DEPARTMENT OF VETERANS AFFAIRS

# OFFICE OF INSPECTOR GENERAL

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

# Comprehensive Healthcare Inspection Program Review of the Erie VA Medical Center

## Pennsylvania

CHIP REPORT | REPORT #18-00618-261 | AUGUST 20, 2018

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***Figure 1.*** *Erie VA Medical Center, Erie, Pennsylvania*
*(Source: https://vaww.va.gov/directory/guide/, accessed on May 24, 2018)*

# Abbreviations

| | |
|---|---|
| CBOC | community based outpatient clinic |
| CHIP | Comprehensive Healthcare Inspection Program |
| 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 |
| OIG | Office of Inspector General |
| LIP | licensed independent practitioner |
| MH | mental health |
| OPPE | Ongoing Professional Practice Evaluation |
| PC | primary care |
| PTSD | post-traumatic stress disorder |
| QSV | quality, safety, and value |
| RCA | root cause analysis |
| SAIL | Strategic Analytics for Improvement and Learning |
| TJC | The Joint Commission |
| UM | utilization management |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Report Overview

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

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

The OIG's current areas of focus are

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

This review was conducted during an unannounced visit made during the week of March 12, 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

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

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), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure, with an Executive Leadership Board having oversight for groups such as the Medical Executive Council, Nursing Executive Council, and Veterans Advisory Council. The leaders are members of the Executive Leadership Board through which they track, trend, and monitor quality of care and patient outcomes.

The OIG found that the Facility leaders had been working together as a team since November 2016. In the review of selected employee and patient survey results regarding Facility leadership, the OIG noted scores that reflected employee and patient satisfaction with Facility leadership.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[2] In context, the current "5-Star" rating demonstrates leadership's continued commitment to improving quality, efficiency, access, and satisfaction.

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

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

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

The OIG noted findings in three of the seven areas of clinical operations reviewed and issued three recommendations that are attributable to the Chief of Staff and ADPCS. These are briefly described below.

## Quality, Safety, and Value

The OIG found general compliance with requirements for utilization management and the processes of reporting patient incident reporting and conducting root cause analyses.[4] However, the OIG identified a deficiency in the protected peer review process.

## Credentialing and Privileging

The OIG found general compliance with requirements for credentialing and privileging and the process of using Focused Professional Practice Evaluations for newly hired providers. However, the OIG identified deficiencies in the Ongoing Professional Practice Evaluations process.

## Environment of Care

The OIG noted a generally safe environment of care, with the exception of one inpatient unit with stained or broken ceiling tiles, four areas with dirty ventilation grills, and an entrance of a construction site missing an adhesive floor mat. The OIG also noted that the representative community based outpatient clinic did not have a secure storage location for medical (biohazardous) waste, and the clean supply room did not have restricted access or solid bottom storage shelves. These conditions were remedied while the OIG was on site. However, the OIG identified a deficiency with medication storage that warranted a recommendation for improvement.

## Summary

In the review of key care processes, the OIG issued three recommendations that are attributable to the Chief of Staff and ADPCS. 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.

[4] 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.

## 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 50–51, 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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Assistant Inspector General
for Healthcare Inspections

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# Purpose and Scope

## Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Erie VA Medical Center (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.[5,6] 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.[7] 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 eight areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management: Controlled Substances (CS) Inspection Program; Mental Health: Post-Traumatic Stress Disorder (PTSD) Care; Long-Term Care: Geriatric Evaluations; and Women's Health: Mammography Results and Follow-up (see Figure 2).[8]

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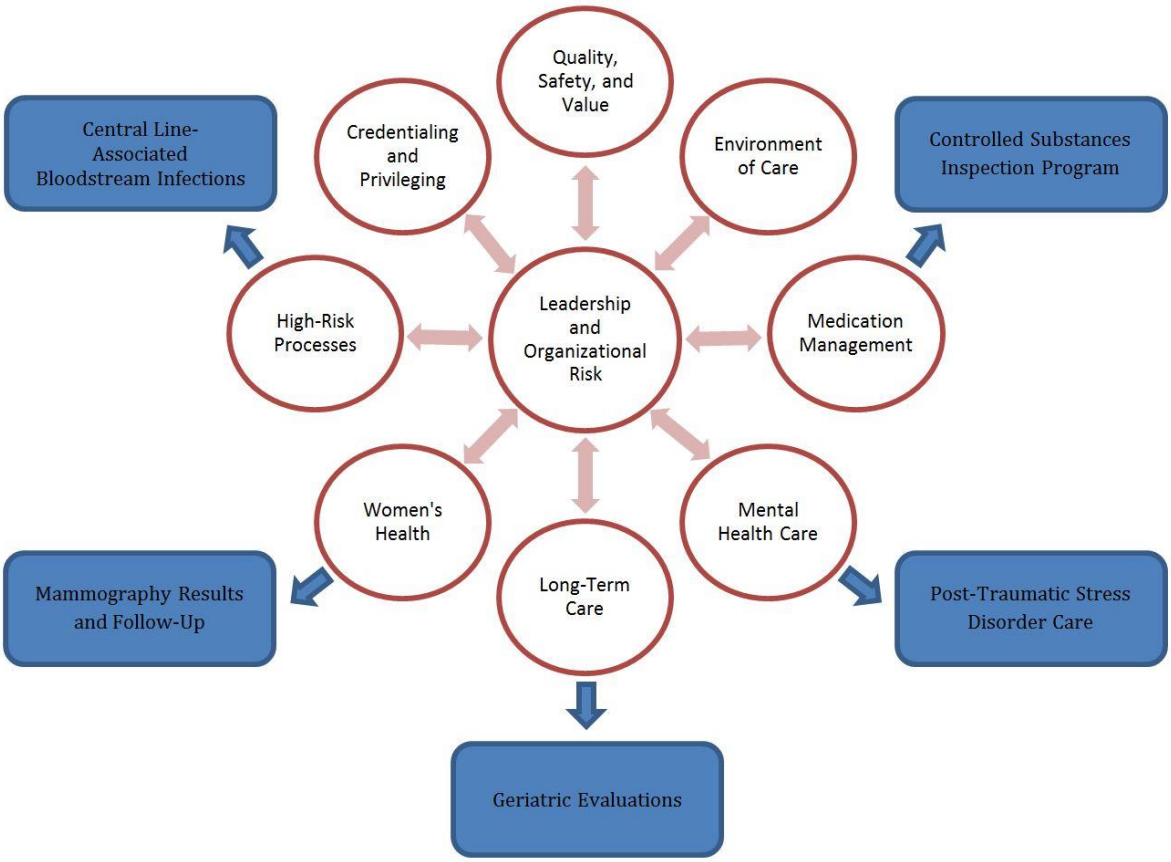
[5] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

