



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare  
Inspection Program Review  
of the Gulf Coast Veterans  
Health Care System

Biloxi, Mississippi



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**Figure 1.** *Gulf Coast Veterans Health Care System, Biloxi, Mississippi*  
(Source: <https://vaww.va.gov/directory/>, accessed on May 8, 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 Gulf Coast Veterans Health Care System (Facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

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

The OIG's current areas of focus are

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

This review was conducted during an unannounced visit made during the week of January 29, 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, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Medical Center Director, and Associate Director for Outpatient Operations. Organizational communication and accountability are carried out through a committee reporting structure, with the Executive Leadership Board having oversight for leadership groups such as the Integrity, Advocacy, and Excellence Councils. 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 Director also serves as chair for the Quality, Safety, and Value Committee, which tracks, trends, and monitors quality of care and patient outcomes.

Although all leaders were permanently assigned, it is important to note that the Director and Chief of Staff were assigned to their respective positions in January 2018. At the time of the OIG site visit, the executive leaders had been working together for less than two weeks.

In the review of selected employee and patient survey results regarding Facility senior leadership, the OIG noted opportunities appear to exist to improve employee attitudes toward leadership and patients' experiences in outpatient areas. Facility leaders were actively discussing opportunities to engage with employees and working to improve employee satisfaction. Facility leaders were also working to improve patient satisfaction through service recovery and the Veteran Experience Program.

The OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).<sup>1</sup> Although the leadership team appeared knowledgeable about selected SAIL metrics, the leaders should continue to take significant actions to improve performance of the Quality of Care and Access metrics likely contributing to the current "1-Star" rating.

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<sup>1</sup> 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.)

Additionally, the OIG reviewed accreditation agency findings, sentinel events,<sup>2</sup> and disclosures of adverse patient events, and did not identify any substantial organizational risk factors. 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.

The OIG noted findings in five of the eight areas of clinical operations reviewed and issued 13 recommendations that are attributable to the Director, Chief of Staff, and Associate Director. These are briefly described below.

### **Quality, Safety, and Value**

The OIG found general compliance with requirements for protected peer review but noted deficiencies with UM interdisciplinary review of data<sup>3</sup> and the patient safety annual report.<sup>4</sup>

### **Credentialing and Privileging**

The OIG found general compliance with credentialing requirements but identified deficiencies with the approval of granting or continuing privileges and Focused and Ongoing Professional Practice Evaluation processes.

### **Environment of Care**

The OIG noted a generally safe and clean environment of care but identified deficiencies with the participation of required staff during EOC rounds and expired dates on sterile surgical instruments.

### **Medication Management**

The OIG found general compliance with the requirements for Controlled Substance Coordinator reports and Controlled Substance Inspectors. However, the OIG identified deficiencies with the annual physical security survey, Alternate Controlled Substance Coordinator's position description, monthly area inspections, and pharmacy inspections.

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

<sup>3</sup> VHA Directive 1117, *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

<sup>4</sup> VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. Requirements include submitting an end of fiscal year Patient Safety Annual Report to facility leaders to provide an overview on program successes, areas for improvement, reports of RCAs, Aggregated Reviews, Sentinel Events, alerts, and advisories.

## Mental Health Care

The OIG found general compliance with providers offering, referring patients for, and completing diagnostic evaluations. However, the OIG identified a deficiency in timely completion of suicide risk assessments that warranted a recommendation for improvement.

## Summary

In the review of key care processes, the OIG issued 13 recommendations that are attributable to the Director, Chief of Staff, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this Facility. The intent is for Facility 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 63–64, for the full text of the Directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.



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# Contents

Abbreviations .....	ii
Report Overview .....	iii
Results and Review Impact .....	iv
Contents .....	vii
Purpose and Scope .....	1
Methodology .....	3
Results and Recommendations .....	4
Leadership and Organizational Risks .....	4
Quality, Safety, and Value .....	17
Recommendation 1 .....	19
Recommendation 2 .....	20
Credentialing and Privileging .....	21
Recommendation 3 .....	23
Recommendation 4 .....	24
Recommendation 5 .....	25
Environment of Care .....	26
Recommendation 6 .....	28
Recommendation 7 .....	29
Medication Management: Controlled Substances Inspection Program .....	31
Recommendation 8 .....	33
Recommendation 9 .....	34
Recommendation 10 .....	35
Recommendation 11 .....	35
Recommendation 12 .....	36
Mental Health Care: Posttraumatic Stress Disorder Care .....	37

Recommendation 13.....	38
Long-term Care: Geriatric Evaluations.....	40
Women’s Health: Mammography Results and Follow-Up.....	42
High-Risk Processes: Central Line-Associated Bloodstream Infections.....	44
Appendix A: Summary Table of Comprehensive Healthcare Inspection Program Review	
Findings.....	46
Appendix B: Facility Profile and VA Outpatient Clinic Profiles.....	50
Facility Profile.....	50
VA Outpatient Clinic Profiles.....	52
Appendix C: Patient Aligned Care Team Compass Metrics.....	55
Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric	
Definitions.....	59
Appendix E: VISN Director Comments.....	63
Appendix F: Facility Director Comments.....	64
OIG Contact and Staff Acknowledgments.....	65
Report Distribution.....	66



## 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 Gulf Coast Veterans Health Care System (Facility) through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of healthcare services to veterans and to share findings with Facility leaders so that informed decisions can be made to improve care.

### Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.<sup>5,6</sup> 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.<sup>7</sup> 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; Women’s Health: Mammography Results and Follow-up; and High-Risk Processes: Central Line-Associated Bloodstream Infections (CLABSI) (see Figure 2).<sup>8</sup>

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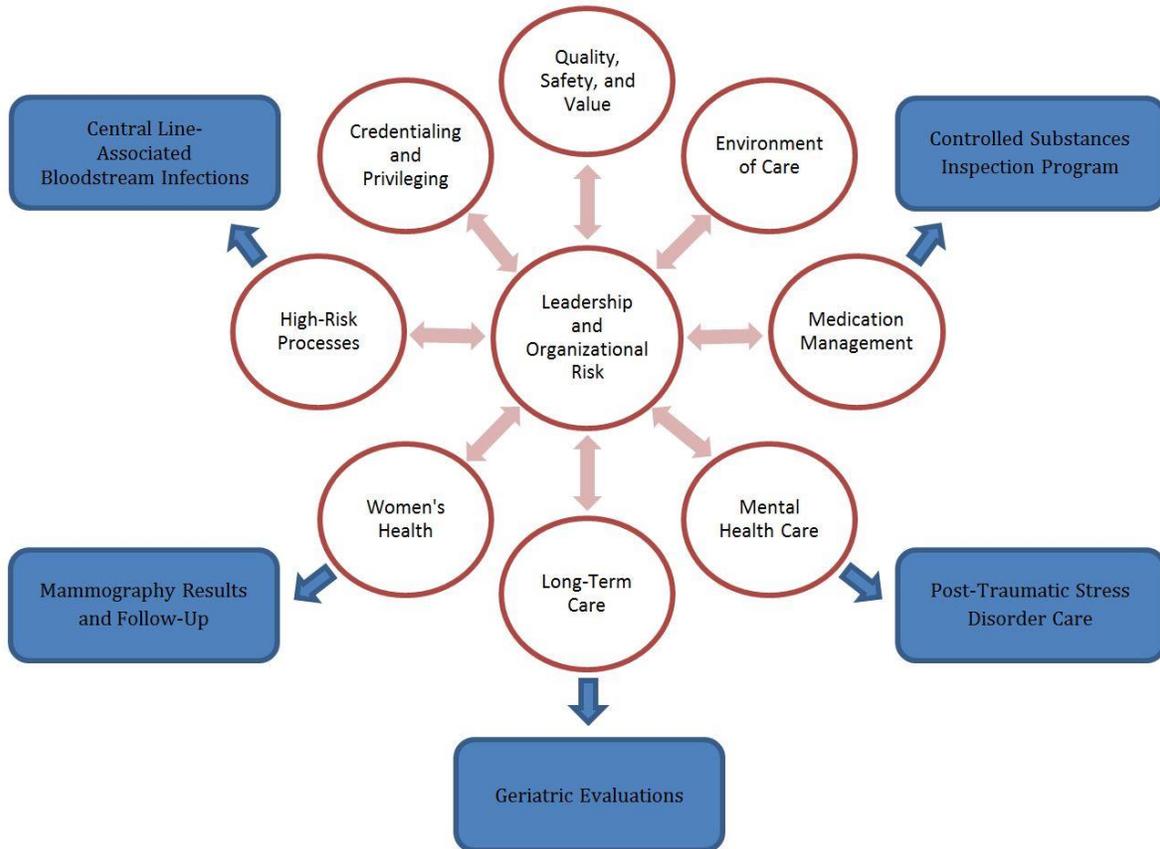
<sup>5</sup> Carol Stephenson, “The role of leadership in managing risk,” *Ivey Business Journal*, November/December 2010. <https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/>. (Website accessed on March 1, 2018.)

<sup>6</sup> 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.)

<sup>7</sup> Institute for Healthcare Improvement, “How risk management and patient safety intersect: Strategies to help make it happen”, March 24, 2015. <http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen>. (Website accessed March 1, 2018.)

<sup>8</sup> 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

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

## Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the EOC, the OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;<sup>9</sup> 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 October 20, 2014,<sup>10</sup> through January 29, 2018, the date when an unannounced week-long site visit commenced. On January 31, 2018, the OIG presented crime awareness briefings to 184 of the Facility's 2,508 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

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

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<sup>9</sup> The OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect Facility accreditation status.

<sup>10</sup> This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient Clinic reviews.

