



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection Program Review
of the VA Boston Healthcare
System

Massachusetts



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Figure 1. VA Boston Healthcare System, Massachusetts
(Source: <https://vaww.va.gov/directory/guide/>, website accessed on July 9, 2018)

Abbreviations

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



Report Overview

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

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

The OIG's current areas of focus are

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

This review was conducted during an unannounced visit made during the week of April 9, 2018. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of Facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

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

Facility leaders have worked together in their current and other positions for many years and appeared very stable. The Director and Deputy Director were permanently assigned in 2013 and 2007, respectively. The Chief of Staff came to the Facility as a staff neurologist in 1989 and has been the Chief of Staff since 2003. The ADPCS has been in the current position since 1996.

In the review of selected employee satisfaction survey results, the OIG noted that Facility leaders also appeared to be maintaining a workplace environment where employees are satisfied with leadership and feel safe to bring forth issues or ethical concerns. In the review of selected patient experience survey results regarding Facility leaders, the OIG noted that patients appear generally satisfied with the leadership and care provided.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is “a way to understand the similarities and differences between the top and bottom performers” within VHA.¹ The leadership team was knowledgeable about selected SAIL metrics and willing to assist other facilities to improve SAIL ratings, but the leaders should continue to take actions to sustain performance and to improve care and performance of poorly performing Quality of Care and Efficiency metrics that are likely contributing to the drop from its previous “5-Star” to the current “4-Star” rating.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,² disclosures of adverse patient events, and Patient Safety Indicator data; and the OIG 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.

¹ VHA’s Office of Operational Analytics and Reporting developed a model for understanding a facility’s performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a “star” rating system to designate a facility’s performance in individual measures, domains, and overall quality.
<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146>. (Website accessed on April 16, 2017.)

² A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

The OIG noted findings in four of the eight areas of clinical operations reviewed and issued seven recommendations that are attributable to the Director, Chief of Staff, and Deputy Director. These are briefly described below.

Quality, Safety, and Value

The OIG found general compliance with requirements for utilization management and patient safety. However, the OIG identified a deficiency in the protected peer review process.

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing and privileging. However, the OIG identified deficiencies in initiating Focused Professional Practice Evaluations for newly hired licensed independent practitioners and using service-specific and specialty-specific criteria for Ongoing Professional Practice Evaluations.

Environment of Care

The OIG found general safety and privacy measures in place at the three campuses and the CBOC and did not note any issues with the availability of medical equipment and supplies. However, the OIG found six inpatient units with dirty ventilation grills, five inpatient units with stained ceiling tiles, and deficiencies with infection prevention and supply storage.

Medication Management

The OIG found general compliance with the requirements for controlled substances (CS) reports, CS Coordinator and CS Inspector requirements, and CS inspections. However, the OIG identified a deficiency with physical security that warranted a recommendation for improvement.

Summary

In the review of key care processes, the OIG issued seven recommendations that are attributable to the Director, Chief of Staff, and Deputy 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 leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the Comprehensive Healthcare Inspection Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 60–61, for the full text

of the Directors' comments.) The OIG considers Recommendations 5, 6, and 7 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Purpose and Scope

Purpose

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

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.^{3,4} Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.⁵ Figure 2 shows the direct relationship leadership and organizational risks have with the processes used to deliver health care to veterans.

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management; Controlled Substances (CS) Inspection Program; Mental Health: Posttraumatic Stress Disorder (PTSD) Care; Long-term Care: Geriatric Evaluations (GE); Women’s Health: Mammography Results and Follow-up; and High-Risk Processes: Central Line-Associated Bloodstream Infections (CLABSI) (see Figure 2).⁶

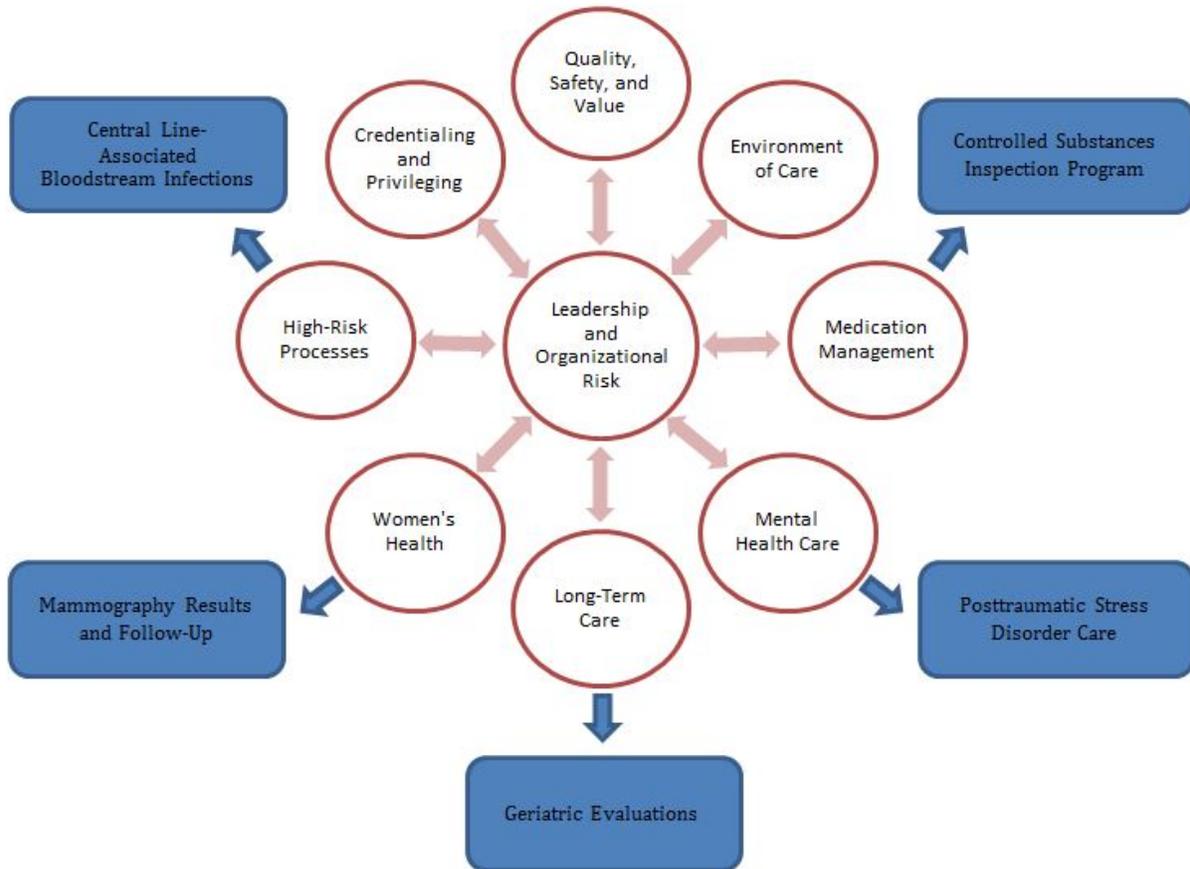
³ Carol Stephenson, “The role of leadership in managing risk,” *Ivey Business Journal*, November/December 2010. <https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/>. (Website accessed on March 1, 2018.)

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

⁵ Institute for Healthcare Improvement, “How risk management and patient safety intersect: Strategies to help make it happen,” March 24, 2015. <http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen>. (Website accessed on March 1, 2018.)

⁶ CHIP reviews address these processes during fiscal year (FY) 2018 (October 1, 2017, through September 30, 2018).

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



Source: VA OIG

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the EOC, the OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;⁷ and discussed processes and validated findings with managers and employees. The OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for March 10, 2015,⁸ through April 2, 2018, the date when an unannounced week-long site visit commenced.

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

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

⁷ The OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect Facility accreditation status.

⁸ This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the Facility's ability to provide care in all the selected clinical areas of focus.⁹ To assess the Facility's risks, the OIG considered the following organizational elements:

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

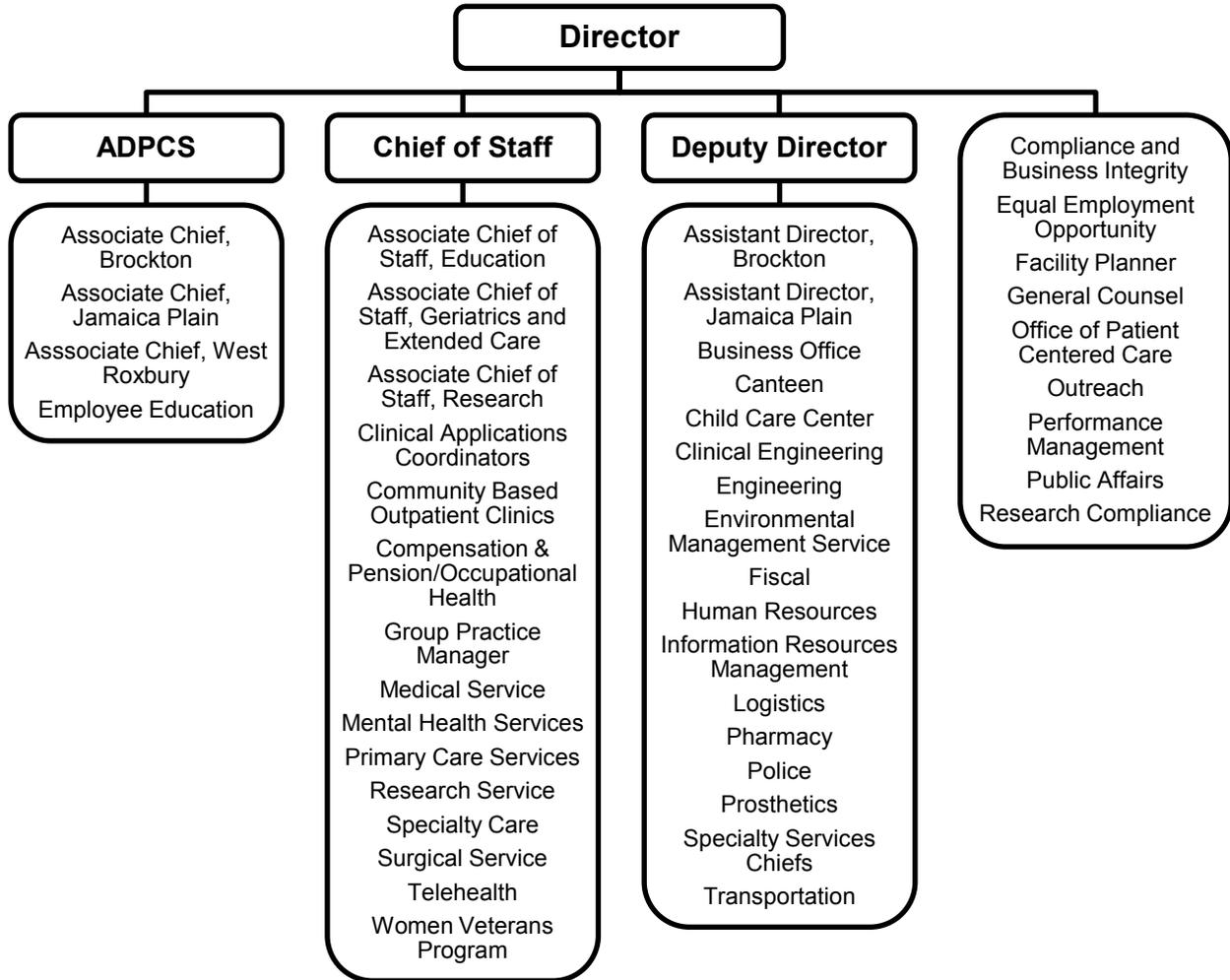
Executive Leadership Stability and Engagement

Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ among facilities. Figure 3 illustrates the Facility's reported organizational structure. The Facility has a leadership team consisting of the Director, Deputy Director, Chief of Staff, and Associate Director for Patient Care Services (ADPCS). The Chief of Staff and ADPCS are responsible for overseeing patient care and service directors as well as program and practice chiefs.

Facility leaders have worked together in their current and other positions for many years and appeared very stable. The Director and Deputy Director were permanently assigned in 2013 and 2007, respectively. The Chief of Staff came to the Facility as a staff neurologist in 1989 and has been the Chief of Staff since 2003. The ADPCS has been in the current position since 1996.

⁹ L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006.
<http://www.ihl.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx>. (Website accessed on February 2, 2017.)

Figure 3. Facility Organizational Chart



Source: VA Boston Healthcare System (received April 9, 2018)

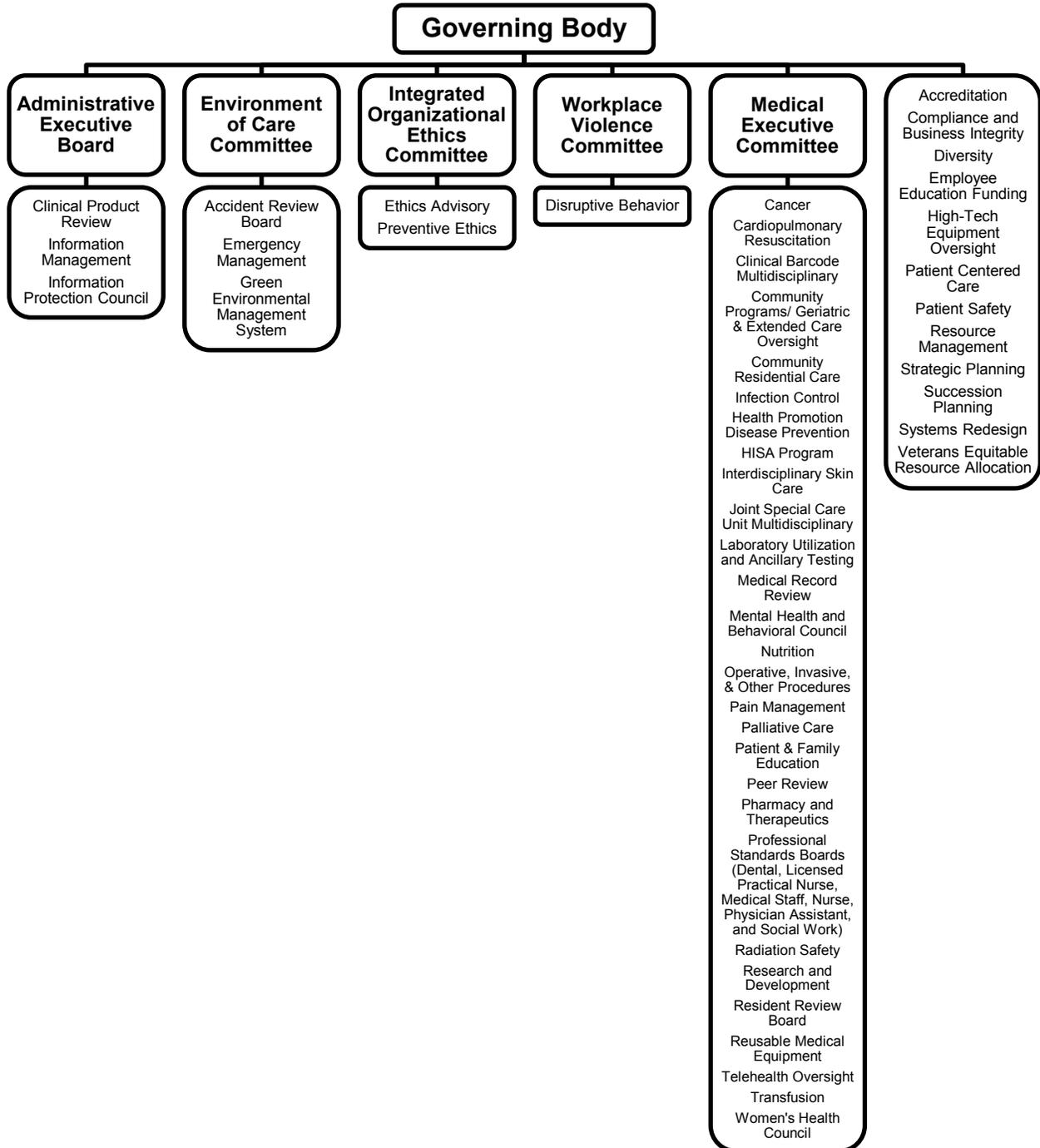
To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Chief of Staff, ADPCS, and Deputy Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members were generally able to speak knowledgeably about actions taken during the previous 12 months 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 were also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Governing Board, which tracks, trends, and monitors quality of care and patient outcomes. The Director serves as the chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational

management and strategic planning. The Governing Board also oversees various committees such the Administrative Executive Board, Environment of Care Committee, and Medical Executive Committee. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: VA Boston Healthcare System (received April 9, 2018)

HISA = Home Improvement and Structural Alterations

Employee Satisfaction and Patient Experience

The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. Since 2001, the instrument has been refined at several points in response to VA leadership inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on Facility leadership.

To assess employee attitudes toward Facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2016, through September 30, 2017. Tables 1–2 provide relevant employee survey results for VHA, the Facility, and selected Facility executive leaders.¹⁰

Table 1 summarizes employee attitudes toward selected Facility leaders as expressed in VHA’s All Employee Survey.¹¹ The Facility averages for both selected survey questions were above the VHA average.¹² Further, the averages for all members of the executive leadership team were higher than the VHA average. Employees appear satisfied with Facility leaders.

¹⁰ Rating is based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, and Deputy 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.

¹² The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Deputy Director Average
All Employee Survey: <i>Servant Leader Index Composite</i>	0–100 where HIGHER scores are more favorable	67.7	72.6	80.3	74.6	73.9	68.6
All Employee Survey Q59. <i>How satisfied are you with the job being done by the executive leadership where you work?</i>	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	3.7	4.1	3.8	3.7	3.6

Source: VA All Employee Survey (accessed March 2, 2018)

Table 2 summarizes employee attitudes toward the workplace as expressed in VHA’s All Employee Survey. The Facility averages for the selected survey questions were higher than the VHA average. Further, the averages for all members of the executive leadership team were generally higher than the VHA average. The Facility leaders appear to be maintaining a workplace environment where employees are satisfied with leadership and feel safe to bring forth issues or ethical concerns.

**Table 2. Survey Results on Employee Attitudes toward Workplace
(October 1, 2016, through September 30, 2017)**

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Deputy Director Average
All Employee Survey Q43. My supervisor encourages people to speak up when they disagree with a decision.	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.9	4.2	4.0	4.0	3.8
All Employee Survey Q44. I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.	1 (Strongly Disagree)– 5 (Strongly Agree)	3.9	4.1	4.3	4.2	4.1	4.0
All Employee Survey Q75. I can talk with my direct supervisor about ethical concerns without fear of having my comments held against me.	1 (Strongly Disagree)– 5 (Strongly Agree)	3.9	4.0	4.2	4.1	4.1	3.9

Source: VA All Employee Survey (accessed March 2, 2018)

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

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017, that reflect patient attitudes towards facility leaders (see Table 3). For this Facility, all four patient survey results reflected higher care ratings than the VHA average. Patients appear generally satisfied with the leadership and care provided.