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

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

[8] 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;[9] 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 December 1, 2014,[10] through March 12, 2018, the date when an unannounced weeklong site visit commenced. On April 2–3, 2018, the OIG presented crime awareness briefings to 74 of the Facility's 807 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 Director's comments submitted in response to the recommendations in this report appear within each topic area.

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

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

[10] 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.[11] To assess the Facility's risks, the OIG considered the following organizational elements

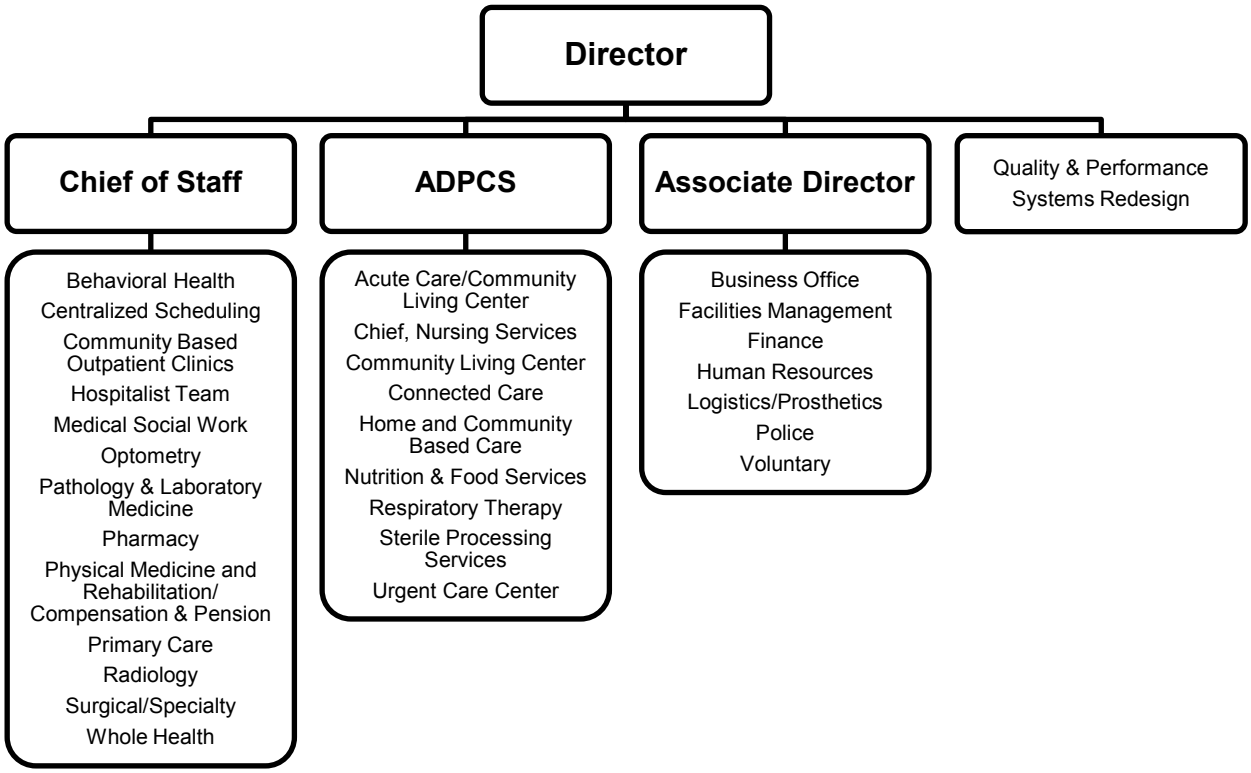
1. Executive leadership stability and engagement,
2. Employee satisfaction and patient experience,
3. Accreditation/for-cause surveys and oversight inspections,
4. Indicators for possible lapses in care, and
5. VHA performance data.

### 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's leaders are led by the Director, who was appointed to the position in June 2016. The Chief of Staff and Associate Director for Patient Care Services (ADPCS) assumed their positions in March 2015 and May 2011, respectively. The Associate Director was most recently appointed in November 2016, so the leaders had worked together as a team for approximately seventeen months prior to the OIG site visit. The Chief of Staff and ADPCS are responsible for overseeing patient care and service directors, as well as program and practice chiefs.

