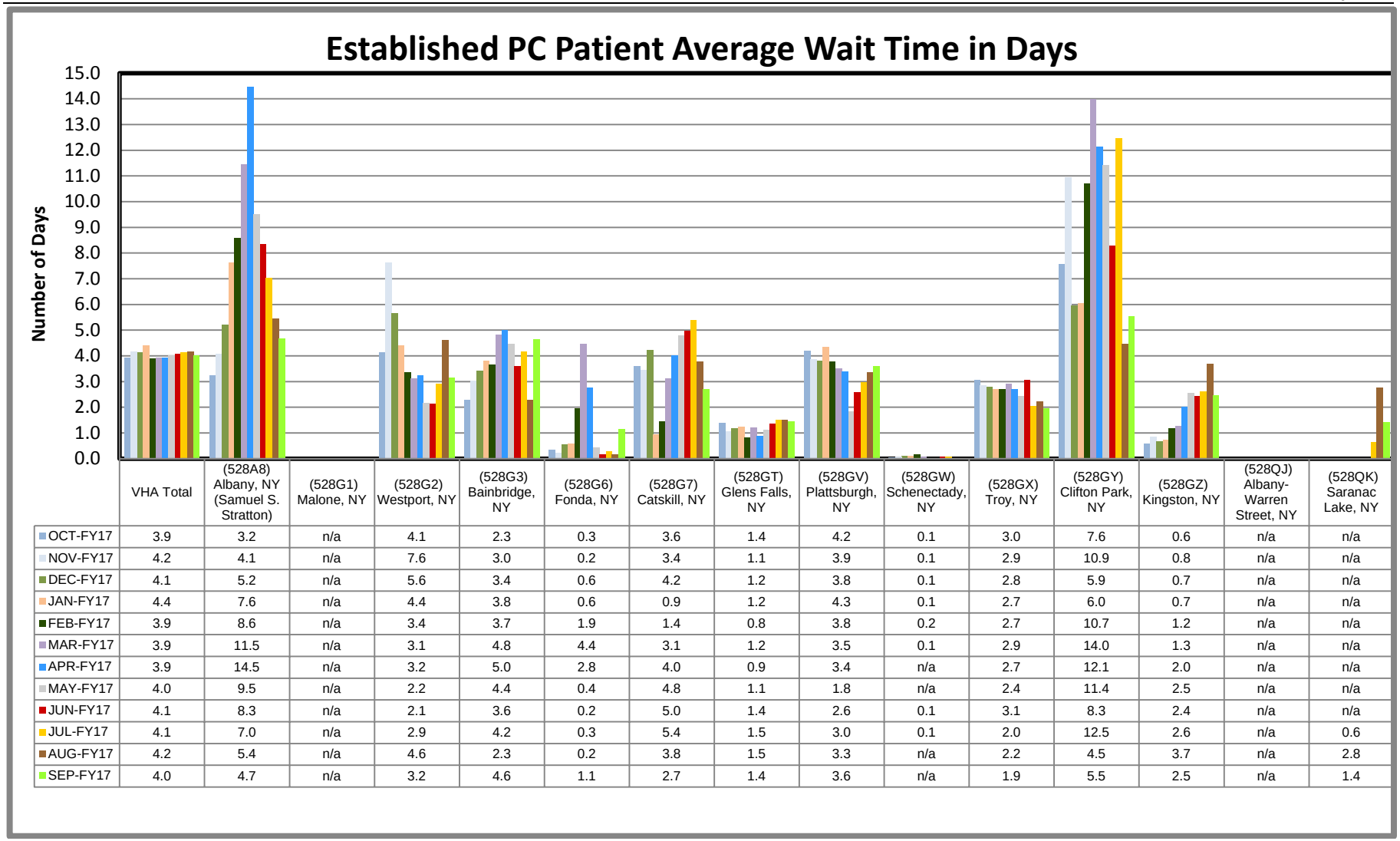
	VHA Total	(528A8) Albany, NY (Samuel S. Stratton)	(528G1) Malone, NY	(528G2) Westport, NY	(528G3) Bainbridge, NY	(528G6) Fonda, NY	(528G7) Catskill, NY	(528GT) Glens Falls, NY	(528GV) Plattsburgh, NY	(528GW) Schenectady, NY	(528GX) Troy, NY	(528GY) Clifton Park, NY	(528GZ) Kingston, NY	(528QJ) Albany-Warren Street, NY	(528QK) Saranac Lake, NY
OCT-FY17	8.7	7.5	n/a	6.2	16.3	n/a	14.8	3.7	8.1	n/a	3.4	23.0	4.4	n/a	n/a
NOV-FY17	8.8	3.8	n/a	7.7	14.3	n/a	n/a	4.5	6.2	n/a	4.0	22.2	1.5	n/a	n/a
DEC-FY17	8.8	4.8	n/a	13.7	17.4	0.5	35.6	1.2	6.4	n/a	4.1	13.4	1.4	n/a	n/a
JAN-FY17	9.2	10.8	n/a	7.7	11.1	n/a	4.3	2.7	5.8	n/a	3.1	12.9	4.1	n/a	n/a
FEB-FY17	8.7	14.4	n/a	11.3	15.8	n/a	5.5	2.1	7.4	0.3	4.2	37.1	4.1	n/a	n/a
MAR-FY17	8.4	17.1	n/a	10.3	10.5	n/a	9.9	1.7	7.4	n/a	4.6	23.7	4.2	n/a	n/a
APR-FY17	8.2	18.7	n/a	7.3	4.8	0.1	29.3	2.4	6.0	n/a	4.0	24.0	5.5	n/a	n/a
MAY-FY17	7.9	20.0	n/a	3.8	24.9	0.3	38.8	1.6	4.6	0.3	3.3	31.2	5.8	n/a	n/a
JUN-FY17	8.2	15.4	n/a	4.1	7.0	n/a	40.9	2.9	4.7	n/a	2.9	29.3	5.1	n/a	n/a
JUL-FY17	8.0	8.9	n/a	6.6	16.1	0.1	32.6	2.8	4.1	n/a	2.0	22.7	3.8	n/a	1.7
AUG-FY17	8.1	6.9	n/a	8.3	16.8	n/a	25.5	2.9	3.3	2.4	2.7	8.1	7.3	n/a	7.6
SEP-FY17	8.2	6.2	n/a	4.0	21.5	1.3	30.1	1.8	4.0	n/a	2.3	7.8	5.9	n/a	4.9

Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness. OIG has on file the facility's explanation for the December 2016 and May–July 2017 data points for Catskill and February and May 2017 data points for Clifton Park.

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.* The absence of reported data is indicated by "n/a."

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

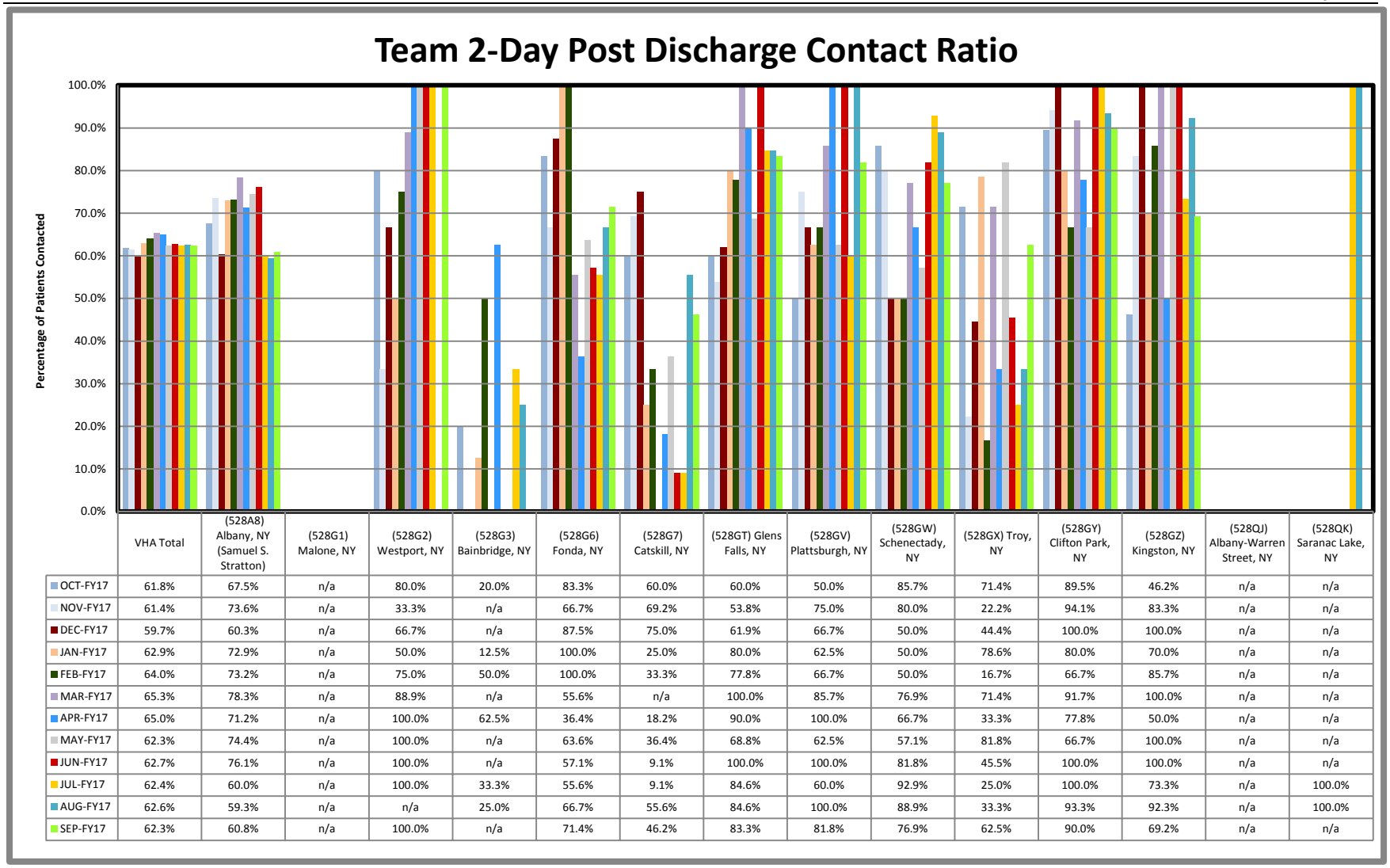


	VHA Total	(528A8) Albany, NY (Samuel S. Stratton)	(528G1) Malone, NY	(528G2) Westport, NY	(528G3) Bainbridge, NY	(528G6) Fonda, NY	(528G7) Catskill, NY	(528GT) Glens Falls, NY	(528GV) Plattsburgh, NY	(528GW) Schenectady, NY	(528GX) Troy, NY	(528GY) Clifton Park, NY	(528GZ) Kingston, NY	(528QJ) Albany-Warren Street, NY	(528QK) Saranac Lake, NY