**Table 3. Survey Results on Patient Attitudes toward Facility Leadership
(October 1, 2016, through September 30, 2017)**

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	66.7	75.7
Survey of Healthcare Experiences of Patients (inpatient): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	83.4	89.1
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	74.9	86.4
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	75.2	85.5

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 22, 2017)

Accreditation/For-Cause Surveys¹³ and Oversight Inspections

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 4 summarizes the relevant Facility inspections most

¹³ The Joint Commission (TJC) conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

recently performed by the OIG and The Joint Commission (TJC).¹⁴ Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 4.¹⁵

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities¹⁶ and College of American Pathologists,¹⁷ which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long-Term Care Institute conducted an inspection of the Facility's Community Living Center,¹⁸ and the Paralyzed Veterans of America conducted inspections of the Facility's spinal cord injury/disease unit and related services.¹⁹

¹⁴ 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 VA medical facilities for over 35 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

¹⁵ A closed status indicates that the Facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

¹⁶ 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.

¹⁷ 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.

¹⁸ Since 1999, the Long Term Care Institute has been to over 3,500 healthcare facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

¹⁹ The Paralyzed Veterans of America inspection took place August 2-4, 2016. This Veteran Service Organization review does not result in accreditation status.

Table 4. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG (<i>Combined Assessment Program Review of the VA Boston Healthcare System, Boston, Massachusetts, June 2, 2015</i>)	March 2015	16	0
OIG (<i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Boston Healthcare System, Boston, Massachusetts, May 14, 2015</i>)	March 2015	6	0
TJC			
<ul style="list-style-type: none"> • Regular <ul style="list-style-type: none"> ○ Hospital Accreditation ○ Behavioral Health Care Accreditation ○ Home Care Accreditation • Regular – Drug Dependence Center <ul style="list-style-type: none"> ○ Behavioral Health Care Accreditation 	December 2017	37	0
		9	0
		4	0
	July 2015	3	0

Sources: OIG and TJC (Inspection/survey results verified with a QM staff member on April 10, 2018)

Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 5 summarizes key indicators of risk since the OIG's previous March 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of April 2, 2018.²⁰

²⁰ It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the Facility. (Note that the VA Boston Healthcare System is a highest complexity (1a) affiliated Facility as described in Appendix B.)

**Table 5. Summary of Selected Organizational Risk Factors
(March 2015 to April 2, 2018)**

Factor	Number of Occurrences
Sentinel Events ²¹	9
Institutional Disclosures ²²	9
Large-Scale Disclosures ²³	0

Source: VA Boston Healthcare System's Patient Safety Manager (received April 13, 2018)

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.²⁴ The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 6 summarizes Patient Safety Indicator data from October 1, 2015, through September 30, 2017.

²¹ A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

²² Institutional disclosure of adverse events (sometimes referred to as “administrative disclosure”) is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or his or her personal representative that an adverse event has occurred during 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.

²³ 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.

²⁴ Agency for Healthcare Research and Quality. <https://www.qualityindicators.ahrq.gov/>. (Website accessed on March 8, 2017.)

**Table 6. Patient Safety Indicator Data
(October 1, 2015, through September 30, 2017)**

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 1	Facility
Pressure ulcers	0.60	0.45	0.25
Death among surgical inpatients with serious treatable conditions	100.97	145.08	152.17
Iatrogenic pneumothorax	0.19	0.27	0.33
Central venous catheter-related bloodstream infection	0.15	0.10	0.00
In-hospital fall with hip fracture	0.08	0.04	0.00
Perioperative hemorrhage or hematoma	1.94	1.55	0.27
Postoperative acute kidney injury requiring dialysis	0.88	0.39	0.44
Postoperative respiratory failure	5.55	16.59	1.41
Perioperative pulmonary embolism or deep vein thrombosis	3.29	2.62	1.30
Postoperative sepsis	4.00	1.85	2.27
Postoperative wound dehiscence	0.52	0.00	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.88	1.81

Source: VHA Support Service Center

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

Three Patient Safety Indicator measures (death among surgical inpatients with serious treatable conditions, iatrogenic pneumothorax, and unrecognized abdominopelvic accidental puncture/laceration) showed higher observed rates than VISN 1 and VHA. Two Patient Safety Indicator measures (postoperative acute kidney injury requiring dialysis and postoperative sepsis) show a higher observed rate than VISN 1.

Fourteen surgical death cases were peer reviewed by Surgical Service. The surgical staff were re-educated as necessary. The surgical deaths were also reviewed in aggregate, and it was determined that there was no trend in terms of complications, specific surgeons, or services involved.

Four patients experienced an iatrogenic pneumothorax. The care for one patient was not reviewed as the patient did not meet review criteria. For the other three cases, no opportunities for improvement were found based on individual case and aggregate reviews, as development of a pneumothorax is a common risk for the procedures performed.

Three cases were reviewed for abdominopelvic puncture. No opportunities for improvement were found; however, a provider was cautioned against the use of a stent in certain situations.

One patient experienced and was reviewed for postoperative kidney injury. No opportunities for improvement were identified.

Five patients experienced and were reviewed for postoperative sepsis. The Facility initiated a performance improvement project for timely administration of the first dose of antibiotics for sepsis.

Veterans Health Administration Performance Data

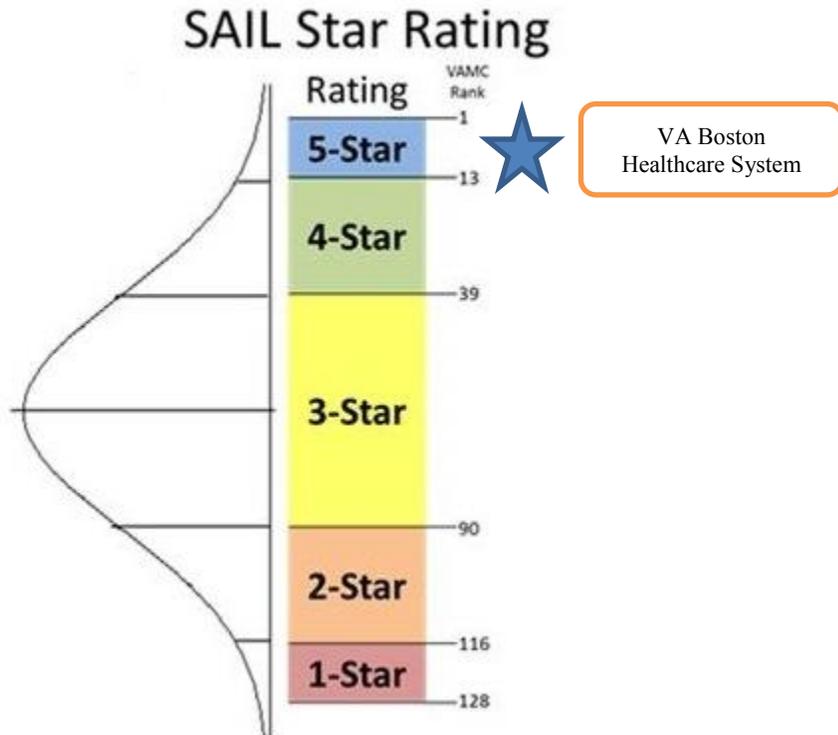
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency but has noted limitations for identifying all areas of clinical risk. The data are presented as one “way to understand the similarities and differences between the top and bottom performers” within VHA.²⁵

VA also uses a star-rating system where facilities with a “5-Star” rating are performing within the top 10 percent of facilities and “1-Star” facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.²⁶ As of June 30, 2017, the Facility was rated at “5-Star” for overall quality. Updated data as of June 30, 2018, indicates that the Facility rating has declined to “4-Star” for overall quality.

²⁵ VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146>. (Website accessed on April 16, 2017.)

²⁶ Based on normal distribution ranking quality domain of 128 VA Medical Centers.

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

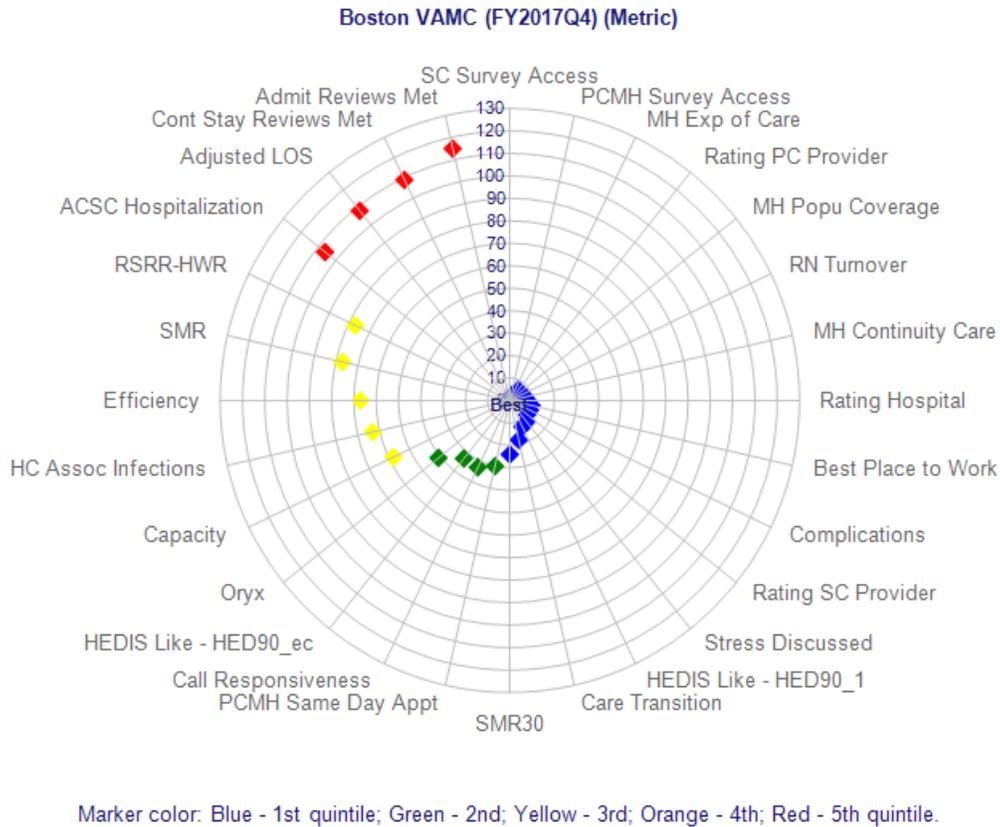


Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed March 2, 2018)

Figure 6 illustrates the Facility’s Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of September 30, 2017. Of note, Figure 6 uses blue and green data points in the top quintiles to indicate high performance (for example in the areas of Specialty Care (SC) Survey Access, Rating (of) Hospital, Best Place to Work, Complications, and Call Responsiveness).²⁷ Metrics in the bottom quintiles reflect areas that need improvement are denoted in red (for example, Continued (Cont) Stay and Admit Reviews Met).