## Results and Recommendations

### Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the Facility's ability to provide care in all of the selected clinical areas of focus.<sup>11</sup> To assess the Facility's risks, the OIG considered the following organizational elements

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

### Executive Leadership Stability and Engagement

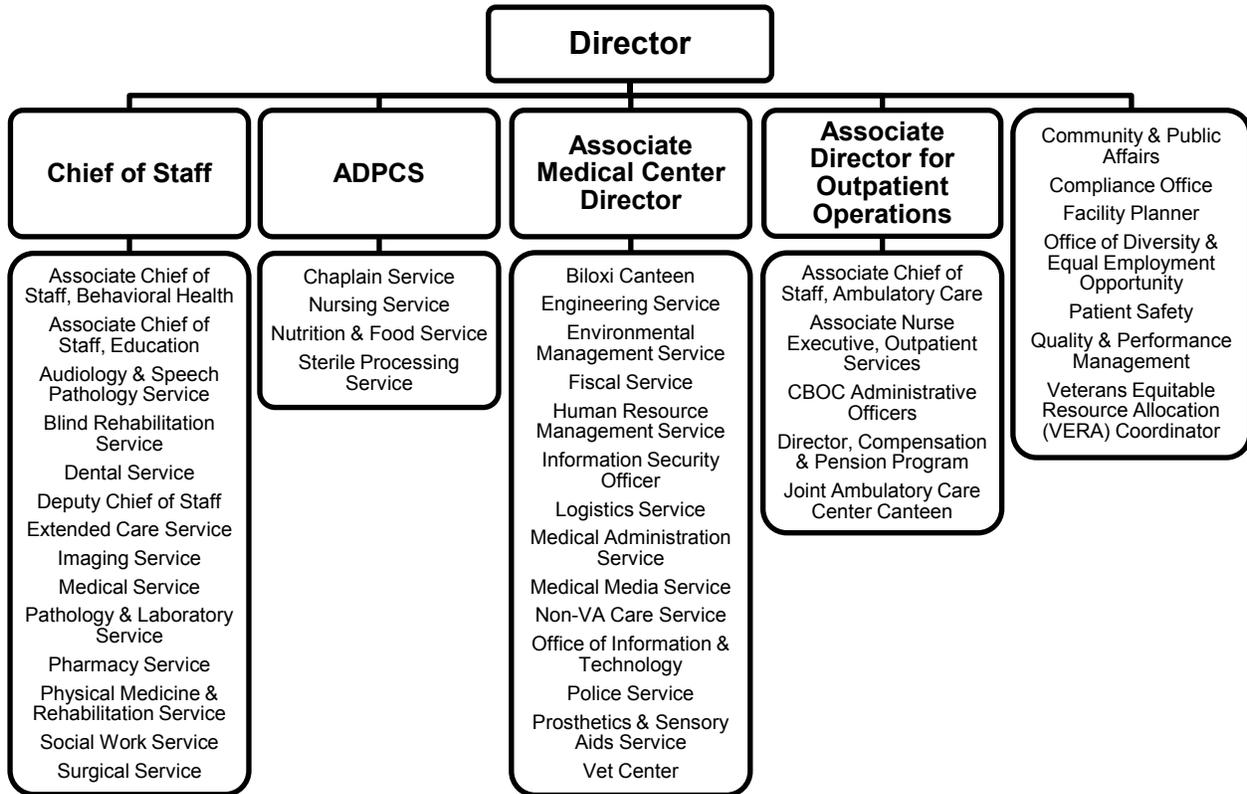
Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ among facilities. Figure 3 illustrates the Facility's reported organizational structure. The Facility has a leadership team consisting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

At the time of the OIG site visit, the executive leaders had been working together for less than two weeks. The Director was assigned to the position in January 2018. The ADPCS, who has been in the role since July 2014, served as acting Director from June 2017 to January 2018. The Chief of Staff was also assigned to the position in January 2018; previously, six interim staff filled this position from November 2015 to January 2018. The Associate Director for Outpatient Operations was assigned to the position in June 2017; this was also previously filled by five interim staff from April 2016 to June 2017. The ADPCS and Associate Medical Center Director had maintained their position the longest, having worked together since January 2015.

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<sup>11</sup> 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 2, 2017.)

**Figure 3. Facility Organizational Chart**



Source: Gulf Coast Veterans Health Care System (received January 29, 2018)

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

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

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Facility’s Executive Leadership Board, and 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 Director also serves as chair for the Quality, Safety, and Value Committee, which tracks, trends, and monitors quality of care and patient outcomes. The Executive Leadership Board also oversees various councils, such as the Integrity, Advocacy, and Excellence Councils. See Figure 4.

**Figure 4. Facility Committee Reporting Structure**



Source: Gulf Coast Veterans Health Care System (received January 29, 2018)

## 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 and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017. Tables 1 and 2 provide relevant survey results for VHA and the Facility. As Table 1 indicates, the Facility leaders’ results (Director’s office average) were rated above the VHA and Facility averages; however, the Facility averages were below the VHA

average.<sup>12</sup> In all, opportunities appear to exist to improve employee attitudes toward leadership. Facility leaders were actively discussing opportunities to engage with employees and were working to improve employee satisfaction scores.

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

Questions/Survey Items	Scoring	VHA Average	Facility Average	Director's Office Average <sup>13</sup>
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	3.1	4.3
All Employee Survey: <i>Servant Leader Index Composite</i>	0–100 where HIGHER scores are more favorable	67.7	66.5	74.6

*Source: VA All Employee Survey (accessed December 22, 2017)*

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 survey items that reflect patient attitudes towards Facility leaders. For this Facility, the two inpatient survey results reflected higher care ratings than the VHA averages while the outpatient results reflected lower care ratings compared to the VHA averages. Opportunities appear to exist to improve patients’ experiences in outpatient areas. Facility leaders were working to improve patient satisfaction through service recovery and the Veteran Experience Program, which is an interdisciplinary team that addresses veteran concerns in real-time.

<sup>12</sup> 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.

<sup>13</sup> Rating is based on responses by employees who report to or are aligned under the Director.

**Table 2. Survey Results on Patient Attitudes toward Facility Leadership  
 (October 1, 2016, through 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	79.8
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	84.5
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	66.7
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	75.2	70.2

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

### **Accreditation/For-Cause Surveys<sup>14</sup> and Oversight Inspections**

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 3 summarizes the relevant Facility inspections most recently performed by the OIG and The Joint Commission (TJC).<sup>15</sup> The OIG noted that the

<sup>14</sup> 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.

<sup>15</sup> TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VHA facilities for more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

Facility has closed all recommendations for improvement, with the exception of the recently published OIG Healthcare Inspection report as listed in Table 3.<sup>16</sup>

The OIG also noted the Facility’s current accreditation status with the Commission on Accreditation of Rehabilitation Facilities<sup>17</sup> and College of American Pathologists,<sup>18</sup> which demonstrates the Facility leaders’ commitment to quality care and services. Additionally, the Long Term Care Institute conducted inspections of the Facility’s Community Living Center.<sup>19</sup>

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

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG ( <i>Combined Assessment Program Review of the Gulf Coast Veterans Health Care System, Biloxi, Mississippi, January 20, 2015</i> )	October 2014	18	0
OIG ( <i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Gulf Coast Veterans Health Care System, Biloxi, Mississippi, January 12, 2015</i> )	October 2014	10	0
OIG ( <i>Healthcare Inspection – Alleged Women’s Health Care Issues, Gulf Coast Veterans Health Care System, Biloxi, Mississippi, January 4, 2018</i> )	July 2016	6	5
TJC			
<ul style="list-style-type: none"> <li>• Regular                             <ul style="list-style-type: none"> <li>○ Hospital Accreditation</li> <li>○ Nursing Care Center Accreditation</li> </ul> </li> </ul>	August 2015	11	0
		2	0

<sup>16</sup> 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.

<sup>17</sup> 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.

<sup>18</sup> 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.

<sup>19</sup> 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.

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
<ul style="list-style-type: none"> <li>○ Behavioral Health Care Accreditation</li> <li>○ Home Care Accreditation</li> <li>● Special Unannounced Event<sup>20</sup></li> </ul>	May 2015	4 14 7	0 0 0

Sources: *OIG and TJC (Inspection/survey results verified with the Quality Manager on January 30, 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 4 summarizes key indicators of risk, as reported by the Facility at the time of the site visit, since the OIG’s previous October 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of January 29, 2018.<sup>21</sup>

<sup>20</sup> TJC conducted special focused surveys of VHA organizations and selected CBOCs from October 2014 to September 2015 at VHA’s request in response to whistleblower accounts of improprieties and delays in patient care at the Phoenix VA Health Care System. The Gulf Coast Veterans Health Care System was surveyed as part of this VHA review.

<sup>21</sup> 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 Gulf Coast Veterans Health Care System is a mid-high complexity (1c) affiliated Facility as described in Appendix B.)

**Table 4. Summary of Selected Organizational Risk Factors  
(October 2014 to January 29, 2018)**

Factor	Number of Occurrences
Sentinel Events <sup>22</sup>	3
Institutional Disclosures <sup>23</sup>	7
Large-Scale Disclosures <sup>24</sup>	0

*Source: Gulf Coast Veterans Health Care System's Chief Quality Performance Management (received February 1, 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.<sup>25</sup> The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 5 summarizes Patient Safety Indicator data from October 1, 2015, through September 30, 2017.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 16	Facility
Pressure ulcers	0.60	0.73	0.00
Death among surgical inpatients with serious treatable conditions	100.97	85.80	111.11
Iatrogenic pneumothorax	0.19	0.21	0.47
Central venous catheter-related bloodstream infection	0.15	0.14	0.00
In-hospital fall with hip fracture	0.08	0.02	0.00

<sup>22</sup> A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

<sup>23</sup> 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.

<sup>24</sup> 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.

<sup>25</sup> Agency for Healthcare Research and Quality website. <https://www.qualityindicators.ahrq.gov/>. (Website accessed on March 8, 2017.)

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 16	Facility
Perioperative hemorrhage or hematoma	1.94	1.86	0.00
Postoperative acute kidney injury requiring dialysis	0.88	1.00	0.00
Postoperative respiratory failure	5.55	2.65	0.00
Perioperative pulmonary embolism or deep vein thrombosis	3.29	3.61	5.04
Postoperative sepsis	4.00	4.84	14.08
Postoperative wound dehiscence	0.52	0.00	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.65	0.00

Source: VHA Support Service Center

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

Four Patient Safety Indicator measures (death among surgical inpatients with serious treatable conditions, iatrogenic pneumothorax (lung injury caused by medical treatment in which air has leaked into the area between the lungs and chest wall), perioperative pulmonary embolism (blood clot in the lungs during surgery) or deep vein thrombosis (blood clot in the veins deep in the muscles), and postoperative sepsis (life-threatening inflammatory response to an infection after surgery))<sup>26</sup> show a higher observed rate than Veterans Integrated Service Network (VISN) 16 and VHA. The measures reportedly involved five patients.