OCT-FY17	3.9	3.2	n/a	4.1	2.3	0.3	3.6	1.4	4.2	0.1	3.0	7.6	0.6	n/a	n/a
NOV-FY17	4.2	4.1	n/a	7.6	3.0	0.2	3.4	1.1	3.9	0.1	2.9	10.9	0.8	n/a	n/a
DEC-FY17	4.1	5.2	n/a	5.6	3.4	0.6	4.2	1.2	3.8	0.1	2.8	5.9	0.7	n/a	n/a
JAN-FY17	4.4	7.6	n/a	4.4	3.8	0.6	0.9	1.2	4.3	0.1	2.7	6.0	0.7	n/a	n/a
FEB-FY17	3.9	8.6	n/a	3.4	3.7	1.9	1.4	0.8	3.8	0.2	2.7	10.7	1.2	n/a	n/a
MAR-FY17	3.9	11.5	n/a	3.1	4.8	4.4	3.1	1.2	3.5	0.1	2.9	14.0	1.3	n/a	n/a
APR-FY17	3.9	14.5	n/a	3.2	5.0	2.8	4.0	0.9	3.4	n/a	2.7	12.1	2.0	n/a	n/a
MAY-FY17	4.0	9.5	n/a	2.2	4.4	0.4	4.8	1.1	1.8	n/a	2.4	11.4	2.5	n/a	n/a
JUN-FY17	4.1	8.3	n/a	2.1	3.6	0.2	5.0	1.4	2.6	0.1	3.1	8.3	2.4	n/a	n/a
JUL-FY17	4.1	7.0	n/a	2.9	4.2	0.3	5.4	1.5	3.0	0.1	2.0	12.5	2.6	n/a	0.6
AUG-FY17	4.2	5.4	n/a	4.6	2.3	0.2	3.8	1.5	3.3	n/a	2.2	4.5	3.7	n/a	2.8
SEP-FY17	4.0	4.7	n/a	3.2	4.6	1.1	2.7	1.4	3.6	n/a	1.9	5.5	2.5	n/a	1.4