²⁷ For data definitions of acronyms in the SAIL metrics, please see Appendix D.

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



Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). For data definitions, see Appendix D.

Conclusion

The OIG noted that Facility leaders have been in their respective positions for at least four years, and the ADPCS and Chief of Staff have long tenures with the Facility and their current positions. The OIG also noted that Facility leaders were actively engaged with employees and patients and were continuously striving to maintain employee and patient satisfaction scores. Facility leaders appeared to support efforts related to patient safety, quality care, and other positive outcomes (such as constant analysis of patient care data to identify opportunities for improvement and maintain positive results from actions taken). However, the presence of organizational risk factors, as evidenced by Patient Safety Indicator data, may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored. Although the leaders were knowledgeable about selected SAIL metrics

and willing to assist other facilities to improve SAIL ratings, the leaders should continue to take actions to sustain performance and to improve care and performance of poorly performing Quality of Care and Efficiency metrics that are likely contributing to the drop from its previous “5-Star” to the current “4-Star” rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.²⁸ VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.²⁹

VHA requires that its facilities operate a Quality, Safety, and Value (QSV) program to monitor the quality of patient care and performance improvement activities. The purpose of the OIG review was to determine whether the Facility implemented and incorporated selected key functions of VHA's Enterprise Framework for QSV into local activities. To assess this area of focus, the OIG evaluated the following: protected peer reviews of clinical care,³⁰ utilization management (UM) reviews,³¹ and patient safety incident reporting with related root cause analyses (RCA).³²

VHA has implemented approaches to improving patient safety, including the reporting of patient safety incidents to its National Center of Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required RCAs help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the organization.³³

²⁸ VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

²⁹ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

³⁰ According to VHA Directive 2010-025, *Peer Review for Quality Management*, 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.)

³¹ According to VHA Directive 1117, *Utilization Management Program*, July 9, 2014 (amended January 18, 2018), UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

³² According to VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011, VHA has implemented approaches to improve patient safety, including the reporting of patient safety incidents to the VHA National Center for Patient Safety, in order for VHA to learn about system vulnerabilities and how to address them as well as the requirement to implement RCA (a widely-used methodology for dealing with safety-related issues) to allow for more accurate and rapid communication throughout an organization of potential and actual causes of harm to patients.

³³ VHA Handbook 1050.01.

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:³⁴

- Protected peer reviews
 - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
 - Implementation of improvement actions recommended by the Peer Review Committee
- UM
 - Completion of at least 75 percent of all required inpatient reviews
 - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
 - Interdisciplinary review of UM data
- Patient safety
 - Entry of all reported patient incidents into VHA's patient safety reporting system³⁵
 - Annual completion of a minimum of eight RCAs³⁶
 - Provision of feedback about RCAs actions to reporting employees
 - Submission of annual patient safety report

Conclusion

The OIG found general compliance with requirements for UM and patient safety. However, the OIG identified a deficiency in the peer review process that warranted a recommendation for improvement.

³⁴ For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

³⁵ WebSPOT has been the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database. However, it is expected that by April 1, 2018, all facilities will have implemented the new Joint Patient Safety Reporting System (JPSR), and it is anticipated that all previous patient safety event reporting systems will be discontinued by July 1, 2018.

³⁶ According to VHA Handbook 1050.01, March 4, 2011, the requirement for a total of eight RCAs and aggregated reviews is a minimum number, as the total number of RCAs is driven by the events that occur and the Safety Assessment Code (SAC) score assigned to them. At least four analyses per fiscal year must be individual RCAs, with the balance being aggregated reviews or additional individual RCAs.

Peer Review: Aspects for Review of Care

VHA requires peer reviewers to use at least one of the 11 aspects of care (such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation) to evaluate level 2³⁷ or 3³⁸ peer review findings.³⁹ In following the facility's procedure, the Peer Review Coordinator assigns appropriate aspects of care to the review.

For three of ten level 2 or 3 peer reviews, the OIG did not find evidence the peer reviewer used at least one aspect of care. This may hinder the peer review committee's ability to review the case and/or provide a consistent, fair, or comprehensive review of the provider's decisions and actions. The peer review coordinator stated that in some services (for example, surgery and anesthesiology), the peer review paperwork is completed internally. Because these reviews did not have oversight by the peer review coordinator, aspects of care were not assigned as required.

Recommendation 1

1. The Chief of Staff ensures that peer reviewers consistently use at least one of the important aspects of care to evaluate peer review findings and monitors compliance.

Facility Concurred.

Target date for completion: November 30, 2018

Facility response: All level 2 and level 3 peer reviews will require that at least one of the eleven aspects of care be identified. The Risk Management RN will be responsible for reviewing and ensuring that, upon receipt, of the peer review findings, an aspect of care has been selected for all that are designated level 2 or level 3. We have a process for ensuring that this review occurs going forward. All peer reviews not in compliance will be returned to the original peer reviewer for selection of the appropriate aspect(s) of care. Monitoring will continue until compliance is sustained at 100 percent for three consecutive months.

³⁷ Level at which the most experienced, competent practitioners might have managed the case differently.

³⁸ Level at which the most experienced, competent practitioners would have managed the case differently.

³⁹ VHA Directive 2010-025.

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently-without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIP).⁴⁰

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This systematic process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.⁴¹

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges need to be specific, based on the individual's clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.⁴²

The purpose of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of 10 LIPs who were hired within 18 months prior to the on-site visit,⁴³ and 20 LIPs who were re-privileged within 12 months prior to the visit.⁴⁴ The OIG evaluated the following performance indicators:

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

⁴⁰ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)

⁴¹ VHA Handbook 1100.19.

⁴² VHA Handbook 1100.19.

⁴³ The 18-month period was from October 9, 2016, through April 9, 2018.

⁴⁴ The 12-month review period was from April 9, 2017, through April 9, 2018.

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

Conclusion

The OIG found general compliance with requirements for credentialing and privileging. However, the OIG identified deficiencies in initiating and completing FPPEs for newly hired LIPs and using service-specific and specialty-specific criteria for Ongoing Professional Practice Evaluations.

Focused Professional Practice Evaluations

VHA requires that all clinical supervisors complete FPPEs for newly hired LIPs, maintain this documentation in the practitioner's provider profile, and report the results to an appropriate committee of the Medical Staff. FPPEs involve the evaluation of privilege-specific competence of the practitioner who has not had documented evidence of competently performing the requested privileges at the Facility. Evaluation methods may include chart review, direct

observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.⁴⁵

For 6 of 10 LIPs, clinical supervisors did not initiate or complete the FPPE, although the Medical Executive Committee recommended granting privileges. As a result, providers continued delivering care without a thorough evaluation of their practice. The Chief of Staff delegated the responsibility for developing criteria and completing FPPEs to the service chiefs, in addition to their other clinical and administrative duties, but did not conduct oversight of this process.

Recommendation 2

2. The Chief of Staff ensures that Service Chiefs initiate and complete Focused Professional Practice Evaluations for newly hired licensed independent providers and monitors compliance.

Facility Concurred.

Target date for completion: September 30, 2019

Facility response: An enhanced tracking system to monitor completion of Focused Professional Practice Evaluations for newly hired licensed independent providers, including information obtained from periodic check-ins with service chiefs and administrative leads, and with protocols for escalation to the Chief of Staff to enforce timely completion once sufficient clinical activity has been reached will be implemented. There is a current report that can be expanded upon and shared with clinical services to improve transparency, documentation and follow-through. The Deputy Chief of Staff will track all FPPE through the Credentialing Committee until completed with outcomes reported up to the Medical Executive Committee. Compliance will be monitored monthly, and monitoring will continue until compliance is sustained at 100 percent for four consecutive quarters.

Ongoing Professional Practice Evaluations

VHA requires that Service Chiefs consider relevant service-and practitioner-specific data utilizing defined criteria when recommending the continuation of an LIP's privileges to the Medical Executive Committee. Such data is maintained as part of the practitioner's provider profile and may include direct observations, clinical discussions, and clinical record reviews. This OPPE process is essential to confirm the quality of care delivered and allows the Facility to identify professional practice trends that may impact quality of care and patient safety.⁴⁶ In

⁴⁵ VHA Handbook 1100.19.

⁴⁶ VHA Handbook 1100.19.

addition, VHA has defined specialty-specific elements to be utilized, where appropriate, for gastroenterology, pathology, nuclear medicine, and radiation oncology OPPEs.⁴⁷

For 4 of the 18 provider profiles where an OPPE was used to support the renewal of a practitioner's privileges, the OIG found no evidence of service-specific criteria or data collection within the OPPE. Further, for two of the six OPPEs with a requirement for defined specialty-specific elements, the OIG found no evidence of the pathology-specific elements required by VHA. As a result, providers continued delivering care without a thorough evaluation of their practice. The Chief of Staff delegated the responsibility for completing OPPEs to the Service Chiefs and did not conduct oversight of this process.

Recommendation 3

3. The Chief of Staff ensures that Ongoing Professional Practice Evaluations include the review of service-specific practitioner data and monitors compliance.

Facility Concurred.