The first patient met criteria for three of the four observed higher rates (death among surgical inpatients with serious treatable conditions, perioperative pulmonary embolism or deep vein thrombosis, and postoperative sepsis). The patient had a surgical procedure for a blood clot in March 2017. Following surgery, the patient developed a respiratory infection. The patient continued to deteriorate, resulting in death.

The second patient met criteria for the iatrogenic pneumothorax measure. The patient's oxygen level dropped at the end of the surgical case, and a radiology test revealed the patient had a pneumothorax. The patient was transferred to an outside facility for further care and did not survive.

The third patient met criteria for the perioperative pulmonary embolism or deep vein thrombosis measure. The patient returned for a follow-up evaluation two separate times following a surgical procedure. After the second post-op evaluation, about two weeks after surgery, the patient was started on anti-blood clotting medication.

<sup>26</sup> Medscape, <https://emedicine.medscape.com/article/1017949-overview>. (Website accessed on July 5, 2018.)

The two remaining patients met criteria for inclusion in the postoperative sepsis measure and had surgical procedures for a lung cancer diagnosis. Following the procedures, both patients developed respiratory complications and were transferred to an outside facility for a higher level of care. Both patients' conditions declined and resulted in death.

In summary, the Facility reported that they have reviewed all cases and that the care provided was generally appropriate. The facility stated no process deficiencies were identified during the reviews.

### **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.<sup>27</sup>

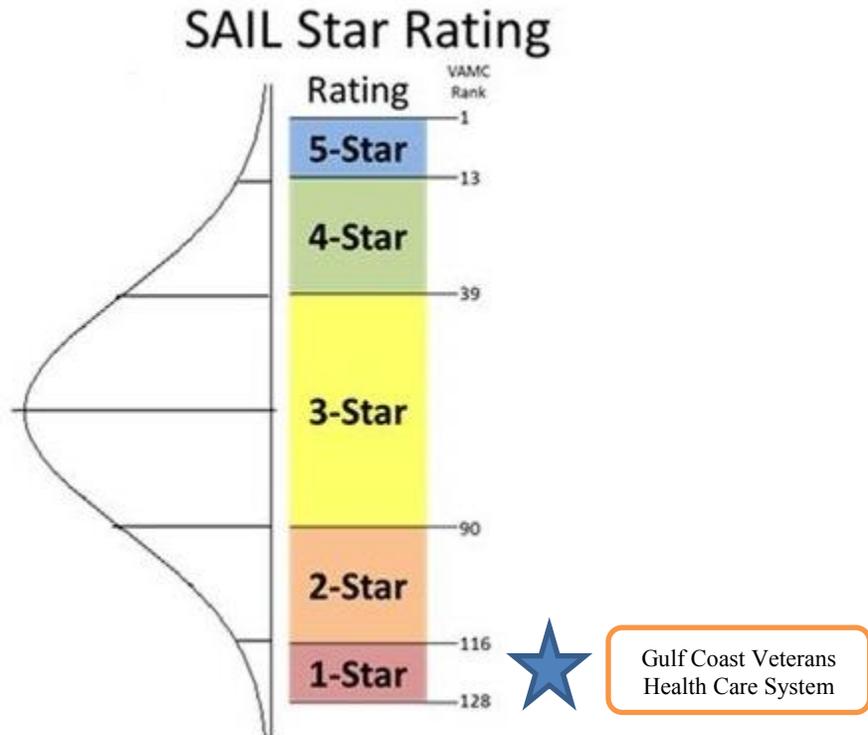
VA also uses a star-rating system that is designed to make model results more accessible for the average user. Facilities with a "5-Star" rating are performing within the top 10 percent of facilities, whereas "1-Star" facilities are performing within the bottom 10 percent of facilities. Figure 4 describes the distribution of facilities by star rating.<sup>28</sup> As of June 30, 2017, the Facility was rated "1 Star" for overall quality.

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<sup>27</sup> 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.)

<sup>28</sup> 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)**

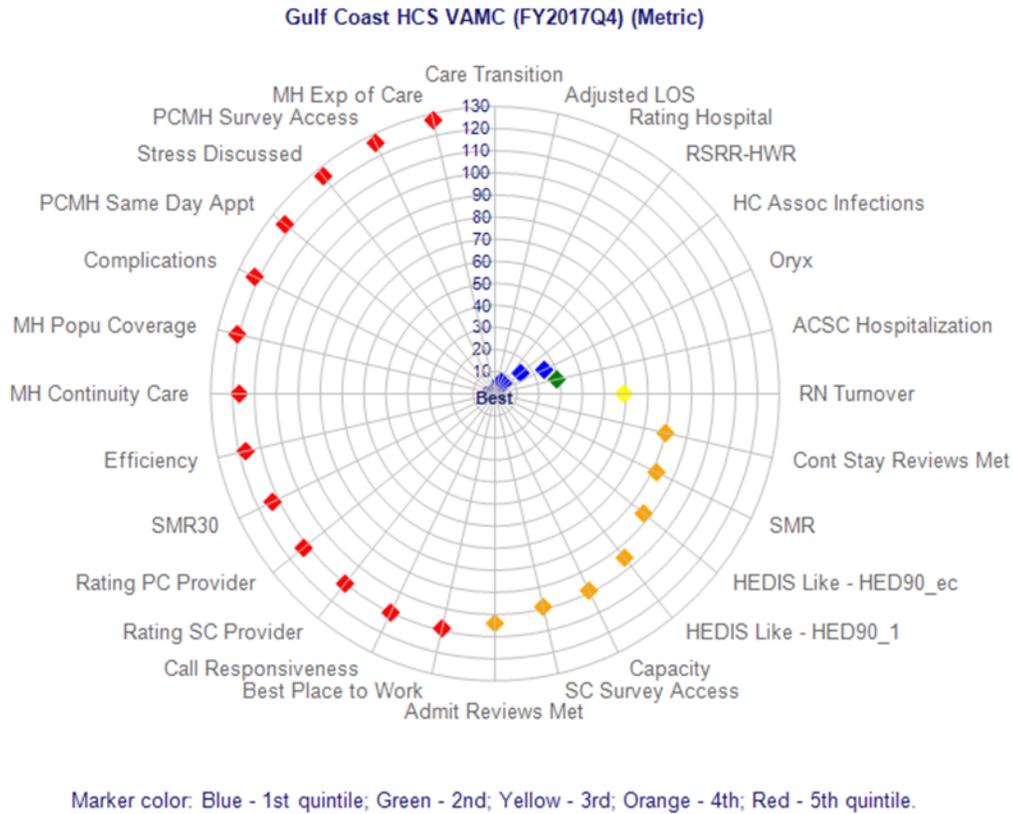


*Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed December 29, 2017)*

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 to indicate high performance (for example, Care Transition, Rating (of) Hospital, and Ambulatory Care Sensitive Condition (ACSC) Hospitalization).<sup>29</sup> Metrics that need improvement are denoted in orange and red (for example, Capacity, Complications, and Mental Health (MH) Experience (Exp) of Care).

<sup>29</sup> 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

At the time of our site visit, the Facility leadership team was still adjusting to the permanent assignment of the Director and Chief of Staff in January 2018. The OIG noted that Facility leaders were actively discussing opportunities to engage with employees and patients and were working to improve the patient experience. Facility leaders appeared to support efforts related to patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the Facility through active stakeholder engagement). 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 leadership team appeared knowledgeable about selected SAIL metrics, the leaders should continue to take significant

actions to improve care and performance of selected Quality of Care and Efficiency metrics that are likely contributing to the “1-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.<sup>30</sup> VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.<sup>31</sup>

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,<sup>32</sup> utilization management (UM) reviews,<sup>33</sup> and patient safety incident reporting with related root cause analyses (RCAs).<sup>34</sup>

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.<sup>35</sup>

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<sup>30</sup> VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

<sup>31</sup> Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

<sup>32</sup> According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff. (Due for recertification June 30, 2015, but has not been updated.)

<sup>33</sup> According to VHA Directive 1117, UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

<sup>34</sup> 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.

<sup>35</sup> 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:<sup>36</sup>

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Entry of all reported patient incidents into WebSPOT<sup>37</sup>
  - Annual completion of a minimum of eight RCAs<sup>38</sup>
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

## Conclusion

The OIG found general compliance with requirements for protected peer review. However, the OIG identified the following deficiencies with UM interdisciplinary review of data and the patient safety annual report, which warranted recommendations for improvement.

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<sup>36</sup> For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

<sup>37</sup> WebSPOT is the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database.

<sup>38</sup> 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.

## Utilization Management: Interdisciplinary Review of Data

VHA requires that an interdisciplinary facility group review UM data.<sup>39</sup> This group must include, but not be limited to, representatives from UM, medicine, nursing, social work, case management, MH, and Chief Business Office Revenue Utilization Review. This ensures that an interdisciplinary approach is taken when reviewing UM data for performance improvement.

The OIG found that the Facility did not have a functional UM Committee; therefore, the OIG requested attendance records of committees where UM data was reviewed. Managers stated that the Patient Flow Committee and the Executive Committee of the Medical Staff were the committees where UM data was reviewed. The OIG reviewed attendance records from these committees. From July 1, 2017, through December 31, 2017, the representative from the Compliance and Business Office did not attend any meetings where UM data was reviewed. In addition, Medical and Behavioral Health Services members did not attend meetings regularly. This resulted in a lack of expertise in the analysis of UM data and program oversight by required representation in required fields. Senior managers reported a lack of understanding of the VHA requirements for membership of the committee responsible for reviewing UM data.