Source: VHA Support Service Center.

Note: 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. The absence of reported data is indicated by "n/a."

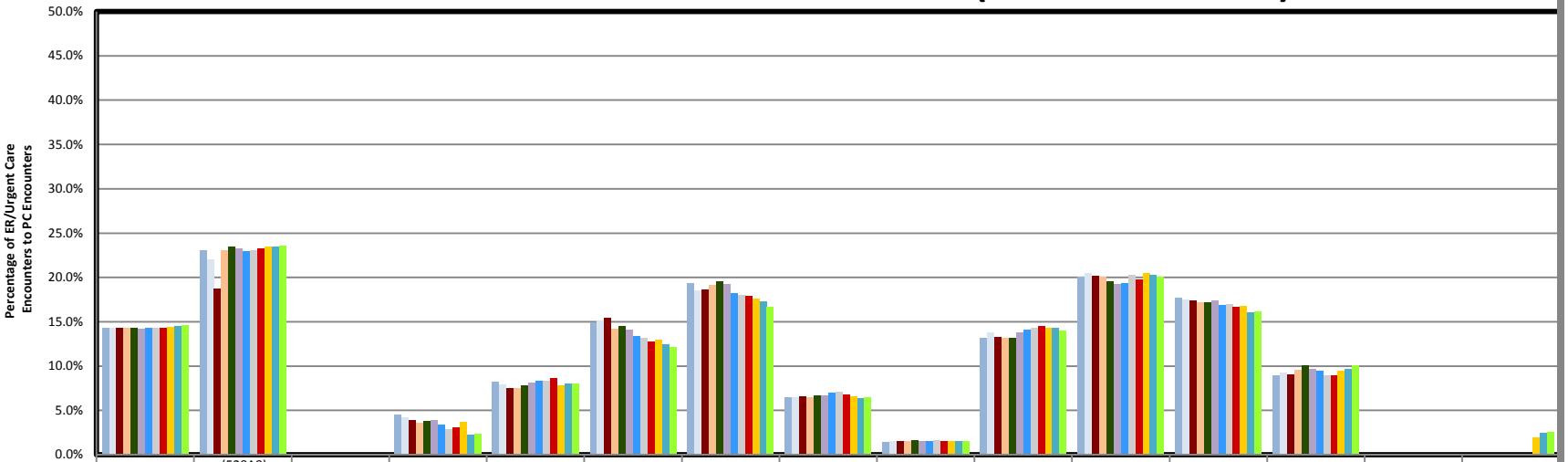


	VHA Total	(528A8) Albany, NY (Samuel S. Stratton)	(528G1) Malone, NY	(528G2) Westport, NY	(528G3) Bainbridge, NY	(528G6) Fonda, NY	(528G7) Catskill, NY	(528GT) Glens Falls, NY	(528GV) Plattsburgh, NY	(528GW) Schenectady, NY	(528GX) Troy, NY	(528GY) Clifton Park, NY	(528GZ) Kingston, NY	(528QJ) Albany-Warren Street, NY	(528QK) Saranac Lake, NY
OCT-FY17	61.8%	67.5%	n/a	80.0%	20.0%	83.3%	60.0%	60.0%	50.0%	85.7%	71.4%	89.5%	46.2%	n/a	n/a
NOV-FY17	61.4%	73.6%	n/a	33.3%	n/a	66.7%	69.2%	53.8%	75.0%	80.0%	22.2%	94.1%	83.3%	n/a	n/a
DEC-FY17	59.7%	60.3%	n/a	66.7%	n/a	87.5%	75.0%	61.9%	66.7%	50.0%	44.4%	100.0%	100.0%	n/a	n/a
JAN-FY17	62.9%	72.9%	n/a	50.0%	12.5%	100.0%	25.0%	80.0%	62.5%	50.0%	78.6%	80.0%	70.0%	n/a	n/a
FEB-FY17	64.0%	73.2%	n/a	75.0%	50.0%	100.0%	33.3%	77.8%	66.7%	50.0%	16.7%	66.7%	85.7%	n/a	n/a
MAR-FY17	65.3%	78.3%	n/a	88.9%	n/a	55.6%	n/a	100.0%	85.7%	76.9%	71.4%	91.7%	100.0%	n/a	n/a
APR-FY17	65.0%	71.2%	n/a	100.0%	62.5%	36.4%	18.2%	90.0%	100.0%	66.7%	33.3%	77.8%	50.0%	n/a	n/a
MAY-FY17	62.3%	74.4%	n/a	100.0%	n/a	63.6%	36.4%	68.8%	62.5%	57.1%	81.8%	66.7%	100.0%	n/a	n/a
JUN-FY17	62.7%	76.1%	n/a	100.0%	n/a	57.1%	9.1%	100.0%	100.0%	81.8%	45.5%	100.0%	100.0%	n/a	n/a
JUL-FY17	62.4%	60.0%	n/a	100.0%	33.3%	55.6%	9.1%	84.6%	60.0%	92.9%	25.0%	100.0%	73.3%	n/a	100.0%
AUG-FY17	62.6%	59.3%	n/a	n/a	25.0%	66.7%	55.6%	84.6%	100.0%	88.9%	33.3%	93.3%	92.3%	n/a	100.0%