Target date for completion: September 30, 2019

Facility response: All current peer review forms used for Ongoing Professional Practice Evaluation will be reviewed with the clinical services, and changes will be made, as required, to ensure that all forms include the review of service-specific practitioner data and are consistently used in ongoing practitioner reviews. The Deputy Chief of Staff will monitor consistent use of the new forms, and monitoring will continue monthly until compliance is sustained at 100 percent for four consecutive quarters.

⁴⁷ Acting Deputy Under Secretary for Health for Operation and Management (10N) memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

Recommendation 4

4. The Chief of Staff ensures that Ongoing Professional Practice Evaluations of pathology practitioners include required pathology-specific criteria, as appropriate, and monitors compliance.

Facility Concurred.

Target date for completion: September 30, 2019

Facility response: The current pathology case review form used for Ongoing Professional Practice Evaluation of pathology practitioners will be revised to ensure that it clearly incorporates pathology-specific criteria. The Deputy Chief of Staff will monitor compliance with consistent use of the new form monthly, and monitoring will continue until compliance is sustained at 100 percent for four consecutive quarters.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.⁴⁸

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG also determined whether the Facility met requirements in selected areas that are often associated with higher risks of harm to patients in the locked Mental Health (MH) Unit and Facility Emergency Management processes.⁴⁹

VHA requires managers to ensure capacity for MH services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting to ensure safety and to provide the type and intensity of clinical intervention necessary to treat the patient. Such care needs to be well integrated with the full continuum of care to support safety and effective management during periods of such severe difficulty. Inpatient MH settings must also provide a healing, recovery-oriented environment.⁵⁰

VHA requires managers to establish a comprehensive Emergency Management program to ensure continuity of patient care and hospital operations in the event of a disaster or emergency, which includes conducting a Hazard Vulnerability Analysis and developing an Emergency Operations Plan.⁵¹ These requirements allow the identification and minimization of impacts from potential hazards, threats, incidents, and events on health care and other essential services provided by facilities. VHA also requires managers to develop Utility Management Plans to ensure reliability and reduce failures of electrical power distribution systems in accordance with TJC,⁵² Occupational Safety and Health Administration,⁵³ and National Fire Protection

⁴⁸ VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

⁴⁹ Applicable requirements include various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

⁵⁰ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

⁵¹ VHA Directive 0320.01, *Comprehensive Emergency Management Program Procedures*, April 6, 2017.

⁵² TJC. EOC standard EC.02.05.07.

⁵³ Occupational Safety and Health (OSHA) is part of the US Department of Labor. OSHA assures safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education, and assistance.

Association standards.⁵⁴ The provision of sustained electrical power during disasters or emergencies is critical to continued operations of a healthcare facility.

The OIG inspected the Brockton, Jamaica Plain, and West Roxbury campuses and the Lowell CBOC. At the Brockton campus, the OIG inspected inpatient units (3rd floor MH and Spinal Cord Injury), outpatient areas (1st floor Primary Care Building 3 and Urgent Care Center), and a Community Living Center (CLC). At the Jamaica Plain campus, the OIG inspected the Women's Health and Primary Care Green Clinics and the Urgent Care Center. At the West Roxbury campus, the OIG inspected inpatient units (2-North medical, medical intensive care, and post-anesthesia care), the outpatient Primary Care clinic, and the Emergency Department.

The OIG also reviewed relevant documents and interviewed key employees and managers. The OIG evaluated 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

⁵⁴ National Fire Protection Association (NFPA) is a global nonprofit organization devoted to eliminating death, injury, and property and economic loss due to fire, electrical, and related hazards.

- Locked MH Unit
 - Bi-annual MH EOC Rounds
 - Nursing station security
 - Public area and general unit safety
 - Patient room safety
 - Infection prevention
 - Availability of medical equipment and supplies
- Emergency Management
 - Hazard Vulnerability Analysis (HVA)
 - Emergency Operations Plan (EOP)
 - Emergency power testing and availability

Conclusion

The OIG noted that general safety and privacy measures were in place at the three campuses and the CBOC and did not find any issues with the availability of medical equipment and supplies. However, 6 of 15 areas inspected had dirty ventilation grills and 5 of the 15 areas had stained ceiling tiles. The OIG also identified the following deficiencies that warranted recommendations for improvement.

Infection Prevention

TJC requires hospitals to minimize the possibility of transmitting infections by ensuring that dirty and used equipment are stored separately from sterile supplies.⁵⁵ This ensures a health care environment that minimizes the spread of infection. Dirty equipment was not separated from clean equipment in 2 of 15 supply areas.⁵⁶ The Deputy Director stated the noncompliance was due to knowledge deficits regarding proper storage requirements.

Recommendation 5

5. The Deputy Director ensures that clean and dirty equipment is stored separately and monitors compliance.

⁵⁵ TJC Infection Prevention and Control standard 02.02.01.

⁵⁶ Brockton 3rd floor MH inpatient unit, Brockton 1st floor Primary Care Building 3, and the Lowell CBOC.

Facility concurred.

Target date for completion: September 7, 2018 (Completed)

Facility response: Nursing Services and Primary Care Services staff have separated storage of dirty equipment from clean equipment in the two clean supply areas identified during the survey. All deficiencies have been corrected. Going forward, all clean supply rooms will be inspected during Environment of Care Rounds to ensure that they are being maintained appropriately.

Equipment Storage Areas

VHA requires that bottom shelves in equipment storage areas must be solid.⁵⁷ This ensures that clean and sterile supplies do not fall to the floor where the cleanliness of supplies may be compromised. The OIG observed that in 5 of 15 supply rooms, the shelving units had bottom shelves that were not solid.⁵⁸ Clinical managers cited the noncompliance was due to a lack of knowledge regarding proper storage requirements.

Recommendation 6

6. The Deputy Director ensures that bottom shelves in equipment storage areas are solid and monitors compliance.

Facility concurred.

Target date for completion: August 31, 2018 (Completed)

Facility response: Logistics staff has placed solid bottom shelves on the equipment storage racks in the five locations identified during the survey. All deficiencies have been corrected. Going forward, all clean supply room racks will be inspected by Logistics staff when delivering supplies to ensure that the bottom shelves are made of solid material and are intact.

⁵⁷ VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016.

⁵⁸ Brockton 3rd floor MH inpatient unit, West Roxbury 2-North medical unit, West Roxbury medical intensive care unit, Jamaica Plain Primary Care Green Clinic, and the Lowell CBOC.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.⁵⁹ Diversion by healthcare workers—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—remains a serious problem that can increase serious patient safety issues, causes harm to the diverter, and elevates the liability risk to healthcare organizations.⁶⁰

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.⁶¹ Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSI), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.

The OIG review of these issues was conducted to determine whether the Facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.⁶² The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;⁶³ monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;⁶⁴ CS inspection quarterly trend reports for the prior four quarters;⁶⁵ and other relevant documents. The OIG evaluated the following performance indicators:

- CSC reports
 - Monthly summary of findings to the Director
 - Quarterly trend report to the Director
 - Actions taken to resolve identified problems
- Pharmacy operations
 - Annual physical security survey of the pharmacy/pharmacies by VA Police

⁵⁹ Drug Enforcement Agency Controlled Substance Schedules. <https://www.deadiversion.usdoj.gov/schedules/>. (Website accessed on August 21, 2017.)

⁶⁰ American Society of Health-System Pharmacists, “ASHP Guidelines on Preventing Diversion of Controlled Substances,” *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

⁶¹ VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

⁶² VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

⁶³ The review period was October 1, 2017, through March 31, 2018.

⁶⁴ The review period was April 1, 2017, through March 31, 2018.

⁶⁵ The four quarters were from April 1, 2017, through March 31, 2018.

- CS ordering processes
- Inventory completion during Chief of Pharmacy transition
- Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
 - Free from conflicts of interest
 - CSC duties included in position description or functional statement
 - Completion of required CSC orientation training course
- Requirements for CSIs
 - Free from conflicts of interest
 - Appointed in writing by the Director for a term not to exceed three years
 - Hiatus of one year between any reappointment
 - Completion of required CSI certification course
 - Completion of required annual updates and/or refresher training
- CS area inspections
 - Monthly inspections
 - Rotations of CSIs
 - Patterns of inspections
 - Completion of inspections on day initiated
 - Reconciliation of dispensing between pharmacy and each dispensing area
 - Verification of CS orders
 - CS inspections performed by CSIs
- Pharmacy inspections
 - Monthly physical counts of the CS in the pharmacy by CSIs
 - Completion of inspections on day initiated
 - Security and documentation of drugs held for destruction⁶⁶
 - Accountability for all prescription pads in pharmacy

⁶⁶ 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.

- 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

Conclusion

The OIG found general compliance with the requirements for CS reports, CSC and CSI requirements, and CS inspections. However, the OIG identified a deficiency with physical security that warranted a recommendation for improvement.

Annual Physical Security Survey

VHA requires that the Chief, VA Police, follow up with the pharmacy to ensure that identified deficiencies from the annual physical security survey have been corrected.⁶⁷ This ensures the security of medications stored in the pharmacy.

The need for a manual lock release switch and vault door replacement were identified during the annual physical security survey in March 2015, November 2016, and November 2017. The OIG found that a work order was placed by pharmacy staff in March 2015 for installation of a manual lock release switch, and a work order for the vault door replacement was submitted in June 2015. However, at the time of the OIG visit, the switch had not been installed and the vault door replacement work order was still pending.⁶⁸ The reason for noncompliance was a lack of communication among VA Police, Pharmacy, and Engineering Services. The Chief of VA Police reported sending a copy of the survey to Pharmacy Service, and the Chief of Pharmacy reported that the survey was received but that it was not shared with Engineering Service. The Chief of Engineering was new to the position and was not aware of the pending work orders.

Recommendation 7

7. The Facility Director ensures that deficiencies identified on the annual physical security survey are addressed and monitors compliance.