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

**Figure 3. Facility Organizational Chart**



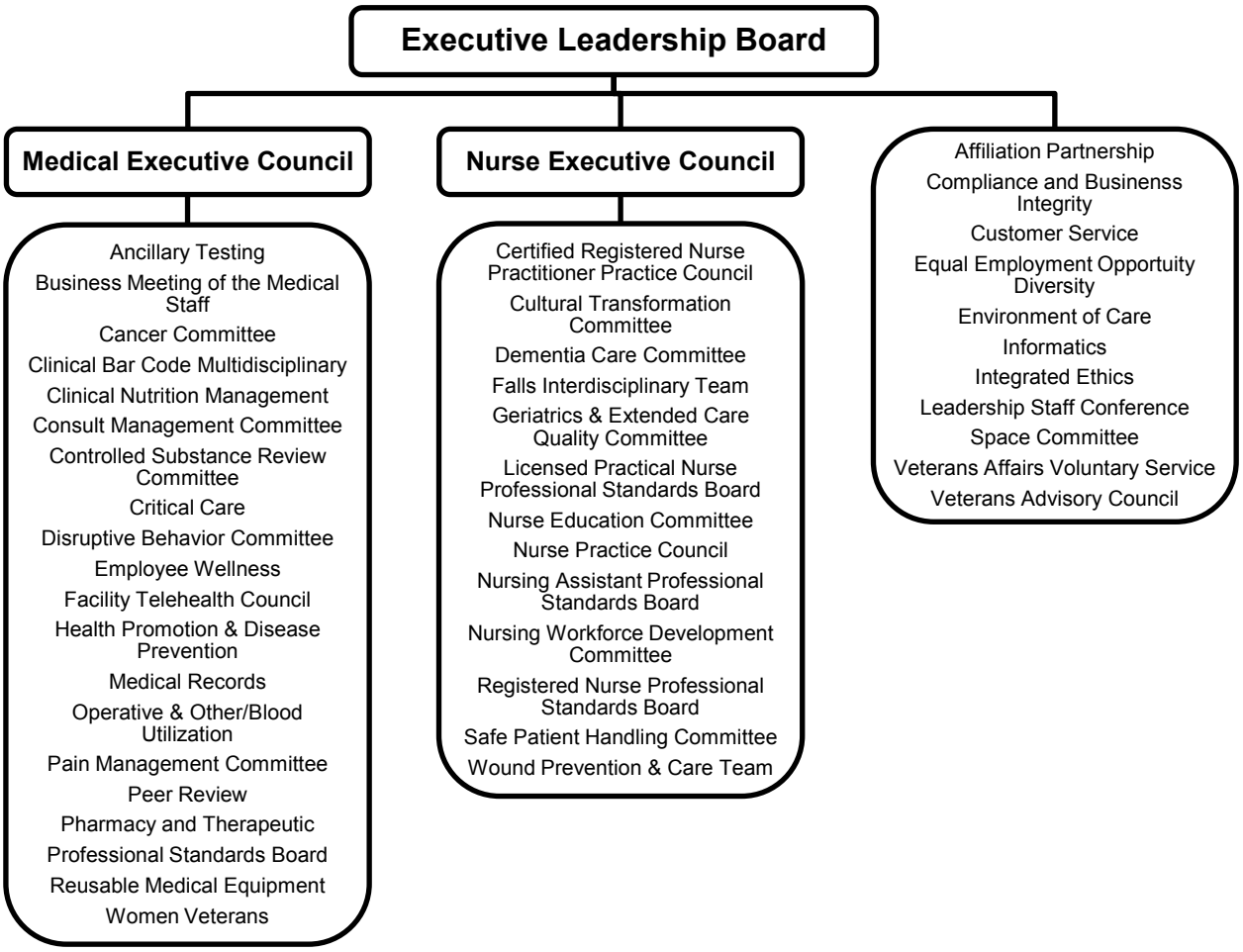

*Source: Erie VA Medical Center (received March 13, 2018)*

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

In individual interviews, these executive leadership team members 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, which tracks, trends, and monitors quality of care and patient outcomes. The Director serves as the chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board also oversees various working committees, such as the Medical Executive Council, Nurse Executive Council, and Veterans Advisory Council. See Figure 4.

**Figure 4. Facility Committee Reporting Structure**




*Source: Erie VA Medical Center (received March 13, 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, it can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on facility leadership.

To assess employee attitudes toward Facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2016, through September 30, 2017. Table 1 provides relevant employee survey results for VHA and the Facility, and indicates that the Facility leaders' results (Director's office average) were rated above VHA and overall Facility averages.[12] The employees appear generally satisfied with leadership.

**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[13] |
|---|---|---|---|---|
| All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?* | 1 (Very Dissatisfied)–5 (Very Satisfied) | 3.3 | 3.5 | 4.3 |
| All Employee Survey: *Servant Leader Index Composite* | 0–100 where HIGHER scores are more favorable | 67.7 | 65.8 | 78.3 |

*Source: VA All Employee Survey (accessed February 9, 2018)*

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

To assess patient attitudes toward Facility leadership, the OIG selected and reviewed four survey items from patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017. For this Facility, all four patient survey results reflected higher care ratings than the VHA average. Patients appear generally satisfied with the leadership and care provided.

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

[13] 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): *Would you recommend this hospital to your friends and family?* | The response average is the percent of "Definitely Yes" responses. | 66.7 | 77.2 |
| Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.* | The response average is the percent of "Agree" and "Strongly Agree" responses. | 83.4 | 85.1 |
| Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.* | The response average is the percent of "Agree" and "Strongly Agree" responses. | 74.9 | 86.2 |
| Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.* | The response average is the percent of "Agree" and "Strongly Agree" responses. | 75.2 | 83.2 |

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

## Accreditation/For-Cause Surveys[14] 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

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

recently performed by the OIG and The Joint Commission (TJC).[15] Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 3.[16]

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities,[17] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute conducted an inspection of the Facility's Community Living Center (CLC).[18]

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

| Accreditation or Inspecting Agency | Date of Visit | Number of Findings | Number of Recommendations Remaining Open |
|---|---|---|---|
| OIG (*Combined Assessment Program Review of the Erie VA Medical Center, Erie, Pennsylvania, February 10, 2015*) | December 2014 | 5 | 0 |
| OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Erie VA Medical Center, Erie, Pennsylvania, February 11, 2015*) | December 2014 | 8 | 0 |
| OIG (*Administrative Summary – Primary Care Access, Scheduling, and Consult Management Concerns, Erie VA Medical Center, Erie, Pennsylvania, August 8, 2017*) | March 2015 | 0 | n/a |
| TJC<br>• Regular<br>  ○ Hospital Accreditation | February 2017 | 15 | 0 |

[15] 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.