SEP-FY17	62.3%	60.8%	n/a	100.0%	n/a	71.4%	46.2%	83.3%	81.8%	76.9%	62.5%	90.0%	69.2%	n/a	n/a

Source: VHA Support Service Center.

Note: 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." The absence of reported data is indicated by "n/a."



	VHA Total	(528A8) Albany, NY (Samuel S. Stratton)	(528G1) Malone, NY	(528G2) Westport, NY	(528G3) Bainbridge, NY	(528G6) Fonda, NY	(528G7) Catskill, NY	(528GT) Glens Falls, NY	(528GV) Plattsburgh, NY	(528GW) Schenectady, NY	(528GX) Troy, NY	(528GY) Clifton Park, NY	(528GZ) Kingston, NY	(528QJ) Albany-Warren Street, NY	(528QK) Saranac Lake, NY
OCT-FY17	14.3%	23.1%	n/a	4.5%	8.2%	14.9%	19.3%	6.4%	1.4%	13.1%	20.0%	17.7%	9.0%	n/a	n/a
NOV-FY17	14.3%	22.0%	n/a	4.2%	7.9%	15.1%	18.5%	6.5%	1.5%	13.8%	20.4%	17.5%	9.2%	n/a	n/a
DEC-FY17	14.2%	18.7%	n/a	3.9%	7.5%	15.4%	18.6%	6.5%	1.6%	13.2%	20.1%	17.3%	9.0%	n/a	n/a
JAN-FY17	14.3%	23.0%	n/a	3.6%	7.5%	14.2%	19.1%	6.5%	1.6%	13.2%	20.0%	17.2%	9.5%	n/a	n/a
FEB-FY17	14.3%	23.4%	n/a	3.7%	7.8%	14.5%	19.5%	6.6%	1.6%	13.2%	19.5%	17.1%	10.0%	n/a	n/a
MAR-FY17	14.2%	23.2%	n/a	3.9%	8.1%	14.0%	19.3%	6.6%	1.5%	13.7%	19.3%	17.3%	9.7%	n/a	n/a
APR-FY17	14.3%	22.9%	n/a	3.3%	8.3%	13.4%	18.2%	7.0%	1.5%	14.1%	19.3%	16.8%	9.4%	n/a	n/a
MAY-FY17	14.3%	23.0%	n/a	2.9%	8.3%	13.2%	18.0%	7.0%	1.6%	14.3%	20.2%	16.9%	8.9%	n/a	n/a
JUN-FY17	14.3%	23.2%	n/a	3.0%	8.6%	12.7%	17.9%	6.7%	1.5%	14.5%	19.7%	16.7%	8.9%	n/a	n/a
JUL-FY17	14.4%	23.4%	n/a	3.7%	7.8%	12.9%	17.6%	6.5%	1.6%	14.3%	20.4%	16.7%	9.4%	n/a	1.9%
AUG-FY17	14.4%	23.5%	n/a	2.2%	8.0%	12.4%	17.2%	6.3%	1.5%	14.3%	20.2%	16.1%	9.6%	n/a	2.4%
SEP-FY17	14.6%	23.6%	n/a	2.3%	8.0%	12.1%	16.7%	6.4%	1.6%	14.0%	20.1%	16.1%	10.0%	n/a	2.6%