⁶⁷ VHA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.

⁶⁸ Brockton Work Order List; Work Order # HB150618-006.

Facility concurred.

Target date for completion: February 28, 2019 (Completed)

Facility response: Annual Physical Security Inspections are conducted by the Physical Security Specialist. Memoranda citing deficiencies are submitted to the Facility Director and chief of the responsible service. The chief of the responsible service must respond to the memoranda within 30 days with resolution or action plan. The written response is sent to the Physical Security Specialist and the Medical Center Director.

In cases where the responsible service chief requires the support of additional services, the responsible service chief will share portions of the Physical Security Deficiency Report, as appropriate, with support services. (Sensitive items not requiring support outside of the responsible service are to be redacted). Support services are required to provide guidance and timelines regarding correction of noted deficiencies and are to be included in the overall responsible service chief response.

If the Physical Security Specialist does not receive a response or the response is not adequate, the specialist will elevate the issue to the Chief, Police Service. If the Chief, Police Service is unable to reach resolution with the responsible service chief, the issue is elevated to the Medical Center Deputy Director. If resolution crosses disciplines into clinical services, the Deputy Director will liaise with the Chief of Staff to formulate a response to effect resolution. If unable to effect resolution, the issue will be elevated to the Medical Center Director, who has ultimate authority.

The work orders noted were known to Engineering Service but not known to the new Pharmacy Chief. The reason was that there was a new chief hired within Pharmacy Service (responsible service chief in this case) and staff were in acting roles during this timeframe which resulted in a breakdown in communications.

All parties have been educated/re-educated on the physical security inspection process as defined above, and the Facility Director will ensure that deficiencies identified on the annual physical security survey are corrected and will monitor compliance going forward.

Updated statuses of the items identified are as follows:

Vault Door Replacement – The reason this work order remained open was due to the unavailability of construction funding. Replacement of the door is not feasible at this time. The work would require removal of a large portion of the existing pharmacy footprint in order to replace the entire vault which is non-compliant. It will also require demolition of the existing door assembly and remove the pharmacy from service for several months. The intended correction for the issue is a new pharmacy. Although the current vault door and structure are deficient, security cameras and security locks are in place so that immediate risks are mitigated until the vault door and structure can be permanently replaced. These ongoing security efforts are in place and consistently employed to ensure the zones (interior and exterior of the vault)

remains secure and monitored appropriately at all times. VA Boston has a SCIP⁶⁹ (Strategic Capital Investment Process) Entry for a new Pharmacy minor construction project pending review and approval at the national level. If approved, the new pharmacy will enter design in 2020. If denied, we will refocus efforts on renovating the existing pharmacy. Determination of action will depend upon scoring of SCIP Business Cases, currently scheduled for February 2019.

Installation of a Manual Lock Release Switch – The manual lock release switch has been installed.

⁶⁹ SCIP -Strategic Capital Investment Process- is an innovative VA Department-wide planning process that results in the creation of a single, integrated prioritized list of projects from the following capital investment accounts: major construction; minor construction; and leases. VA prioritizes construction projects using the Strategic Capital Investment Planning(SCIP) process, which began in 2010. <https://www.va.gov/OSDBU/docs/FY-2019-VA-Long-Range-Construction-Contract-Opportunities.pdf>

Mental Health Care: Posttraumatic Stress Disorder Care

Posttraumatic Stress Disorder (PTSD) may occur “following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one’s physical integrity; witnessing an event that involves death, injury, or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate.”⁷⁰ 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.⁷¹

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.⁷² VHA requires that

1. PTSD screening is performed for every new patient and then is repeated every year for the first five years post-separation and every five years thereafter, unless there is a clinical need to re-screen earlier;
2. If the patient’s PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.⁷³

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG team reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 31 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

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

⁷⁰ VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010. (Rescinded November 16, 2017).

⁷¹ VHA Handbook 1160.03.

⁷² 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.

⁷³ Department of Veterans Affairs, Information Bulletin, *Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 6, 2015.

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

Conclusion

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

Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.⁷⁴ As a group, veterans experience more chronic disease and disability than their non-veteran peers. VA must plan for the growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.⁷⁵ Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.⁷⁶

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.⁷⁷ This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. The healthcare team would then manage the patient with treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.⁷⁸ Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.⁷⁹

In determining whether the Facility provided an effective geriatric evaluation, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of 43 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

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

⁷⁴ VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

⁷⁵ VHA Directive 1140.04.

⁷⁶ Chad Boulton, Lisa B. Boulton, Lynne Morishita, Bryan Dowd, Robert L. Kane, and Cristina F. Urdangarin, "A randomized clinical trial of outpatient geriatric evaluation and management," *Journal of the American Geriatrics Society* 49, no. 4 (April 2001): 351–359.

⁷⁷ Public Law 106-117.

⁷⁸ VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

⁷⁹ VHA Directive 1140.04.

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

Conclusion

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

Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.⁸⁰ Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veteran's Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.⁸¹ The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services including mammography services to eligible women veterans.⁸²

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Communication with patients must be documented.⁸³

The OIG team examined whether the Facility complied with selected VHA requirements for the reporting of mammography results by reviewing relevant documents and interviewing selected employees and managers. The team also reviewed the EHRs of 49 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

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

⁸⁰ U.S. Breast Cancer Statistics. <http://www.BreastCancer.org>. (Website accessed on May 18, 2017.)

⁸¹ VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011 (Handbook rescinded and replaced with VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018).

⁸² Veterans Health Care Act of 1992, Title I, Publ L. 102-585 (1992).

⁸³ VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017, and further amended July 24, 2018).

- Performance of follow-up mammogram if indicated
- Performance of follow-up study

Conclusion

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

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.⁸⁴ 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,”⁸⁵ 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.⁸⁶

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 central line-associated bloodstream infection (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.”⁸⁷

Infections occurring on or after the third calendar day following admission to an inpatient location are considered “healthcare-associated.”⁸⁸ 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. External factors are associated with a 2.27-fold increased risk for mortality and increased healthcare costs.⁸⁹

The OIG’s review of these issues examined whether the Facility established and maintained programs to reduce the incidence of healthcare-associated bloodstream infections in intensive care unit patients with indwelling central lines. In addition to conducting manager and staff interviews, the OIG team reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents. The team also reviewed the training records of 25 clinical employees involved in inserting and/or managing central lines. The OIG evaluated the following performance indicators:

- Presence of Facility policy on the use and care of central lines

⁸⁴ TJC. Infection Prevention and Control IC.01.03.01.

⁸⁵ Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

⁸⁶ These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.

⁸⁷ The Centers for Disease Control and Prevention, *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011.

⁸⁸ 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.

⁸⁹ Association for Professionals in Infection Control and Epidemiology, 2015.

- 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 and families
- Use of a checklist for central line insertion and maintenance

Conclusion

Generally, the Facility met requirement with the above performance indicators. The OIG made no recommendations.

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

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	<ul style="list-style-type: none"> • 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 	Seven OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Director, Chief of Staff, and Deputy Director. See details below.

Quality, Safety, and Value	<ul style="list-style-type: none"> • Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs 	<ul style="list-style-type: none"> • Peer reviewers consistently use at least one of the important aspects of care to evaluate peer review findings. 	<ul style="list-style-type: none"> • None
Credentialing and Privileging	<ul style="list-style-type: none"> • Medical licenses • Privileges • FPPEs • OPPEs 	<ul style="list-style-type: none"> • Service Chiefs initiate and complete FPPEs for newly hired LIPs. • OPPEs include the review of service-specific practitioner data. • OPPEs of pathology practitioners include required pathology-specific criteria. 	<ul style="list-style-type: none"> • None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
<p>Environment of Care</p>	<ul style="list-style-type: none"> • Parent Facility <ul style="list-style-type: none"> ○ EOC rounds and deficiency tracking ○ Infection prevention ○ General safety ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies • CBOC <ul style="list-style-type: none"> ○ General safety ○ Medication safety and security ○ Infection prevention ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies • Locked MH Unit <ul style="list-style-type: none"> ○ Bi-annual MH EOC rounds ○ Nursing station security ○ Public area and general unit safety ○ Patient room safety ○ Infection prevention ○ Availability of medical equipment and supplies • Emergency Management <ul style="list-style-type: none"> ○ Hazard Vulnerability Analysis ○ Emergency Operations Plan ○ Emergency power testing and availability 	<ul style="list-style-type: none"> • Clean and dirty equipment is stored separately. 	<ul style="list-style-type: none"> • Bottom shelves in equipment storage areas are solid.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	<ul style="list-style-type: none"> • CSC reports • Pharmacy operations • Annual physical security survey • CS ordering processes • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections 	<ul style="list-style-type: none"> • Deficiencies identified on the annual physical security survey are corrected. 	<ul style="list-style-type: none"> • None
Mental Health Care: Posttraumatic Stress Disorder Care	<ul style="list-style-type: none"> • Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Long-term Care: Geriatric Evaluations	<ul style="list-style-type: none"> • Provision of or access to geriatric evaluation • Program oversight and evaluation requirements • Geriatric evaluation requirements • Geriatric management requirements 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Women's Health: Mammography Results and Follow-Up	<ul style="list-style-type: none"> • Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
High-Risk Processes: Central Line-Associated Bloodstream Infections	<ul style="list-style-type: none"> • Policy and infection prevention risk assessment • Committee discussion • Infection incidence data 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	<ul style="list-style-type: none"> • Education and educational materials • Policy, procedure, and checklist for insertion and maintenance of central venous catheters 		

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this highest complexity (1a)⁹⁰ affiliated⁹¹ Facility reporting to VISN 1.