### Recommendation 1

1. The Facility Director ensures that an interdisciplinary facility group reviews utilization management data and monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: The Patient Flow Committee at Gulf Coast Veterans Health Care System is the interdisciplinary committee where UM data is reviewed. During this Committee meeting, key flow metrics are discussed to include data from the Emergency Department as well as UM Admission and Continued Stay review outcomes. In February of 2018, increased monitoring of the attendance at the Patient Flow Committee was initiated to ensure all appropriate disciplines attend in accordance with policy and the national directive. A representative of the Business Office was recently added to the attendance roster as well to ensure someone from that office is present to serve as an active participant. Attendance at the meeting will continue to be monitored and compliance will be demonstrated when all appropriate disciplines are represented for three (3) consecutive months.

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<sup>39</sup> VHA Directive 1117.

## Patient Safety: Annual Report

VHA requires the Patient Safety Manager to submit an annual patient safety report that provides an overview of the patient safety program, relevant data and trends, program successes, and areas for improvement to Facility leaders.<sup>40</sup> The annual report serves to keep Facility leaders informed of patient safety activities and required program functions. The Facility's Annual Safety Report for FY17 was not completed and available for review during the OIG's site visit. As a result, senior Facility managers did not receive a timely consolidated overview of key Patient Safety activities, trends, and analysis for FY17. The Patient Safety Manager reported being assigned additional duties, which caused a lapse in timely submission of the required report.

### Recommendation 2

2. The Facility Director ensures that the Patient Safety Manager submits an annual patient safety report to Facility leaders at the completion of each fiscal year and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: The Patient Safety Annual Report for FY17 was completed on February 15, 2018 and a copy was provided to the Inspector General's office upon completion. The facility consulted with VA's National Center for Patient Safety (NCPS) and determined that there is no official deadline requirement established for the completion of the annual report. The NCPS also noted that some of the information required for completing the report is not available immediately at the conclusion of the previous fiscal year, which in turn affects the timeliness of the report. The facility has set a target that the annual report will be completed by the end of the first quarter of the following fiscal year for all future reports.

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<sup>40</sup> VHA Handbook 1050.01.

## 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).<sup>41</sup>

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.<sup>42</sup>

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.<sup>43</sup>

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,<sup>44</sup> and 20 LIPs who were re-privileged within 12 months prior to the visit.<sup>45</sup> The OIG evaluated the following performance indicators:

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

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<sup>41</sup> VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)

<sup>42</sup> VHA Handbook 1100.19.

<sup>43</sup> VHA Handbook 1100.19.

<sup>44</sup> The 18-month period was from July 29, 2016, through January 29, 2018.

<sup>45</sup> The 12-month review period was from January 29, 2017, through January 29, 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 credentialing requirements. However, the OIG identified deficiencies in documentation requirements related to meeting minutes and FPPE and OPPE processes that warranted recommendations for improvement.

## Documentation of Committee Approval

VHA requires the Executive Committee of the Medical Staff to review and evaluate LIPs' initial and re-privileging requests. Committee minutes must reflect the documents reviewed (for example, FPPE and OPPE results) and the rationale for the stated conclusion. The committee's recommendation is then submitted to the Facility Director for approval.<sup>46</sup> The OIG requested the

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<sup>46</sup> VHA Handbook 1100.19.

relevant months of Executive Committee of the Medical Staff minutes to verify evidence of this documentation. Managers stated that minutes were unavailable for review for four months in FY 2016 and two months in FY 2017. Further, meeting minutes were unsigned (and therefore are considered incomplete) for four months in FY 2016 and one month in FY 2017. This resulted in incomplete evidence to support the Facility Director's approval for granting or continuing privileges. Facility managers stated the reason for noncompliance was due to the lack of consistent oversight by the interim Chiefs of Staff.

### Recommendation 3

3. The Chief of Staff ensures that Executive Committee of the Medical Staff minutes consistently reflect the documents reviewed and the rationale for the stated conclusion in order to recommend approval of clinical privileges for licensed independent practitioners and monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: The Professional Credentials Office and the Chief of Staff's Office has developed a process to improve the Credentialing Committee's information that is communicated upward to the Executive Committee of the Medical Staff (ECMS) and reflected in the ECMS minutes. The Professional Credentials Office now provides a comprehensive summary along with a provider specific report to ECMS at each meeting. The summary contains a narrative write up of the provider that was presented for privileging or re-privileging to the Credentials Committee, as well as the recommendation made by the Committee on that date (e.g., recommend appointment with 90 days Focused Professional Practice Evaluation). This new process ensures that the ECMS minutes reflect what information was considered by both Committees prior to the approval of clinical privileges. Meeting minutes will be monitored to ensure the privileging information is included and compliance will be demonstrated when this is accomplished for three (3) consecutive months.

### Focused Professional Practice Evaluation

VHA requires that managers initiate and document a completed FPPE in the provider profiles of all newly hired practitioners and report the completion to an appropriate committee of the Medical Staff.<sup>47</sup> The process uses objective criteria and involves the evaluation of privilege-specific competence of the practitioner who has not had documented evidence of competently performing the requested privileges. FPPEs may include periodic chart reviews, direct

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<sup>47</sup> VHA Handbook 1100.19

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

For 2 of 10 newly hired LIPs, FPPEs were not initiated. This resulted in inconsistent evaluation of the clinical competency of newly hired providers in delivering quality care. Service chiefs stated shortages in administrative support staff, turnover in key leadership positions, and focus on other priorities resulted in noncompliance.

## Recommendation 4

4. The Chief of Staff ensures service chiefs initiate and complete Focused Professional Practice Evaluations on all newly hired licensed independent practitioners and monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: The Chief of Staff's Office, in collaboration with the Professional Credentials Office, has revised the current tracking system for all newly hired LIPs. New providers are tracked by the Professional Credentials Office to ensure Focused Professional Practice Evaluations (FPPE) are established by the individual Services and reported to the Committee. The Chief of Staff has enhanced the reporting process at the Service level by ensuring that Service Chiefs complete the FPPE within the established timeframe (e.g., 90 days) or provide a sound rationale as to why the FPPE period is to be extended if such a need arises. All FPPE outcomes are to be tracked through the Professional Credentials Committee until completed with outcomes reported up to the Executive Committee of the Medical Staff. Compliance will be demonstrated when 90% or greater of those with required reporting is accomplished for three (3) consecutive months.

## Ongoing Professional Practice Evaluation

VHA requires managers to conduct ongoing professional practice evaluations at least every six months to continually assess the competency of clinical staff for re-privileging.<sup>48</sup> Ongoing monitoring of practitioners' professional performance is essential to confirm the quality of care delivered and allows the Facility to identify professional practice trends that impact the quality of care and patient safety.<sup>49</sup>

In 11 of 20 practitioners' profiles, managers did not complete the required OPPEs. This resulted in insufficient evidence to confirm the quality of care delivered by providers. Clinical leaders

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<sup>48</sup> VHA Handbook 1100.19.

<sup>49</sup> VHA Handbook 1100.19.

stated vacancies and frequent turnover in key leadership positions, lack of confidence in the value of OPPE data, and focus on other priorities resulted in noncompliance.

## Recommendation 5

5. The Chief of Staff ensures that clinical managers consistently review Ongoing Professional Practice Evaluation data every six months and monitors compliance.

Facility concurred.

Target date for completion: November 30, 2018

Facility response: The Chief of Staff's Office, in collaboration with the Professional Credentials Office, has revised the current tracking system for providers who are on an Ongoing Professional Practice Evaluation (OPPE). Providers on an OPPE are tracked by the Professional Credentials Office to ensure the evaluations are established by the individual Services and reported to the Committee. The Chief of Staff has enhanced the reporting process at the Service level by ensuring that Service Chiefs complete the OPPE as required by submitting the completed product to their office for review once the six-month review period has closed. Prior practice was to wait until the Committee met to identify and discuss outstanding OPPE documents. If an OPPE period is to be extended, a sound rationale as to why must be provided. All OPPE outcomes are to be tracked through the Professional Credentials Committee until completed with outcomes reported up to the Executive Committee of the Medical Staff. Providers on an OPPE will be monitored to ensure the evaluations are completed at the end of the six-month period and compliance will be demonstrated when this is accomplished for 90% or greater of those tracked at the end of the next rating period which ends September 30, 2018.

## 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.<sup>50</sup>

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements.<sup>51</sup> The OIG also determined whether the Facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case with a special emphasis on construction safety<sup>52</sup> and Nutrition and Food Services processes.<sup>53</sup>

VHA requires a safe and healthy worksite for staff, patients, and the general public during construction and renovation-related activities. The implementation of a proactive and comprehensive construction safety program reduces the potential for injury, illness, accidents, or exposures.<sup>54</sup>

The Nutrition and Food Services Program must provide quality meals that meet the regulatory requirements for food safety in accordance with the U.S. Food and Drug Administration's Food Code and VHA's food safety program. Facilities must have a hazard analysis critical control point food safety plan, food services inspections, a food service emergency operations plan, and safe food transportation and storage practices.<sup>55</sup>

In all, the OIG inspected five inpatient units (inpatient psychiatry, intensive care, medical/surgical, Community Living Center–Memory Care, and post-anesthesia care), three outpatient clinics (primary care, podiatry, and respiratory therapy), the Emergency Department, Same Day Surgery, and Nutrition and Food Services. The OIG also inspected the Panama City CBOC.<sup>56</sup> Additionally, the OIG reviewed the most recent Infection Prevention Risk Assessment,

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<sup>50</sup> VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

<sup>51</sup> 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).

<sup>52</sup> VHA Directive 7715, *Safety and Health during Construction*, April 6, 2017.

<sup>53</sup> VHA Handbook 1109.04, *Food Service Management Program*, October 11, 2013.

<sup>54</sup> VHA Directive 7715.

<sup>55</sup> VHA Handbook 1109.04.

<sup>56</sup> Each outpatient site selected for physical inspection was randomized from all PC CBOCs, multi-specialty CBOCs, and health care centers reporting to the parent facility and was operational and classified as such in VA's Site Tracking Database by August 15, 2017.

Infection Prevention/Infection Control Committee minutes for the past six months, and other relevant documents, and the OIG 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
- Nutrition and Food Services
  - Hazard Analysis Critical Control Point Food Safety System plan
  - Food Services inspections
  - Emergency operations plan for food service
  - Safe transportation of prepared food
  - Environmental safety
  - Infection prevention
  - Storage areas

The performance indicators below did not apply to this Facility:

- Construction Safety
  - Completion of infection control risk assessment for all sites
  - Infection Prevention/Infection Control Committee discussions on construction activities
  - Dust control
  - Safety and security
  - Selected requirements based on project type and class<sup>57</sup>

## Conclusion

Generally, safety, infection prevention, and privacy measures were in place at the parent Facility and representative CBOC areas. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified deficiencies with EOC rounds attendance and expired labels on sterile surgical instruments that warranted recommendations for improvement.