[16] 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.

[17] 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.

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

| Accreditation or Inspecting Agency | Date of Visit | Number of Findings | Number of Recommendations Remaining Open |
|---|---|---|---|
| ○ Behavioral Health Care Accreditation | | 3 | 0 |
| ○ Home Care Accreditation | | 6 | 0 |
| • Regular (Laboratory Accreditation) | September 2016 | 1 | 1 |
| • New Service | April 2016 | 0 | 0 |

*Source: OIG and TJC (Inspection/survey results verified with the Director on March 14, 2018)*
*n/a – not applicable*

## Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 4 summarizes key indicators of risk since the OIG's previous December 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of March 12, 2018.[19]

[19] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the Facility. (Note that the Erie VA Medical Center is a low complexity (3) affiliated Facility as described in Appendix B.)

**Table 4. Summary of Selected Organizational Risk Factors (December 2014 to March 12, 2018)**

| Factor | Number of Occurrences |
|---|---|
| Sentinel Events[20] | 1 |
| Institutional Disclosures[21] | 5 |
| Large-Scale Disclosures[22] | 0 |

*Source: Erie VA Medical Center's Patient Safety Manager (received March 12, 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.[23] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 5 summarizes Patient Safety Indicator data from October 1, 2015, through 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 4 | Facility |
| Pressure ulcers | 0.60 | 0.54 | 0.00 |
| Death among surgical inpatients with serious treatable conditions | 100.97 | 89.89 | n/a |

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

[21] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or his or her personal representative that an adverse event has occurred during care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.

[22] Large-scale disclosure of adverse events (sometimes referred to as "notification") is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.

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

| Measure | Reported Rate per 1,000 Hospital Discharges | | |
|---|---|---|---|
| | VHA | VISN 4 | Facility |
| Iatrogenic pneumothorax | 0.19 | 0.06 | 0.00 |
| Central venous catheter-related bloodstream infection | 0.15 | 0.15 | 0.00 |
| In-hospital fall with hip fracture | 0.08 | 0.11 | 0.00 |
| Perioperative hemorrhage or hematoma | 1.94 | 1.90 | 0.00 |
| Postoperative acute kidney injury requiring dialysis | 0.88 | 0.22 | n/a |
| Postoperative respiratory failure | 5.55 | 4.73 | n/a |
| Perioperative pulmonary embolism or deep vein thrombosis | 3.29 | 3.33 | 0.00 |
| Postoperative sepsis | 4.00 | 3.85 | n/a |
| Postoperative wound dehiscence | 0.52 | 0 | n/a |
| Unrecognized abdominopelvic accidental puncture/laceration | 0.53 | 0.78 | 0.00 |

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

None of the applicable Patient Safety Indicator measures show an observed rate in excess of the observed rates for Veterans Integrated Service Network (VISN) 4 or VHA.

## Veterans Health Administration Performance Data

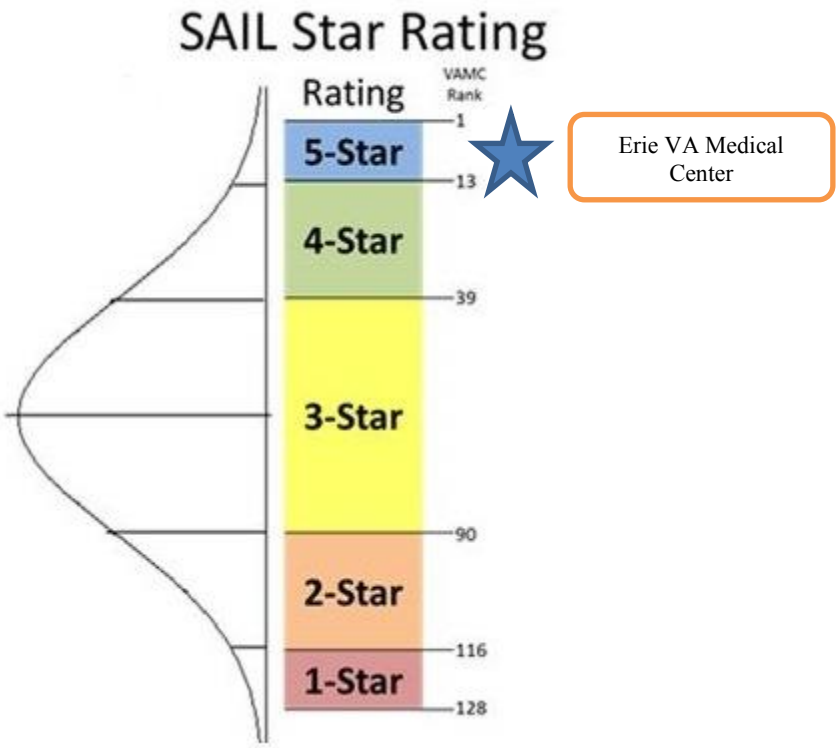
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[24]

VA also uses a star-rating system where facilities with a "5-Star" rating are performing within the top 10 percent of facilities and "1-Star" facilities are performing within the bottom 10 percent

[24] 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.)

of facilities. Figure 5 describes the distribution of facilities by star rating.[25] As of June 30, 2017, the Facility received a "5-Star" rating for overall quality.