**Table 7. Facility Profile for Boston (523)
(October 1, 2014, through September 30, 2017)**

Profile Element	Facility Data FY 2015 ⁹²	Facility Data FY 2016 ⁹³	Facility Data FY 2017 ⁹⁴
Total Medical Care Budget in Millions	\$758.0	\$766.9	\$810.2
Number of:			
• Unique Patients	63,132	63,410	62,982
• Outpatient Visits	711,592	738,576	730,039
• Unique Employees ⁹⁵	3,381	3,555	3,547
Type and Number of Operating Beds:			
• Community Living Center	112	112	112
• Domiciliary	98	98	98
• Medicine	103	103	103
• Mental Health	126	126	126
• Neurology	6	6	6
• Rehabilitation Medicine	5	5	5
• Residential Rehabilitation	33	33	33
• Spinal Cord Injury	64	64	64
• Surgery	45	45	45

⁹⁰ The VHA medical centers are classified according to a facility complexity model; 1a designation indicates a Facility with high volume, high risk patients, most complex clinical programs, and large research and teaching programs.

⁹¹ Associated with a medical residency program.

⁹² October 1, 2014, through September 30, 2015.

⁹³ October 1, 2015, through September 30, 2016.

⁹⁴ October 1, 2016, through September 30, 2017.

⁹⁵ Unique employees involved in direct medical care (cost center 8200).

Profile Element	Facility Data FY 2015	Facility Data FY 2016	Facility Data FY 2017
Type and Number of Operating Beds:			
• Community Living Center	88	89	92
• Domiciliary	70	67	70
• Medicine	77	73	76
• Mental Health	84	92	92
• Neurology	3	4	3
• Rehabilitation Medicine	4	2	3
• Residential Rehabilitation	26	26	26
• Spinal Cord Injury	33	39	40
• Surgery	27	25	24

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

VA Outpatient Clinic Profiles⁹⁶

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 8 provides information relative to each of the clinics.

Table 8. VA Outpatient Clinic Workload/Encounters⁹⁷ and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services ⁹⁸ Provided	Diagnostic Services ⁹⁹ Provided	Ancillary Services ¹⁰⁰ Provided
Lowell, MA	523BY	6,196	3,914	Dermatology Endocrinology Gastroenterology Neurology Anesthesia Eye Podiatry	EKG Radiology	Pharmacy Weight Management Nutrition

⁹⁶ Includes all outpatient clinics in the community that were in operation as of August 15, 2017.

⁹⁷ An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

⁹⁸ Specialty care services refer to non-PC and non-MH services provided by a physician.

⁹⁹ Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

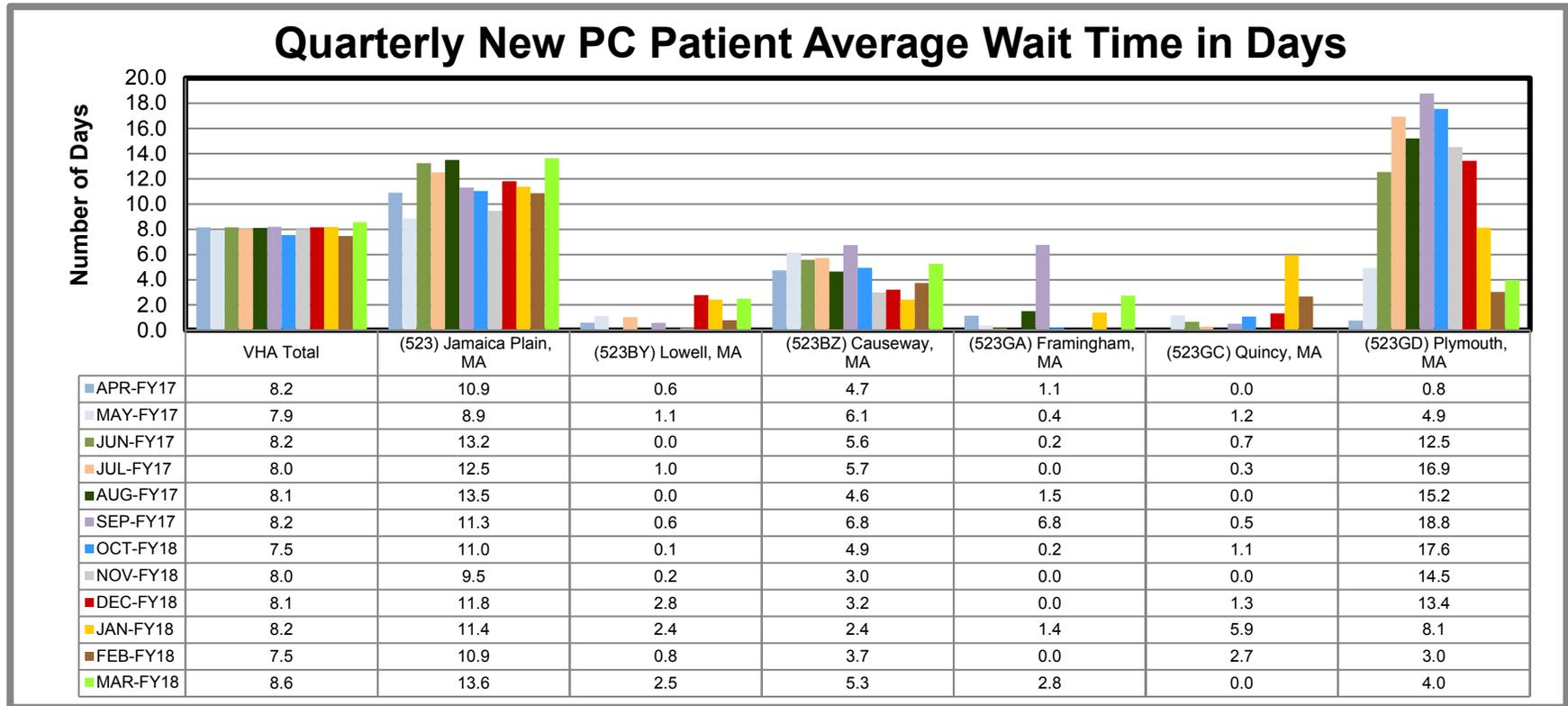
¹⁰⁰ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services ⁹⁸ Provided	Diagnostic Services ⁹⁹ Provided	Ancillary Services ¹⁰⁰ Provided
Causeway-Boston, MA	523BZ	5,336	9,518	Dermatology Rheumatology Eye Podiatry	n/a	Pharmacy Weight Management Nutrition
Framingham, MA	523GA	3,876	957	Dermatology	EKG	Pharmacy Nutrition
Quincy, MA	523GC	3,022	n/a	n/a	n/a	n/a
Plymouth, MA	523GD	3,193	n/a	Dermatology Endocrinology Neurology	EKG	Weight Management Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse

n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics¹⁰¹

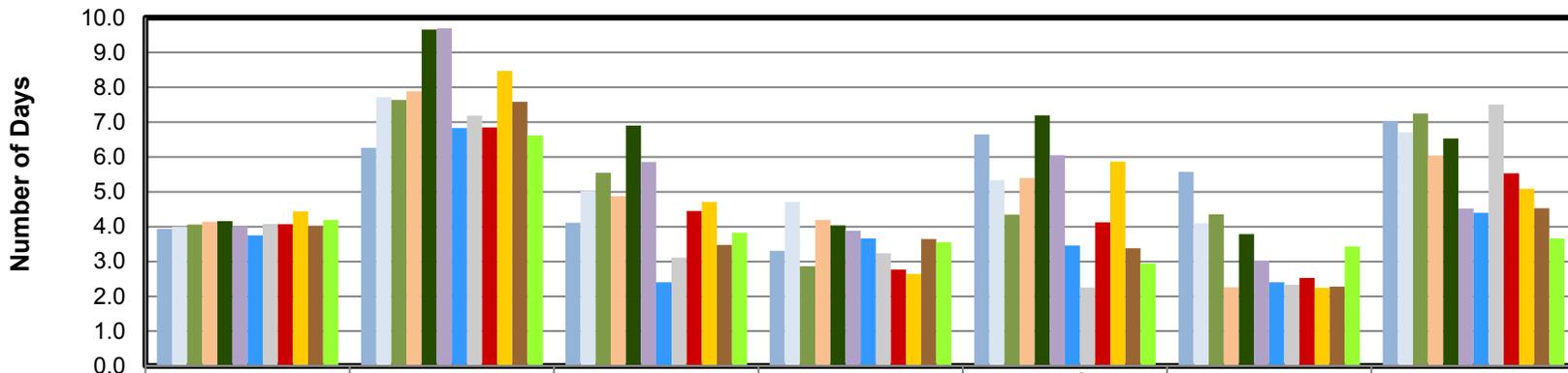


Source: VHA Support Service Center

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.

¹⁰¹ Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.