Source: VHA Support Service Center.

Note: 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. The absence of reported data is indicated by "n/a."

Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[98]

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
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS Like – HED90_1	HEDIS-EPRP Based PRV TOB BHS	A higher value is better than a lower value
HEDIS Like – HED90_ec	HEDIS-eOM Based DM IHD	A higher value is better than a lower value
MH Wait Time	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

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

Measure	Definition	Desired Direction
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
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
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

Measure	Definition	Desired Direction
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.

Relevant OIG Reports

October 6, 2014 through March 1, 2018[99]

Audit of VHA's Patient Advocacy Program
3/31/2017 | *15-05379-146* | *Summary* | *Report*

Audit of VHA's Home Telehealth Program
3/9/2015 | *13-00716-101* | *Summary* | *Report*

Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York
1/14/2015 | *14-04210-63* | *Summary* | *Report*

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Samuel S. Stratton VA Medical Center, Albany, New York
1/6/2015 | *14-04368-56* | *Summary* | *Report*

[99] These are relevant reports that discuss review results for the Facility or were national-level evaluations of which the Facility was one of the sites sampled for review.

VISN Director Comments

Department of Veterans Affairs

Memorandum

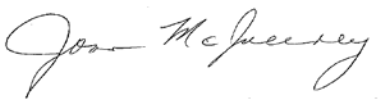
Date: March 5, 2018

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

Subject: **CHIP Review of the Samuel S. Stratton VA Medical Center, Albany, NY**

To: Director, Bay Pines Office of Healthcare Inspections (54SP)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I concur with the OIG's recommendations contained within the attached CHIP Review of the Samuel S. Stratton VA Medical Center, Albany NY.



Dr. Joan McInerney, MD MBA, MA FACEP

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: February 28, 2018

From: Interim Director, Samuel S. Stratton VA Medical Center (528A8/00)

Subject: **CHIP Review of the Samuel S. Stratton VA Medical Center, Albany, NY**

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

I concur with the recommendations listed in the Office of Inspector General's report, Comprehensive Healthcare Inspection Program of the Samuel S. Stratton VA Medical Center Albany, New York.

Darlene Delancey, MS

Interim Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact OIG at (202) 461-4720.
Inspection Team	Valerie Zaleski, RN, BSN, Team Leader Charles Cook, MHA Carol Torczon, ACNP, MSN Elizabeth Whidden, ARNP, MS Michelle Wilt, MBA, BSN Jenny Walenta, Special Agent, Office of Investigations
Other Contributors	Elizabeth Bullock Limin Clegg, PhD Justin Hanlon, BS Chip Harvey, MS LaFonda Henry, RN-BC, MSN Scott McGrath, BS Larry Ross, Jr., MS Marilyn Stones, BS April Terenzi, BA, BS Mary Toy, RN, MSN Robert Wallace, MPH, ScD

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