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



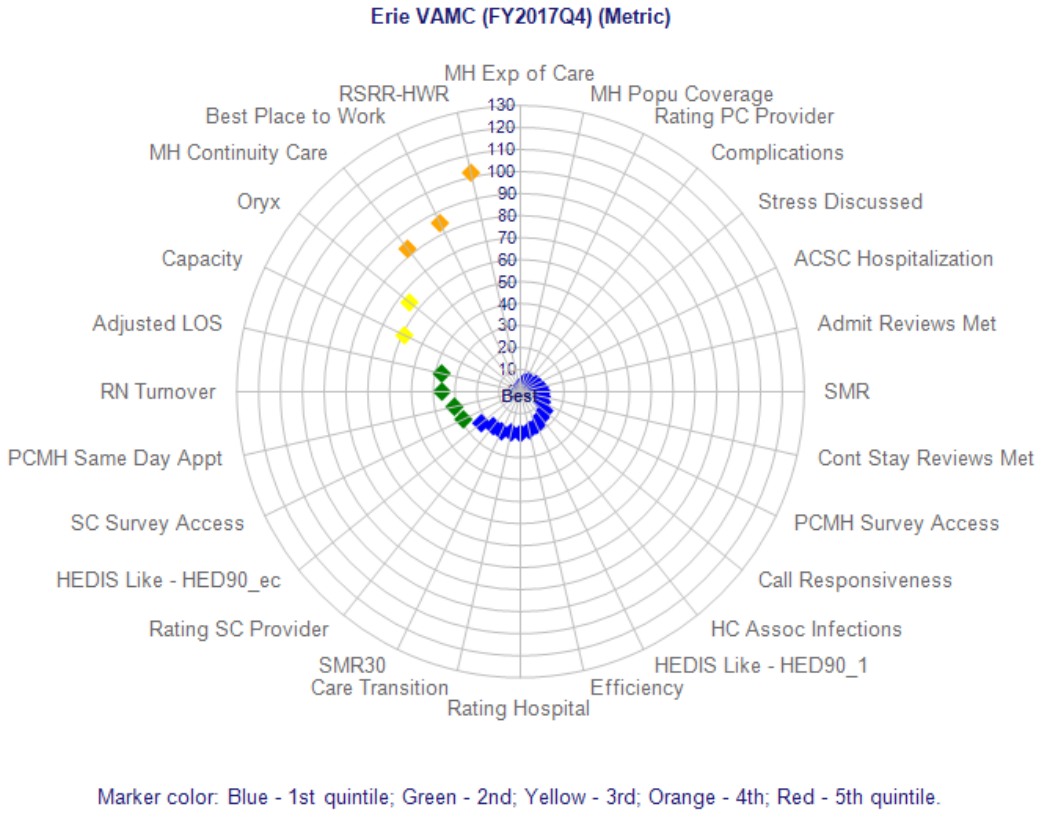

*Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed February 9, 2018)*

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of September 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example, Mental Health (MH) Experience (Exp) of Care, Complications, Rating (of) Hospital, and Registered Nurse (RN)

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

Turnover).[26] Metrics that need improvement are denoted in orange (for example, Mental Health (MH) Continuity (of) Care and Best Place to Work).

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




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

## Conclusion

The Facility has stable executive leadership and active engagement with employees and patients as evidenced by high satisfaction scores. Organizational leaders support patient safety, quality

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

care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the Facility through active stakeholder engagement). The OIG's review of accreditation organization findings, sentinel events, disclosures, and Patient Safety Indicator data did not identify any substantial organizational risk factors. Although the leadership team was knowledgeable about selected SAIL metrics and the Facility is currently rated as "5-Star," the leaders should continue to take actions to improve or maintain performance of Quality of Care metrics.

## 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.[27] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[28]

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,[29] utilization management (UM) reviews,[30] and patient safety incident reporting with related root cause analyses (RCAs).[31]

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.[32]

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

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

[29] According to VHA Directive 2010-025, *Peer Review for Quality Managemen*t, 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.)

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

[31] 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.

[32] 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:[33]

- 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[34]
  - Annual completion of a minimum of eight RCAs[35]
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

## Conclusion

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

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

[34] 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.

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

## Peer Review: Eleven Aspects for Review of Care

VHA requires peer reviewers to use the Eleven Aspects for Review of Care to indicate the aspects that apply in determining the peer review level.[36] This information helps the Peer Review Committee and peer-reviewed individual to focus concerns with a specific episode of care, with the goal of improving patient care and health outcomes.

For two of eight Level 2 or 3 cases examined, the peer reviewer did not identify any of the Eleven Aspects for Review of Care. This may hinder the Peer Review Committee's ability to evaluate for quality and resource issues that may have affected the patient care or health outcomes. The Chief of Staff and risk and quality managers did not fully understand the role of the peer reviewers and thought the Peer Review Committee held the primary responsibility for selecting one or more of the Eleven Aspects for Review of Care.

## Recommendation 1

1. The Chief of Staff ensures that the peer reviewer identifies one or more of the Eleven Aspects for Review of Care in the completion of peer reviews and monitors compliance.

Facility Concurred.

Target date for completion: December 31, 2018

Facility response: Risk Management will be responsible for ensuring ongoing compliance that at least one of the 11 aspects of care are identified by the initial reviewer when a #2 or #3 level of determination is selected. Monitoring began by the Risk Manager in April 2018.

April 4/4=100 percent

May 4/4=100 percent

June 0/0=100 percent

Results will be reported at scheduled Peer Review meetings and quarterly to Medical Executive Council (MEC). Target is 90 percent compliance for 6 consecutive months.

[36] VHA Directive 2010-025.

## Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIP).[37]

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.[38]

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.[39]

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 three LIPs who were hired within 18 months prior to the on-site visit,[40] and 22 LIPs who were re-privileged within 12 months prior to the visit.[41] The OIG evaluated the following performance indicators:

- Credentialing
  - Current licensure
  - Primary source verification
- Privileging

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

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] The 18-month period was from September 12, 2016, through March 12, 2018.

[41] The 12-month review period was from March 12, 2017, through March 12, 2018.

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

## Conclusion

The OIG found general compliance with requirements for credentialing, privileging, and FPPE processes. However, the OIG identified the following deficiencies with the OPPE process.

## OPPE Re-privileging Process

VHA requires that, at the time of re-privileging, Service Chiefs consider relevant service- and practitioner-specific data utilizing defined criteria when recommending the continuation of LIPs' privileges to the Medical Executive Council.[42] Such data is maintained as part of the practitioner's provider profile and may include direct observations, clinical discussions, and clinical record reviews. This OPPE process is essential to confirm the quality of care delivered and allows the Facility to identify professional practice trends that impact the quality of care and patient safety.