## Parent Facility's Environment of Care Rounds

VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.<sup>58</sup> From October 1, 2016, through September 30, 2017, the information security officer (a required member of the EOC rounds team) did not consistently attend rounds. This resulted in a lack of subject matter expertise on EOC rounds. Facility managers stated the information security officer is aware of requirement for attendance and of the rounds schedule. However, the information security officer's collateral duties affected the ability to consistently attend rounds.

## Recommendation 6

6. The Associate Director ensures required team member participate in environment of care rounds and monitors compliance.

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<sup>57</sup> VA Master Construction Specifications, Section 01-35-26, Sub-Section 1.12. The Type assigned to construction work ranges from Type A (non-invasive activities) to Type D (major demolition and construction). Type C construction involves work that generates a moderate to high level of dust or requires demolition or removal of any fixed building components or assemblies. The Class assigned to construction work ranges from Class I (low-risk groups affected) to Class IV (highest risk groups affected). Class III construction projects affect patients in high-risk areas such as the Emergency Department, inpatient medical and surgical units, and the pharmacy.

<sup>58</sup> VHA Directive 1608.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: To ensure the Information Security is represented during Environment of Care Rounds, a designee has been appointed by the agency to support the Office in this area. The designee is the Administrative Officer for the Joint Ambulatory Care Center located in Pensacola, FL. This person will represent the Information Security Office, in the absence of the Information Security Officer, as needed to ensure continuity of practice across the health care system to include the Community Outpatient Based Clinics (CBOC's). Compliance will be demonstrated when the Information Security Office is represented at 85% or greater of the assigned EOC rounds.

### **Parent Facility: Sterile Surgical Instruments**

VHA requires that sterilized materials are to be packaged, labeled, and stored in a manner to ensure package integrity.<sup>59</sup> This ensures the instruments are sterilized according to guidelines and ready for use. In the podiatry clinic, the OIG found several storage bins containing surgical instruments labeled with expiration dates in 2013. This resulted in the potential for inappropriate use of these instruments on patients. The Chief of Sterile Processing Service stated that in 2016 the Facility switched from using expiration dates to using an expiration statement;<sup>60</sup> however, clinic managers stated that staff failed to check the expiration dates on supplies stored in the podiatry clinic and re-label them with expiration statements.

### **Recommendation 7**

7. The Associate Director ensures sterilized surgical instruments in the podiatry clinic are appropriately labeled with expiration dates or statements and monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: Soon after the review, actions were implemented by the facility to address this finding. Those actions include: Reminding clinic staff of the "First In First Out" principle regarding their inventory control; Sterile Processing, Quality and Infection Control collaborating on rounds and communicating to end-users the expectation that equipment dates must be

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<sup>59</sup> According to VHA Directive 1116(2), *Sterile Processing Services*, March 23, 2016, expiration statements such as "sterile unless opened or damaged" are acceptable. This label must be placed on the outside of the surgical instrument packages.

<sup>60</sup> VHA Directive 1116(2).

checked for expiration prior to use and discarded if the expiration date has been reached; Spot checks were initiated by Sterile Processing Service for clinical areas, wards, the Intensive Care Unit and the operating room with outcomes reported through the Reusable Medical Equipment Committee; and clinical sites such as the operating room were visited and all RME dated >3 years were removed and/or, reprocessed. Compliance will be demonstrated when no outdated RME is found in the Podiatry Clinic for three (3) consecutive months.

## 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.<sup>61</sup> 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.<sup>62</sup>

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.<sup>63</sup> 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.<sup>64</sup> The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;<sup>65</sup> monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;<sup>66</sup> CS inspection quarterly trend reports for the prior four quarters;<sup>67</sup> 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

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<sup>61</sup> Drug Enforcement Agency Controlled Substance Schedules. <https://www.deadiversion.usdoj.gov/schedules/>. (Website accessed on August 21, 2017.)

<sup>62</sup> 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.

<sup>63</sup> VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (Amended March 6, 2017).

<sup>64</sup> 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.

<sup>65</sup> The review period was July 1, 2017, through December 31, 2017.

<sup>66</sup> The review period was January 1, 2017, through December 31, 2017.

<sup>67</sup> The four quarters were from October 1, 2016, through September 30, 2017.

- CS ordering processes
- Inventory completion during Chief of Pharmacy transition
- Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from conflicts of interest
  - Appointed in writing by the Director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSIs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated
  - Security and documentation of drugs held for destruction<sup>68</sup>

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<sup>68</sup> 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.

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

## Conclusion

The OIG found general compliance with the requirements for CSC reports and CSIs; however, the OIG identified the following deficiencies that warranted a recommendation for improvement.

### Annual Physical Security Survey

VHA requires that a physical security survey be conducted annually to ensure effective planning and utilization of security resources.<sup>69</sup> This also ensures security of CS and staff in the pharmacy areas. The Facility's 2017 annual physical security survey report identified two findings. Facility managers did not provide evidence to the OIG that work orders were submitted or that the deficiencies were corrected. This could potentially result in the loss or theft of CS. The Chief of Quality and Performance indicated that a lack of oversight contributed to the failure to track or monitor deficiencies from the security survey.

### Recommendation 8

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

Facility concurred.

Target date for completion: October 31, 2018

Facility response: The FY 18 Physical Security Surveys have been completed as required by Police Service. The verbiage in the Physical Security Surveys was changed to alleviate any perception of optional versus mandated requirements with regards to corrective actions such as inputting work orders for identified deficiencies. Police Service has created a tracking tool for all deficiencies and will work collaboratively with responsible Services (e.g., Pharmacy, Engineering) to track findings until closure. Findings and associated corrective actions (e.g., work orders) will be monitored/tracked through the Environment of Care Committee. The Controlled Substance Inspection Coordinator will be tracking to ensure resolution as well.

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<sup>69</sup> VHA Directive 1108.2(1).

Compliance will be demonstrated once all identified deficiencies on the FY 18 Surveys have been addressed.

### **Alternate Controlled Substance Coordinator Duties**

VHA requires assignment of CSC duties in the employee's position description or functional statement.<sup>70</sup> These duties may be added as an addendum to the job description. This ensures that the Director can discuss the duties and the time commitment with the CSC. The OIG was provided a copy of the Alternate CSC's position description; however, it did not contain the CSC duties as required nor was there an addendum attached that identified the CSC duties. This could result in unclear communication of duties and expectations. Facility managers stated that the reason for noncompliance was a miscommunication between the alternate CSC's supervisor and the Human Resource Department, and there was no follow up to ensure that the duties were included.

### **Recommendation 9**

9. The Facility Director ensures that the Alternate Controlled Substance Coordinator's position description or functional statement includes an addendum for the Controlled Substance Coordinator's duties and monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: Corrective action was taken on March 12, 2018 to ensure the Alternate Controlled Substance Coordinator had an addendum added to the position description outlining the duties of the position. Compliance with this recommendation has been established and at the outset of the next fiscal year, the addendum will be reviewed with the designated employee to ensure compliance for FY19.

### **Controlled Substances Area Inspections: Monthly Inspections**

VHA requires CSIs to conduct monthly inspections of CS storage areas.<sup>71</sup> This ensures the integrity of the CSI program. The OIG noted that for 6 of 11 clinical areas, monthly inspection checklists were incomplete for the six-month review period (July to December 2017). This compromised the integrity of the CS inspection program. The CSC acknowledged lack of oversight as the reason for noncompliance.

<sup>70</sup> VHA Directive 1108.2(1).

<sup>71</sup> VHA Directive 1108.2(1).

## Recommendation 10

10. The Facility Director ensures that monthly controlled substance inspections are completed in all required areas and monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: Since the review, the Controlled Substance Coordinator (CSC) has been working with the Inspectors to reinforce previously established processes to ensure that monthly inspections are completed in all required areas. The CSC has reinforced that Inspectors should strive to complete their assigned inspection by the 3<sup>rd</sup> week of the month. If the CSC finds an inspection has not been completed by the end of the 3<sup>rd</sup> week, the Inspector is contacted to discuss the matter. If the inspection is not completed by the 26<sup>th</sup> of the month, the CSC completes the inspection. Compliance will be demonstrated when 100% of all assigned and required inspections are completed for three (3) consecutive months.

## Controlled Substances Storage Areas Inspections: Completion on Day Initiated

VHA requires that the physical inventory of the CS storage areas be completed monthly, on the same day initiated.<sup>72</sup> This helps to ensure accountability for all CS. For 9 of 11 areas, the OIG did not find evidence that monthly inspections were completed on the day the inspection was initiated. The documentation contained initiation and completion dates that had gaps in time from days to weeks. This resulted in a potential lack of accountability for all CS. The CSC acknowledged the lack of oversight as the reason for noncompliance.

## Recommendation 11

11. The Facility Director ensures that all controlled substance inspectors complete the physical inventory of the controlled substance storage areas on the same day initiated and monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: Since the review, the Controlled Substance Coordinator (CSC) has been working with the Inspectors to reinforce previously established processes to ensure that the physical inventory of the controlled substance storage areas are completed on the same date the

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<sup>72</sup> VHA Directive 1108.2(1).

inspection is initiated. Greater emphasis has been placed on this requirement during the initial and refresher training of the Inspectors as well. The CSC reviews all inspection reports as they are completed to ensure this standard is met and follows up with corrective actions if necessary. Compliance will be demonstrated when 100% of all reports reflect compliance with this inspection standard for three (3) consecutive months.

## **Pharmacy Inspections: Controlled Substance Monthly Physical Count**

VHA requires a complete physical count of CS in the pharmacy during the first month of each quarter and a random physical count of 50 line items during the other two months.<sup>73</sup> Completion of the physical count on the same day ensures accountability for CS in the pharmacy areas. The OIG noted that for two of the pharmacy areas, the inspection checklists were not complete. The CSC said that the reason for noncompliance was lack of adequate oversight of the inspection documentation.