Quarterly Established PC Patient Average Wait Time in Days

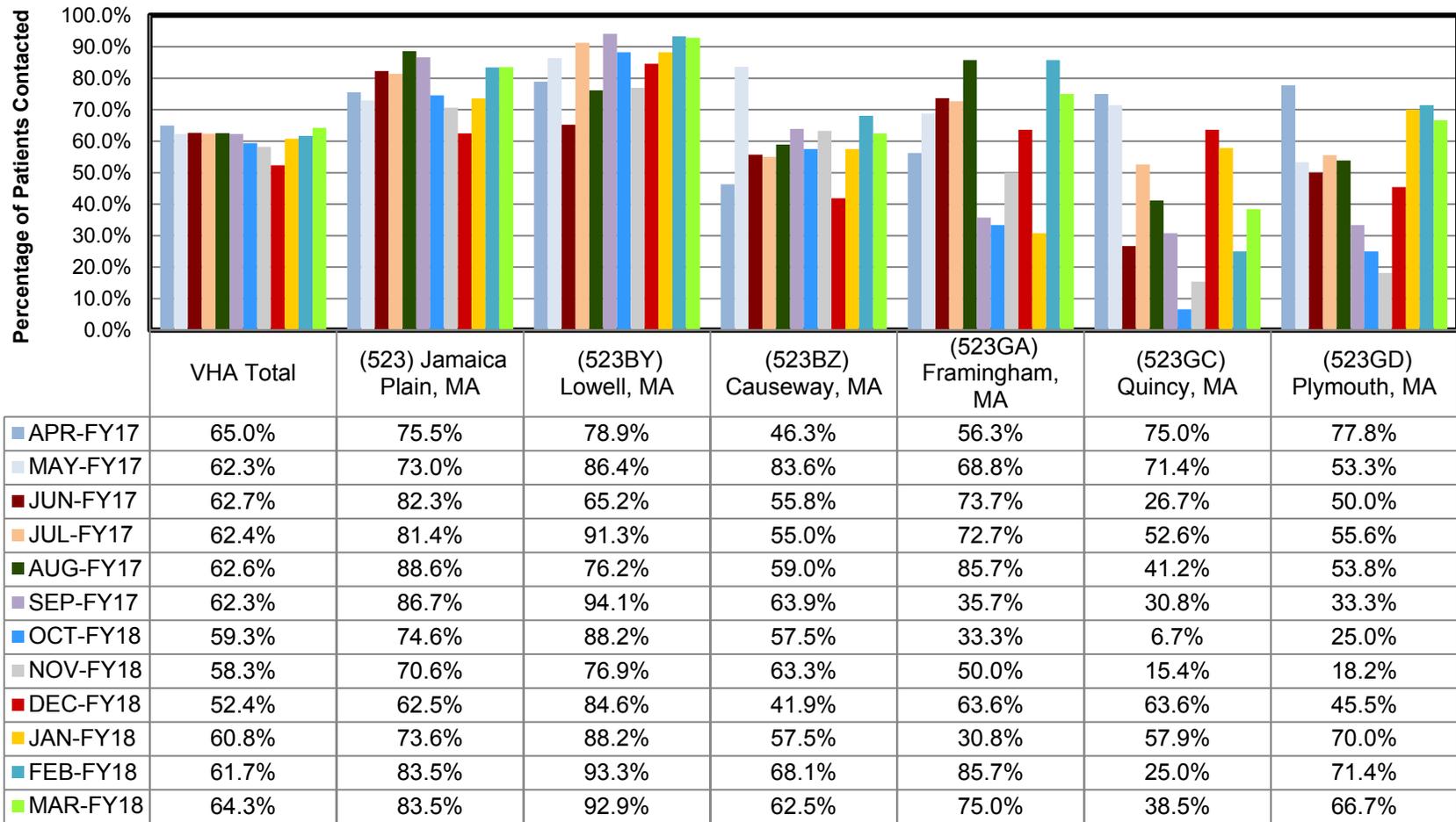


	VHA Total	(523) Jamaica Plain, MA	(523BY) Lowell, MA	(523BZ) Causeway, MA	(523GA) Framingham, MA	(523GC) Quincy, MA	(523GD) Plymouth, MA
■ APR-FY17	3.9	6.3	4.1	3.3	6.6	5.6	7.0
■ MAY-FY17	4.0	7.7	5.0	4.7	5.3	4.1	6.7
■ JUN-FY17	4.1	7.6	5.6	2.9	4.3	4.3	7.2
■ JUL-FY17	4.1	7.9	4.9	4.2	5.4	2.3	6.0
■ AUG-FY17	4.2	9.7	6.9	4.0	7.2	3.8	6.5
■ SEP-FY17	4.0	9.7	5.9	3.9	6.1	3.0	4.5
■ OCT-FY18	3.7	6.8	2.4	3.7	3.5	2.4	4.4
■ NOV-FY18	4.1	7.2	3.1	3.2	2.3	2.3	7.5
■ DEC-FY18	4.1	6.8	4.4	2.8	4.1	2.5	5.5
■ JAN-FY18	4.4	8.5	4.7	2.6	5.9	2.2	5.1
■ FEB-FY18	4.0	7.6	3.5	3.6	3.4	2.3	4.5
■ MAR-FY18	4.2	6.6	3.8	3.6	2.9	3.4	3.7

Source: VHA Support Service Center

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.

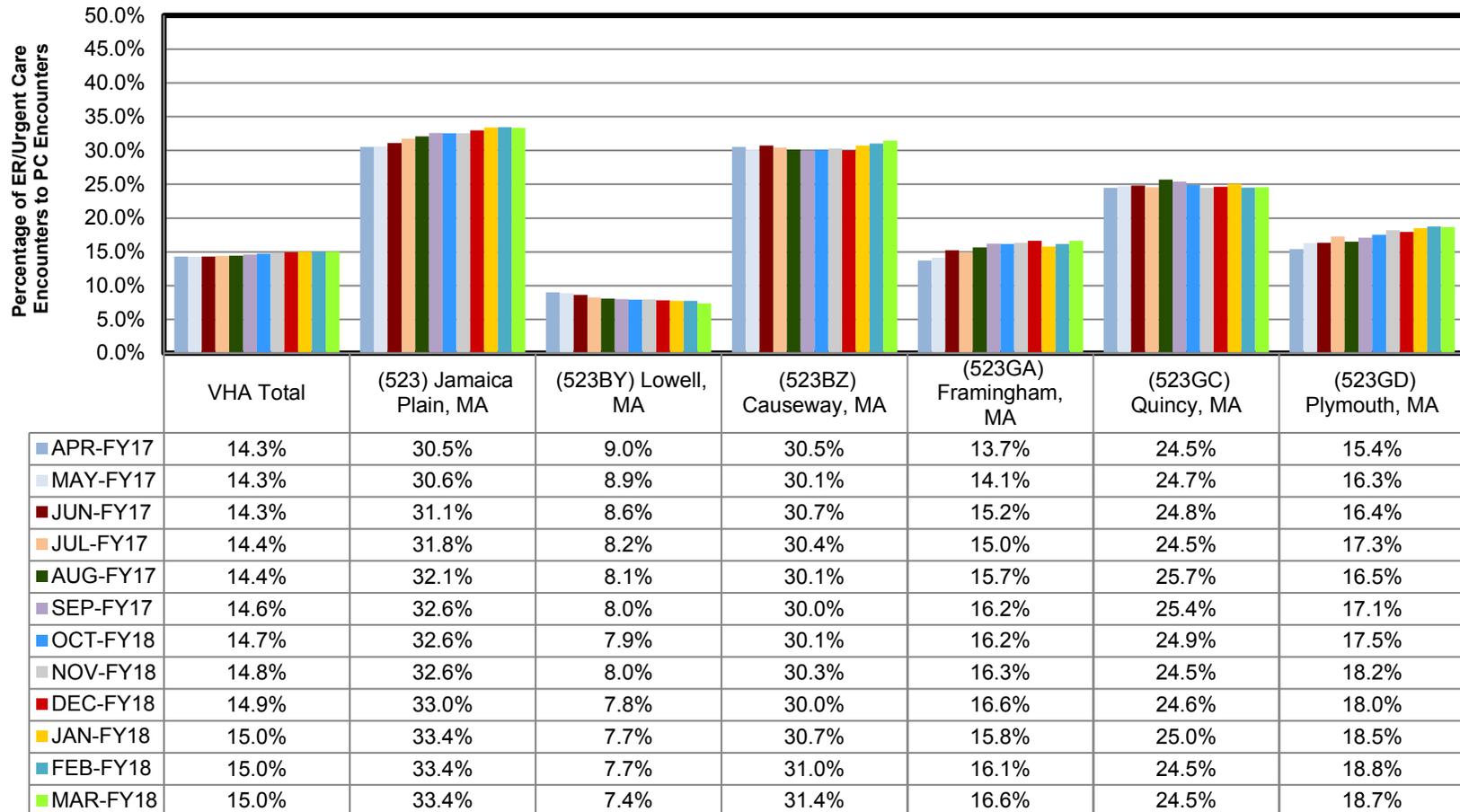
Quarterly Team 2-Day Post Discharge Contact Ratio



Source: VHA Support Service Center

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within two business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within two 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.”

Quarterly Ratio of ER/Urgent Care Encounters While on Panel to PC Encounters While on Panel (FEE ER Excluded)



Source: VHA Support Service Center

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

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions¹⁰²

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

¹⁰² VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed February 14, 2018.

Measure	Definition	Desired Direction
HC Assoc Infections	Healthcare associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS Like – HED90_1	HEDIS-EPRP Based PRV TOB BHS	A higher value is better than a lower value
HEDIS Like – HED90_ec	HEDIS-eOM Based DM IHD	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH Same Day Appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH Survey Access	Timely Appointment, care and information (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Rating Hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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

Measure	Definition	Desired Direction
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress Discussed	Stress Discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 13, 2018
From: Director, VA New England Healthcare System (10N1)
Subj: CHIP Review of the VA Boston Healthcare System, Boston, MA
To: Director, Bay Pines Office of Healthcare Inspections (54SP)
Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed and concur with the findings, recommendations, and submitted action plans regarding the Comprehensive Healthcare Inspection Program (CHIP) review conducted at the VA Boston Healthcare System.

(Original signed by:)

Ryan Lilly, M.P.A. (10N1)
Network Director

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

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 30, 2018

From: Director, VA Boston Healthcare System (523/00)

Subj: CHIP Review of the VA Boston Healthcare System, Boston, MA

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

I have reviewed and concur with the action plans regarding the Comprehensive Healthcare Inspection Program (CHIP) review conducted at the VA Boston Healthcare System.

(Original signed by:)

Vincent Ng (523/00)
Medical Center Director

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

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House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Ed Markey, Elizabeth Warren
U.S. House of Representatives: Michael E. Capuano, Katherine Clark, Bill Keating, Joe Kennedy, Stephen F. Lynch, Jim McGovern, Seth Moulton, Richard Neal, Niki Tsongas

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