For 19 of 22 practitioners re-privileged within the last 12 months, the OIG found that Service Chiefs could not demonstrate that the re-privileging decisions were based upon OPPE information that was service and practitioner-specific, although 3 of 22 re-privileged solo practitioners did have appropriate OPPEs conducted by off-site reviewers. The Chief of Staff signed a blanket OPPE approval letter for all practitioners twice yearly and reported that since TJC accepted the Facility's process during their last review, leaders continued the process.

## Recommendation 2

2. The Chief of Staff ensures that the Ongoing Professional Practice Evaluation process includes the development and utilization of service- and practitioner-specific data and monitors compliance.

Facility Concurred.

Target date for completion: January 31, 2019

Facility response: A new Ongoing Professional Practice Evaluation (OPPE) memorandum process was created and approved by the Medical Executive Council in May 2018. Every 6 months, after reviewing pertinent service and practitioner-specific OPPE information for re-privileging decisions, the individual Medical Directors of the program will complete an OPPE memorandum on each individual provider assigned to them. This OPPE information will be forwarded to the Chief of Staff and the Professional Standards Board for review and validation of completeness. The Credentialing Coordinator will monitor all OPPE reviews monthly until 90 percent compliance is maintained for 6 consecutive months.

[42] VHA Handbook 1100.19.

## Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[43]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements.[44] 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[45] and Nutrition and Food Services processes.[46]

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.[47]

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.[48]

In all, the OIG team inspected two inpatient units (4th floor CLC and 5th floor acute care/CLC) and five outpatient areas (3rd floor ambulatory clinic, surgical clinic, women's clinic, pre- and post-operative unit, and urgent care center). In addition, the OIG inspected Nutrition and Food

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

[44] 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).

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

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

[47] VHA Directive 7715.

[48] VHA Handbook 1109.04.

Services and two construction sites. The team also inspected the Ashtabula CBOC.[49] The OIG reviewed the most recent Infection Prevention Risk Assessment, Infection Prevention/Control Committee minutes for the past 11 months, and other relevant documents, and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

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

[49] Each outpatient site selected for physical inspection was randomized from all primary care CBOCs, multi-specialty CBOCs, and healthcare 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 discussions on construction activities
  - Dust control
  - Safety and security
  - Selected requirements based on project type and class[50]
- 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

## Conclusion

General 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, one inpatient unit[51] had stained ceiling tiles and four of seven areas had dusty ventilation grills.[52] The CBOC did not have medical (biohazardous) waste stored in a secured location, and the clean supply room did not have restricted access or solid bottom storage shelves. A construction area at the Facility lacked adequate adhesive floor mats at the interior entrance to the construction site. All of these conditions were remedied while the OIG was on site. However, the OIG identified the following deficiency that warranted a recommendation for improvement.

[50] 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.

[51] 4th floor CLC.

[52] 4th floor CLC, 5th floor Acute Care/CLC, surgical clinic, and women's clinic.

## Parent Facility Medication Storage

TJC requires that expired, damaged, and/or contaminated medications are stored separately from medications available for administration. Expired, damaged, and/or contaminated medications that are not stored separately could result in unsafe medication administration and patient harm.[53] The OIG observed that three of seven areas had multi-dose vials and bottles of eye drops that were not marked with the date opened,[54] expired medications that were stored with medications available for administration,[55] and opened containers of topical anesthetic gel with no expiration dates.[56] Due to a lack of oversight, staff were not routinely following Facility policies regarding medication administration, storage, and disposal.

## Recommendation 3

3. The Associate Director of Patient Care Services ensures that staff follow medication administration, storage, and disposal policies and monitors compliance.

Facility concurred.

Target date for completion: February 28, 2019

Facility response: Staff will be reminded on the facility policies for medication administration, storage and disposal, and labeling of multi-dose vials and bottles with the expiration date, through read and sign, at staff huddles and monthly unit meetings July 31, 2018. All multi-dose medications will be stored individually in clear plastic bags provided by the Pharmacy, marked with the expiration date, and returned to pharmacy in plastic bags for disposal and stored separately from medications available for administration in a designated return bin in the Medication Room.

The nursing assignment sheets will be updated by July 31, 2018 to designate the staff member responsible to inspect medication areas, bins, and computer roll-abouts for damaged, expired, and contaminated medication that needs to be returned to the Pharmacy. Inspections will also include monitoring for properly labeled medications and ensure they are stored correctly in individual clear plastic bags and placed in the locked medication bins specific to each patient.

[53] TJC. Medication Management standard MM.03.01.01, EP8, July 2017.

[54] Fifth floor acute care/CLC.

[55] Fourth floor CLC.

[56] Third floor ambulatory clinic.

The Charge Nurse or designee will monitor medication storage and labeling compliance monthly until 90 percent compliance for 6 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.[57] 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.[58]

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.[59] 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.[60] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[61] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months; [62] CS inspection quarterly trend reports for the prior four quarters;[63] 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

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

[58] 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.

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

[60] 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.

[61] The review period was July 1, 2017, through December 31, 2017.

[62] The review period was January 1, 2017, through December 31, 2017.

[63] The review period was January 1, 2017, through December 31, 2017.

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

- Completion of inspections on day initiated
- Security and documentation of drugs held for destruction[64]
- 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

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

[64] 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.

## Mental Health Care: Post-Traumatic Stress Disorder Care

Post-Traumatic Stress Disorder (PTSD) may occur "following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury, or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."[65] 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.[66]

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.[67] 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.[68]

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

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

[66] VHA Handbook 1160.03.

[67] 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.

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

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

## Conclusion

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

## Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.[69] 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.[70] 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.[71]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[72] 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.[73] 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.[74]

In determining whether the Facility provided an effective GE, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of eight 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

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

[70] VHA Directive 1140.04.