### **Recommendation 12**

12. The Facility Director ensures that required pharmacy inspections are completed monthly and monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: Since the review, the Controlled Substance Coordinator (CSC) has worked with Inspectors to reinforce previously established processes to ensure monthly inspections are completed as required. The CSC has reinforced that Inspectors should strive to complete their assigned inspection by the 3rd week of the month. If the CSC finds an inspection has not been completed, the Inspector is contacted to discuss the matter. If the inspection is not completed by the 26th of the month, the CSC completes the inspection. Compliance will be demonstrated when 100% of all assigned and required inspections are completed for three (3) consecutive months.

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<sup>73</sup> VHA Directive 1108.2(1).

## 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.”<sup>74</sup> 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.<sup>75</sup>

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.<sup>76</sup> 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.<sup>77</sup>

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 43 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

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<sup>74</sup> VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (rescinded November 16, 2017).

<sup>75</sup> VHA Handbook 1160.03.

<sup>76</sup> 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.

<sup>77</sup> 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 OIG noted compliance with provider documentation of further diagnostic evaluation being offered, referred, and completed. However, the OIG identified a deficiency in timely completion of suicide risk assessments that warranted a recommendation for improvement.

## Suicide Risk Assessments

VHA requires an appropriate provider to complete a suicide risk assessment for patients with a positive PTSD screen by the end of the next business day to ensure immediate safety risks are identified and addressed.<sup>78</sup> The OIG estimated that providers completed suicide risk assessments by the end of the next business day in 72 percent of the EHRs reviewed; 95 percent of the time, the true compliance rate is between 58.0 and 85.9 percent, which is statistically significantly below the 90 percent benchmark. Facility managers could not attribute a specific reason why the suicide risk assessments were not completed timely on all patients with positive PTSD screens.

## Recommendation 13

13. The Chief of Staff ensures that providers complete suicide risk assessments within the required timeframe for patients with positive Posttraumatic Stress Disorder screens and monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: Behavioral Health Suicide Prevention staff will provide in-depth training on the proper process to address positive Posttraumatic Stress Disorder (PTSD) screenings and Suicide Risk Screenings to the Chief Medical Officers in the outpatient setting. This information is to be disseminated to the providers in these settings as well. In addition, all Behavioral Health staff will be retrained on the screening process and appropriate documentation requirements. Lastly, a tool is now being utilized to identify Veterans whose screenings were missed. This report is reviewed daily by the Suicide Prevention Coordinators and will be used as an aid to take appropriate action on addressing the missing screens. Compliance will be demonstrated when

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<sup>78</sup> Department of Veterans Affairs, Information Bulletin: *Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 6, 2015.

90% of the identified suicide risk assessments are completed within the required timeframe for patients with a positive PTSD screen for three (3) consecutive months.

## 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.<sup>79</sup> 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.<sup>80</sup> 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.<sup>81</sup>

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.<sup>82</sup> 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.<sup>83</sup> 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.<sup>84</sup>

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 45 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

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<sup>79</sup> VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

<sup>80</sup> VHA Directive 1140.04.

<sup>81</sup> 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.

<sup>82</sup> Public Law 106-117.

<sup>83</sup> VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

<sup>84</sup> VHA Directive 1140.04.

- Assessment by GE nurse
- 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.<sup>85</sup> Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veterans Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.<sup>86</sup> The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services, including mammography services to eligible women veterans.<sup>87</sup>

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Verbal communication with patients must be documented.<sup>88</sup>

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

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<sup>85</sup> U.S. Breast Cancer Statistics. <http://www.BreastCancer.org>. (Website accessed on May 18, 2017.)

<sup>86</sup> Veterans Health Care Amendments of 1983, Pub. L. 98-160 (1983).

<sup>87</sup> Veterans Health Care Act of 1992, Title I, Pub. L. 102-585 (1992).

<sup>88</sup> VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017, and further amended July 24, 2018); VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011, which was rescinded and replaced by VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 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.<sup>89</sup> 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,”<sup>90</sup> 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.<sup>91</sup>

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.”<sup>92</sup>

Infections occurring on or after the third calendar day following admission to an inpatient location are considered “healthcare-associated.”<sup>93</sup> 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.<sup>94</sup>

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 35 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

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<sup>89</sup> TJC. Infection Control and National Patient Safety Goals: IC.01.03.01, EP 4, 5, July 2017.

<sup>90</sup> Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

<sup>91</sup> These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.

<sup>92</sup> The Centers for Disease Control and Prevention, *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011.

<sup>93</sup> 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.

<sup>94</sup> 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 requirements 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"> <li>• Executive leadership stability and engagement</li> <li>• Employee satisfaction and patient experience</li> <li>• Accreditation/for-cause surveys and oversight inspections</li> <li>• Indicators for possible lapses in care</li> <li>• VHA performance data</li> </ul>	Thirteen 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 Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> <li>• Protected peer review of clinical care</li> <li>• UM reviews</li> <li>• Patient safety incident reporting and RCAs</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• An interdisciplinary facility group reviews UM data.</li> <li>• The Patient Safety Manager submits an annual patient safety report to Facility leaders at the completion of each FY.</li> </ul>
Credentialing and Privileging	<ul style="list-style-type: none"> <li>• Medical licenses</li> <li>• Privileges</li> <li>• FPPEs</li> <li>• OPPEs</li> </ul>	<ul style="list-style-type: none"> <li>• Service chiefs initiate and complete FPPEs on all newly hired LIPs.</li> <li>• Clinical managers consistently review OPPE data every six months.</li> </ul>	<ul style="list-style-type: none"> <li>• Executive Committee of the Medical Staff minutes consistently reflect the documents reviewed and the rationale for the stated conclusion in order to recommend approval of clinical privileges for LIPs.</li> </ul>

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	<ul style="list-style-type: none"> <li>• Parent Facility                             <ul style="list-style-type: none"> <li>○ EOC rounds and deficiency tracking</li> <li>○ Infection prevention</li> <li>○ General safety</li> <li>○ Environmental cleanliness</li> <li>○ General and exam room privacy</li> <li>○ Availability of medical equipment and supplies</li> </ul> </li> <li>• CBOC                             <ul style="list-style-type: none"> <li>○ General safety</li> <li>○ Medication safety and security</li> <li>○ Infection prevention</li> <li>○ Environmental cleanliness</li> <li>○ General and exam room privacy</li> <li>○ Availability of medical equipment and supplies</li> </ul> </li> <li>• Construction Safety                             <ul style="list-style-type: none"> <li>○ Infection control risk assessment</li> <li>○ Infection Prevention/ Infection Control Committee discussions</li> <li>○ Dust control</li> <li>○ Safety/security</li> <li>○ Selected requirements based on project type and class</li> </ul> </li> <li>• Nutrition and Food Services                             <ul style="list-style-type: none"> <li>○ Hazard Analysis Critical Control Point Food Safety System plan</li> <li>○ Food Services inspections</li> <li>○ Safe transportation of prepared food</li> <li>○ Environmental safety</li> <li>○ Infection prevention</li> <li>○ Storage areas</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• Required team members participate in EOC rounds.</li> <li>• Sterilized surgical instruments in the podiatry clinic are appropriately labeled with expiration dates or statements.</li> </ul>

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	<ul style="list-style-type: none"> <li>• CSC reports</li> <li>• Pharmacy operations</li> <li>• Annual physical security survey</li> <li>• CS ordering processes</li> <li>• Inventory completion during Chief of Pharmacy transition</li> <li>• Review of balance adjustments</li> <li>• CSC requirements</li> <li>• CSI requirements</li> <li>• CS area inspections</li> <li>• Pharmacy inspections</li> </ul>	<ul style="list-style-type: none"> <li>• All deficiencies identified on the Annual Physical Security Survey are corrected.</li> <li>• Monthly CS inspections are completed in all required areas.</li> <li>• All CSIs complete the physical inventory of the CS storage areas on the same day initiated.</li> <li>• Pharmacy inspections are completed monthly.</li> </ul>	<ul style="list-style-type: none"> <li>• The Alternate CSC's position description or functional statement includes an addendum for the CSC's duties.</li> </ul>
Mental Health Care: Posttraumatic Stress Disorder Care	<ul style="list-style-type: none"> <li>• Suicide risk assessment</li> <li>• Offer of further diagnostic evaluation</li> <li>• Referral for diagnostic evaluation</li> <li>• Completion of diagnostic evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• Providers complete suicide risk assessments within the required timeframe for patients with positive PTSD screens.</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Long-Term Care: Geriatric Evaluations	<ul style="list-style-type: none"> <li>• Provision of or access to GE</li> <li>• Program oversight and evaluation</li> <li>• Provision of clinical care</li> <li>• Geriatric management</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Women's Health: Mammography Results and Follow-Up	<ul style="list-style-type: none"> <li>• Result linking</li> <li>• Report scanning and content</li> <li>• Communication of results and recommended actions</li> <li>• Follow-up mammograms and studies</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
High-Risk Processes: Central Line-Associated Bloodstream Infections	<ul style="list-style-type: none"> <li>• Policy and infection prevention risk assessment</li> <li>• Committee discussion</li> <li>• Infection incidence data</li> <li>• Education and</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

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

## Appendix B: Facility Profile and VA Outpatient Clinic Profiles

### Facility Profile

The table below provides general background information for this mid-high complexity (1c)<sup>95</sup> affiliated<sup>96</sup> Facility reporting to VISN 16.

**Table 6. Facility Profile for Biloxi (520)  
 (October 1, 2014, through September 30, 2017)**

Profile Element	Facility Data FY 2015 <sup>97</sup>	Facility Data FY 2016 <sup>98</sup>	Facility Data FY 2017 <sup>99</sup>
Total Medical Care Budget in Millions	\$416.2	\$442.3	\$452.9
Number of:			
• Unique Patients	68,693	68,340	70,127
• Outpatient Visits	706,024	711,104	713,482
• Unique Employees <sup>100</sup>	1,876	1,895	1,946
Type and Number of Operating Beds:			
• Blind Rehabilitation	18	18	18
• Community Living Center	101	101	101
• Domiciliary	72	72	72
• Medicine	33	33	24
• Mental Health	22	22	22
• Surgery	10	10	6
Average Daily Census:			
• Blind Rehabilitation	15	16	16
• Community Living Center	84	76	77

<sup>95</sup> The VHA medical centers are classified according to a facility complexity model; 1c designation indicates a Facility with medium-high volume, medium-risk patients, some complex clinical programs, and medium-sized research and teaching programs.

<sup>96</sup> Associated with a medical residency program.

<sup>97</sup> October 1, 2014, through September 30, 2015.

<sup>98</sup> October 1, 2015, through September 30, 2016.

<sup>99</sup> October 1, 2016, through September 30, 2017.

<sup>100</sup> Unique employees involved in direct medical care (cost center 8200).

<b>Profile Element</b>	<b>Facility Data FY 2015<sup>97</sup></b>	<b>Facility Data FY 2016<sup>98</sup></b>	<b>Facility Data FY 2017<sup>99</sup></b>
• Domiciliary	67	65	62
• Medicine	17	13	10
• Mental Health	22	17	16
• Surgery	2	3	2

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

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

## VA Outpatient Clinic Profiles<sup>101</sup>

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

**Table 7. VA Outpatient Clinic Workload/Encounters<sup>102</sup> 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 <sup>103</sup> Provided	Diagnostic Services <sup>104</sup> Provided	Ancillary Services <sup>105</sup> Provided
Eglin Air Force Base, FL	520GC	19,870	7,245	Dermatology Endocrinology Gastroenterology Nephrology Cardio Thoracic Vascular	Laboratory & Pathology Radiology	Nutrition Pharmacy Weight Management Dental

<sup>101</sup> Includes all outpatient clinics in the community that were in operation as of August 15, 2017.

<sup>102</sup> An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.

<sup>103</sup> Specialty care services refer to non-PC and non-MH services provided by a physician.

<sup>104</sup> Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

<sup>105</sup> 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 <sup>103</sup> Provided	Diagnostic Services <sup>104</sup> Provided	Ancillary Services <sup>105</sup> Provided
Mobile, AL	520GA	23,608	17,628	Dermatology Endocrinology Gastroenterology Nephrology Neurology Cardio Thoracic Eye General Surgery GYN Orthopedics Podiatry Vascular	Laboratory & Pathology Radiology	Nutrition Pharmacy Social Work Weight Management
Panama City Beach, FL,	520GB	20,149	6,323	Cardiology Dermatology Endocrinology Gastroenterology Nephrology Rehab Physician Anesthesia Cardio Thoracic General Surgery Vascular	Laboratory & Pathology Radiology	Nutrition Pharmacy Prosthetics Social Work Weight Management Dental
Panama City Beach West, FL	520QA	1	1,347	Dermatology	n/a	Nutrition Weight Management

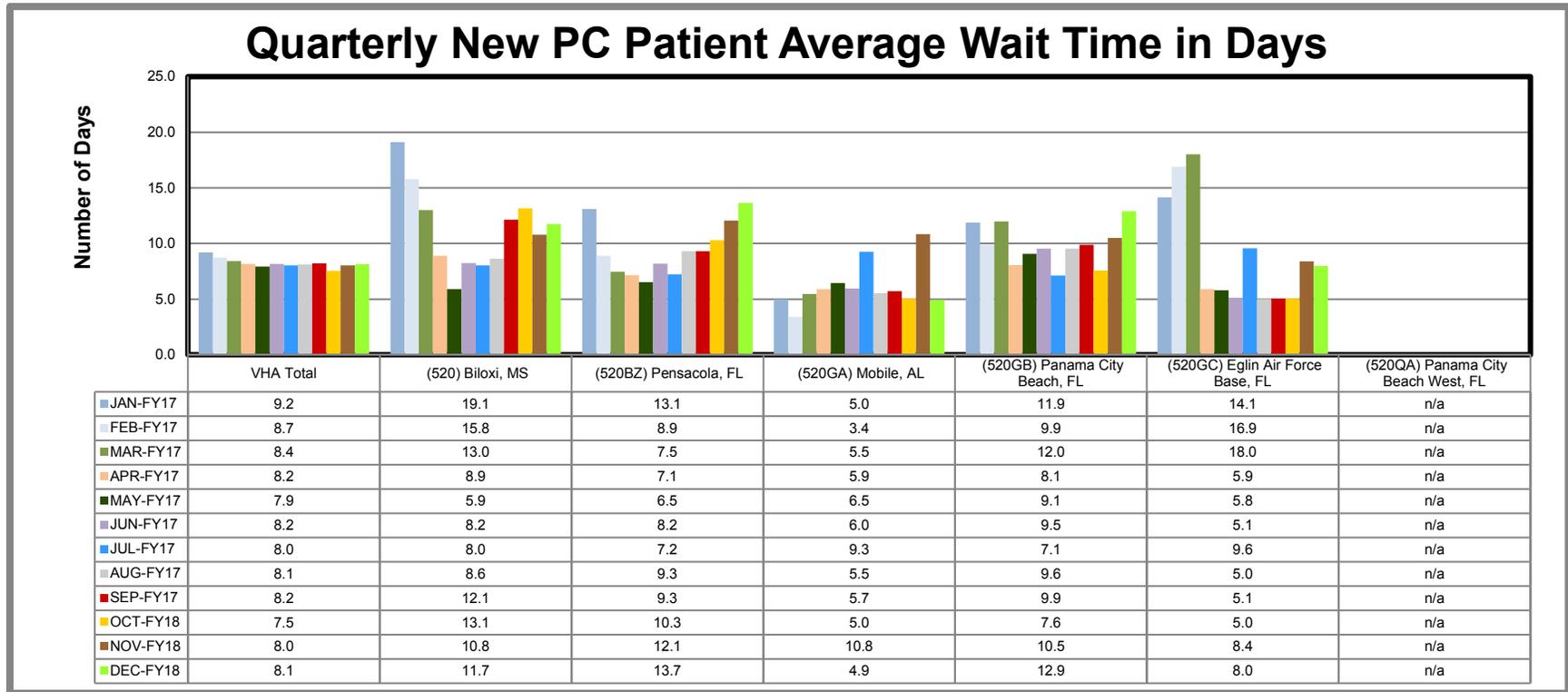
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services <sup>103</sup> Provided	Diagnostic Services <sup>104</sup> Provided	Ancillary Services <sup>105</sup> Provided
Pensacola, FL	520BZ	40,861	26,435	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Nephrology Neurology Pulmonary/ Respiratory Disease Rheumatology Poly-Trauma Rehab Physician Spinal Cord Injury Cardio Thoracic Eye General Surgery GYN Orthopedics Otolaryngology Podiatry Urology Vascular	EKG EMG Laboratory & Pathology Nuclear Med Radiology Vascular Lab	Nutrition Pharmacy Prosthetics Social Work Weight Management Dental

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

n/a = not applicable

## Appendix C: Patient Aligned Care Team Compass Metrics<sup>106</sup>



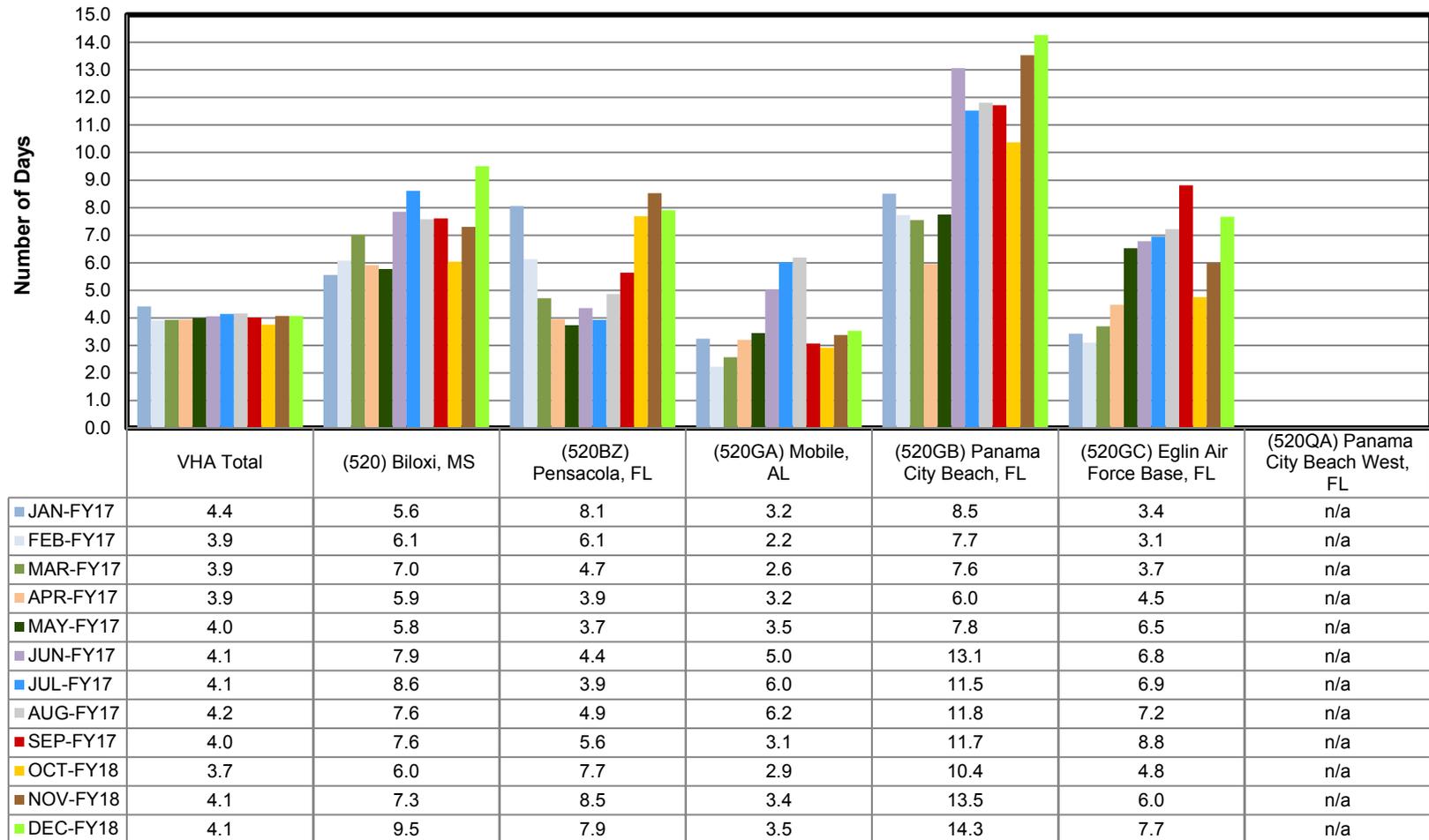
Source: VHA Support Service Center

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

**Data Definition:** The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. Note that prior to FY 2015, this metric was calculated using the earliest possible create date. The absence of reported data is indicated by "n/a."