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

[72] Public Law 106-117.

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

[74] VHA Directive 1140.04.

- Provision of clinical care
  - Medical evaluation by GE provider
  - 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; however, the OIG noted that the clinical team did not develop a plan of care based on GE for two of the eight patients reviewed. Due to the small sample size, 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.[75] 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.[76] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services, including mammography services to eligible women veterans.[77]

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.[78]

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 46 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

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

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

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

[78] 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.

- Communication of results and any recommended course of action to ordering provider
- Communication of results and any recommended course of action to patient
- Performance of follow-up mammogram if indicated
- Performance of follow-up study[79]

## Conclusion

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

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

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

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

| Healthcare Processes | Performance Indicators | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|---|---|
| Quality, Safety, and Value | • Protected peer review of clinical care<br>• UM reviews<br>• Patient safety incident reporting and RCAs | • None | • Peer reviewers identify one or more of the Eleven Aspects for Review of Care when completing peer reviews. |
| Credentialing and Privileging | • Medical licenses<br>• Privileges<br>• FPPEs<br>• OPPEs | • The OPPE process includes the development and utilization of service- and practitioner-specific data. | • None |

| Healthcare Processes | Performance Indicators | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|---|---|
| Environment of Care | • Parent Facility<br>○ EOC rounds and deficiency tracking<br>○ Infection prevention<br>○ General safety<br>○ Environmental cleanliness<br>○ General and exam room privacy<br>○ Availability of medical equipment and supplies<br>• CBOC<br>○ General safety<br>○ Medication safety and security<br>○ Infection prevention<br>○ Environmental cleanliness<br>○ General and exam room privacy<br>○ Availability of medical equipment and supplies<br>• Construction Safety<br>○ Infection control risk assessment<br>○ Infection Prevention/ Infection Control Committee discussions<br>○ Dust control<br>○ Safety/security<br>○ Selected requirements based on project type and class<br>• Nutrition and Food Services<br>○ Hazard Analysis Critical Control Point Food Safety System plan<br>○ Food Services inspections<br>○ Safe transportation of prepared food<br>○ Environmental safety<br>○ Infection prevention<br>○ Storage areas | • Staff follow medication administration, storage, and disposal policies. | • None |

| Healthcare Processes | Performance Indicators | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|---|---|
| Medication Management | • CSC reports<br>• Pharmacy operations<br>• Annual physical security survey<br>• CS ordering processes<br>• Inventory completion during Chief of Pharmacy transition<br>• Review of balance adjustments<br>• CSC requirements<br>• CSI requirements<br>• CS area inspections<br>• Pharmacy inspections | • None | • None |
| Mental Health Care: Post-Traumatic Stress Disorder Care | • Suicide risk assessment<br>• Offer of further diagnostic evaluation<br>• Referral for diagnostic evaluation<br>• Completion of diagnostic evaluation | • None | • None |
| Long-Term Care: Geriatric Evaluations | • Provision of or access to GE<br>• Program oversight and evaluation<br>• Provision of clinical care<br>• Geriatric management | • None | • None |
| Women's Health: Mammography Results and Follow-Up | • Result linking<br>• Report scanning and content<br>• Communication of results and recommended actions<br>• Follow-up mammograms and studies | • None | • None |

# Appendix B: Facility Profile and VA Outpatient Clinic Profiles

## Facility Profile

The table below provides general background information for this low-complexity (3)[80] affiliated[81] Facility reporting to VISN 4.

**Table 6. Facility Profile for Erie (562)**
**(October 1, 2014, through September 30, 2017)**

| Profile Element | Facility Data FY 2015[82] | Facility Data FY 2016[83] | Facility Data FY 2017[84] |
|---|---|---|---|
| Total Medical Care Budget in Millions | $136.3 | $141.7 | $124.8 |
| Number of: | | | |
| • Unique Patients | 21,861 | 21,579 | 21,666 |
| • Outpatient Visits | 264,123 | 262,272 | 261,243 |
| • Unique Employees[85] | 543 | 563 | 576 |
| Type and Number of Operating Beds: | | | |
| • Community Living Center | 39 | 45 | 45 |
| • Medicine | 21 | 21 | 21 |
| Average Daily Census: | | | |
| • Community Living Center | 36 | 38 | 42 |
| • Medicine | 3 | 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.*

[80] The VHA medical centers are classified according to a facility complexity model; 3 designation indicates a facility with low-volume, low-risk patients, few to no complex clinical programs, and small or no research and teaching programs.
[81] Associated with a medical residency program.
[82] October 1, 2014, through September 30, 2015.
[83] October 1, 2015, through September 30, 2016.
[84] October 1, 2016, through September 30, 2017.
[85] Unique employees involved in direct medical care (cost center 8200).

## VA Outpatient Clinic Profiles[86]

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[87] 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[88] Provided | Diagnostic Services[89] Provided | Ancillary Services[90] Provided |
|---|---|---|---|---|---|---|
| Meadville, PA | 562GA | 6,244 | 2,241 | Cardiology<br>Dermatology<br>Endocrinology<br>Nephrology<br>Rheumatology<br>Podiatry<br>Urology | n/a | Nutrition<br>Social Work<br>Weight Management |

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

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

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

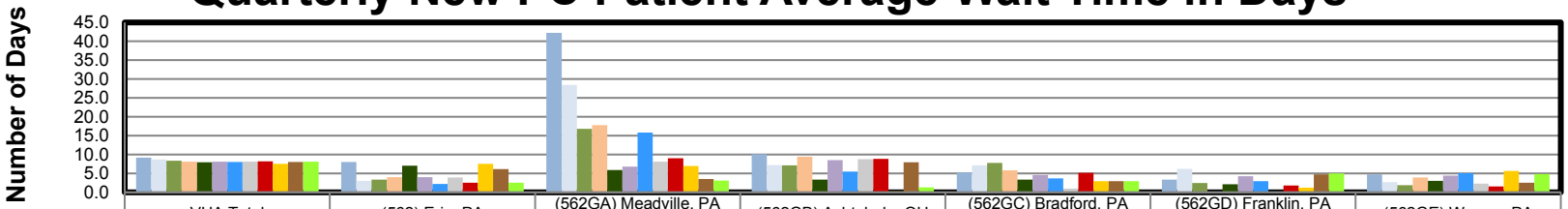
[89] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