<sup>106</sup> Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.

### Quarterly Established PC Patient Average Wait Time in Days

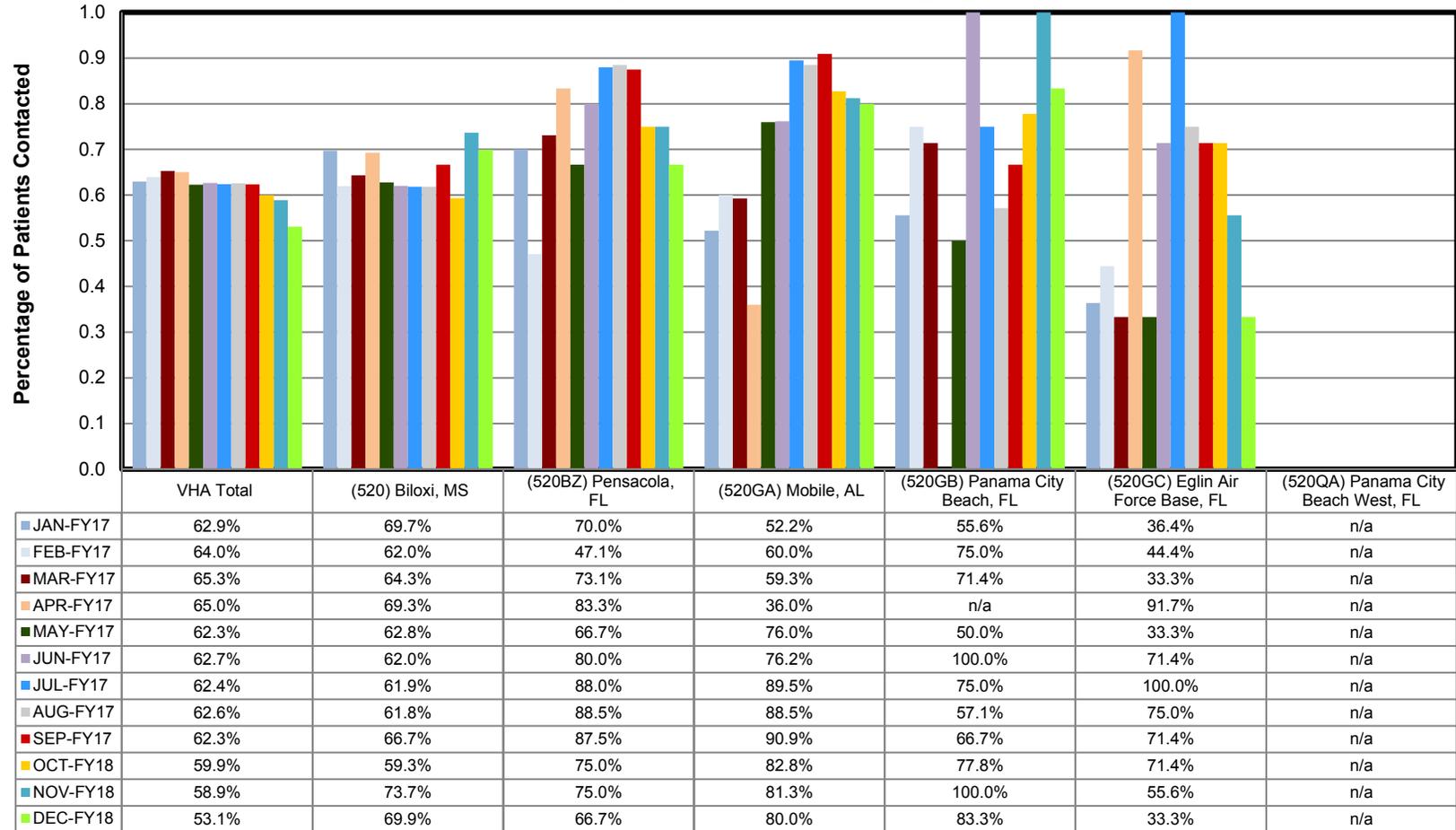


Source: VHA Support Service Center

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

**Data Definition:** The average number of calendar days between an established patient’s PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. The absence of reported data is indicated by “n/a.”

## Quarterly Team 2-Day Post Discharge Contact Ratio

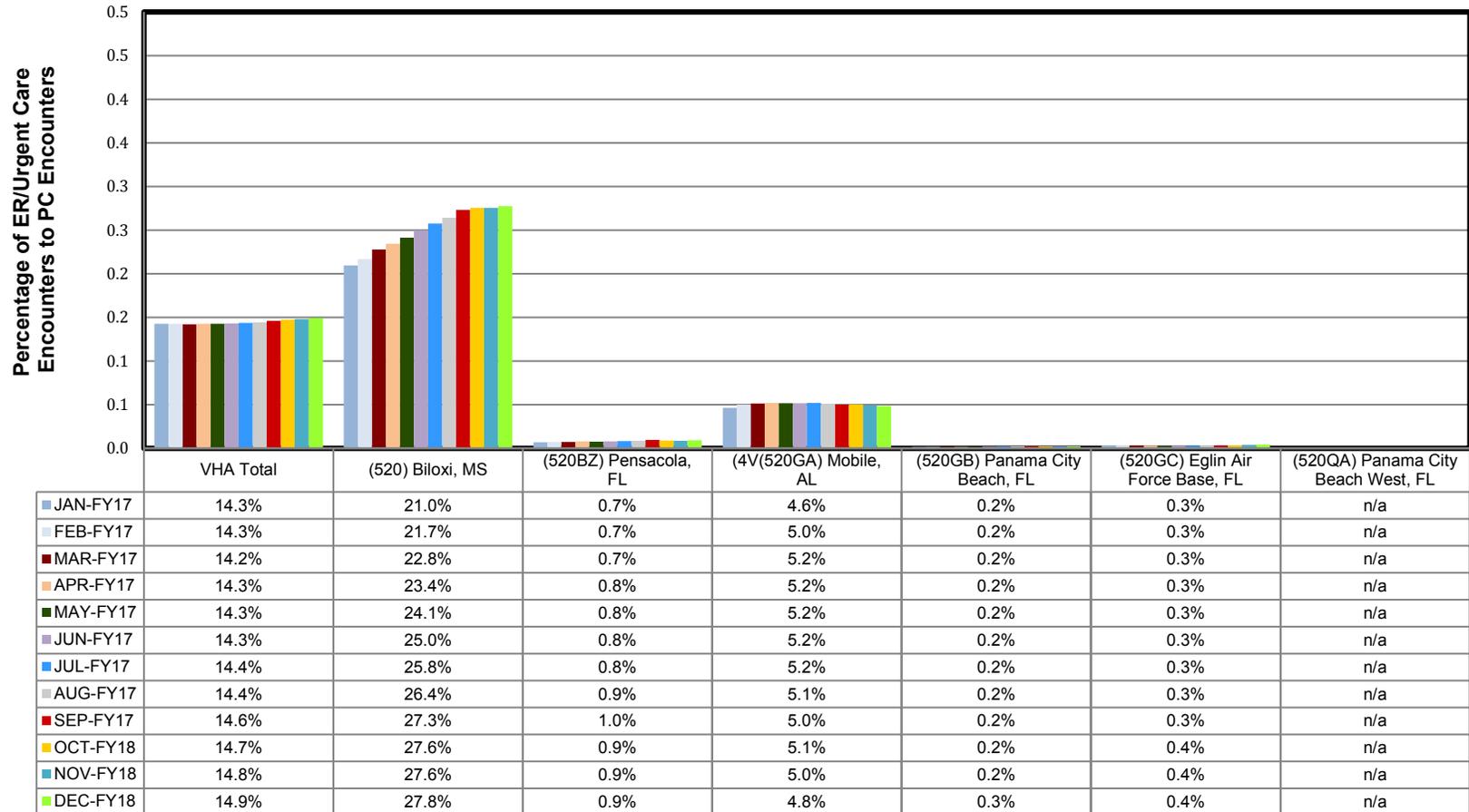


Source: VHA Support Service Center

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

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

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



Source: VHA Support Service Center

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

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

## Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions<sup>107</sup>

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

<sup>107</sup> VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: February 14, 2018.

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

Measure	Definition	Desired Direction
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value

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

*Source: VHA Support Service Center*

## Appendix E: VISN Director Comments

### Department of Veterans Affairs Memorandum

Date: July 16, 2018

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

Subj: CHIP Review of the Gulf Coast Veterans Health Care System, Biloxi, MS

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

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

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the findings, recommendations, and action plans submitted by the Gulf Coast Veterans Health Care System, Biloxi, MS, in response to the OIG Draft Report.
2. Please contact the VISN QMO if you have questions.

*(Original signed by:)*

Skye McDougall, PhD  
Director, South Central VA Health Care Network (10N16)

*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: July 16, 2018

From: Director, Gulf Coast Veterans Health Care System (520/00)

Subj: CHIP Review of the Gulf Coast Veterans Health Care System, Biloxi, MS

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

Thank you for the opportunity to review this report. The collaborative, consultative and professional approach of the review team is worth nothing as this contributed greatly to a thorough and beneficial assessment of health care system operations.

I concur with the recommendations outlined in the attached report. All findings have been reviewed and facility level action plans initiated as required.

Sincerely,

*(Original signed by:)*

Brian C. Matthews, MBA

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

## OIG Contact and Staff Acknowledgments

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