[90] 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[88] Provided | Diagnostic Services[89] Provided | Ancillary Services[90] Provided |
|---|---|---|---|---|---|---|
| Ashtabula, OH | 562GB | 7,280 | 2,710 | Dermatology<br>Endocrinology<br>Rheumatology<br>Podiatry<br>Urology | n/a | Nutrition<br>Social Work<br>Weight Management |
| Bradford, PA | 562GC | 2,668 | 363 | Dermatology<br>Rheumatology<br>Urology | n/a | Nutrition<br>Social Work<br>Weight Management |
| Franklin, PA | 562GD | 4,547 | 1,686 | Dermatology<br>Endocrinology<br>Rheumatology<br>Podiatry<br>Urology | Laboratory & Pathology | Nutrition<br>Social Work<br>Weight Management |
| Warren, PA | 562GE | 5,632 | 1,267 | Cardiology<br>Dermatology<br>Endocrinology<br>Nephrology<br>Rheumatology<br>Podiatry<br>Urology | Laboratory & Pathology | Nutrition<br>Social Work<br>Weight Management |

*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[91]



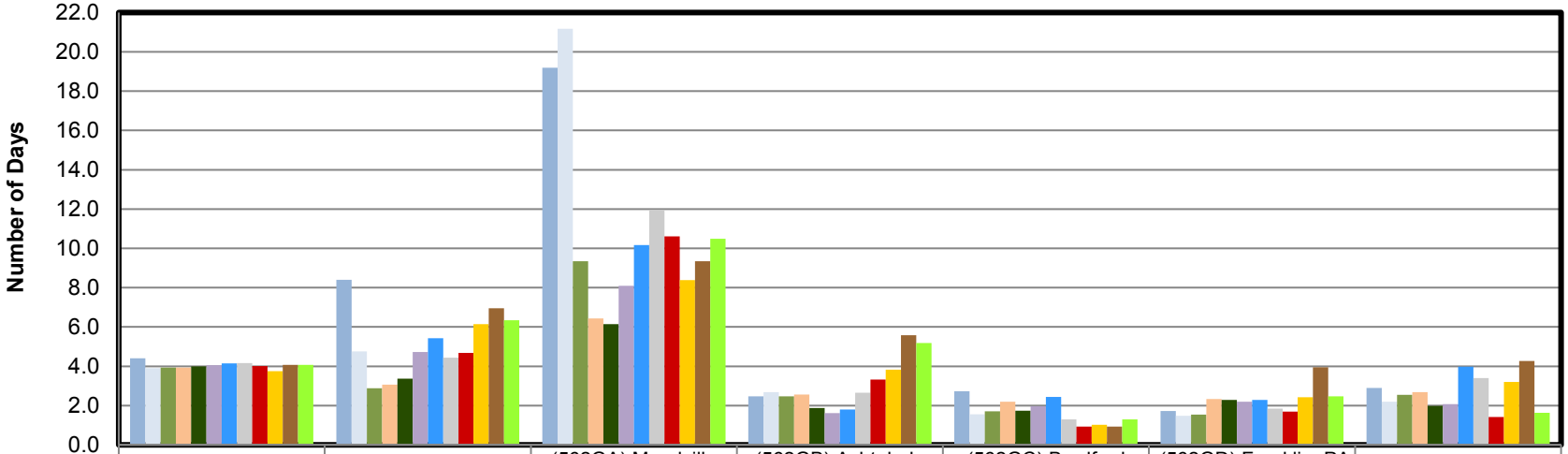

| | VHA Total | (562) Erie, PA | (562GA) Meadville, PA (Crawford County) | (562GB) Ashtabula, OH | (562GC) Bradford, PA (McKean County) | (562GD) Franklin, PA (Venango County) | (562GE) Warren, PA |
|---|---|---|---|---|---|---|---|
| JAN-FY17 | 9.2 | 8.0 | 42.2 | 10.1 | 5.3 | 3.4 | 4.7 |
| FEB-FY17 | 8.7 | 3.0 | 28.5 | 7.2 | 7.1 | 6.3 | 2.7 |
| MAR-FY17 | 8.4 | 3.4 | 16.8 | 7.1 | 7.8 | 2.5 | 1.9 |
| APR-FY17 | 8.2 | 4.0 | 17.8 | 9.4 | 5.8 | 0.0 | 3.9 |
| MAY-FY17 | 7.9 | 7.1 | 6.0 | 3.4 | 3.4 | 2.1 | 3.1 |
| JUN-FY17 | 8.2 | 4.0 | 6.8 | 8.5 | 4.6 | 4.3 | 4.4 |
| JUL-FY17 | 8.0 | 2.2 | 15.8 | 5.5 | 3.7 | 3.0 | 5.1 |
| AUG-FY17 | 8.1 | 4.0 | 8.1 | 8.8 | 1.0 | 0.0 | 2.3 |
| SEP-FY17 | 8.2 | 2.5 | 9.0 | 8.9 | 5.2 | 1.8 | 1.6 |
| OCT-FY18 | 7.5 | 7.6 | 7.0 | 0.3 | 3.0 | 1.2 | 5.7 |
| NOV-FY18 | 8.0 | 6.2 | 3.5 | 8.0 | 3.0 | 4.8 | 2.6 |
| DEC-FY18 | 8.1 | 2.5 | 3.2 | 1.3 | 3.0 | 5.0 | 4.9 |

*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.*

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

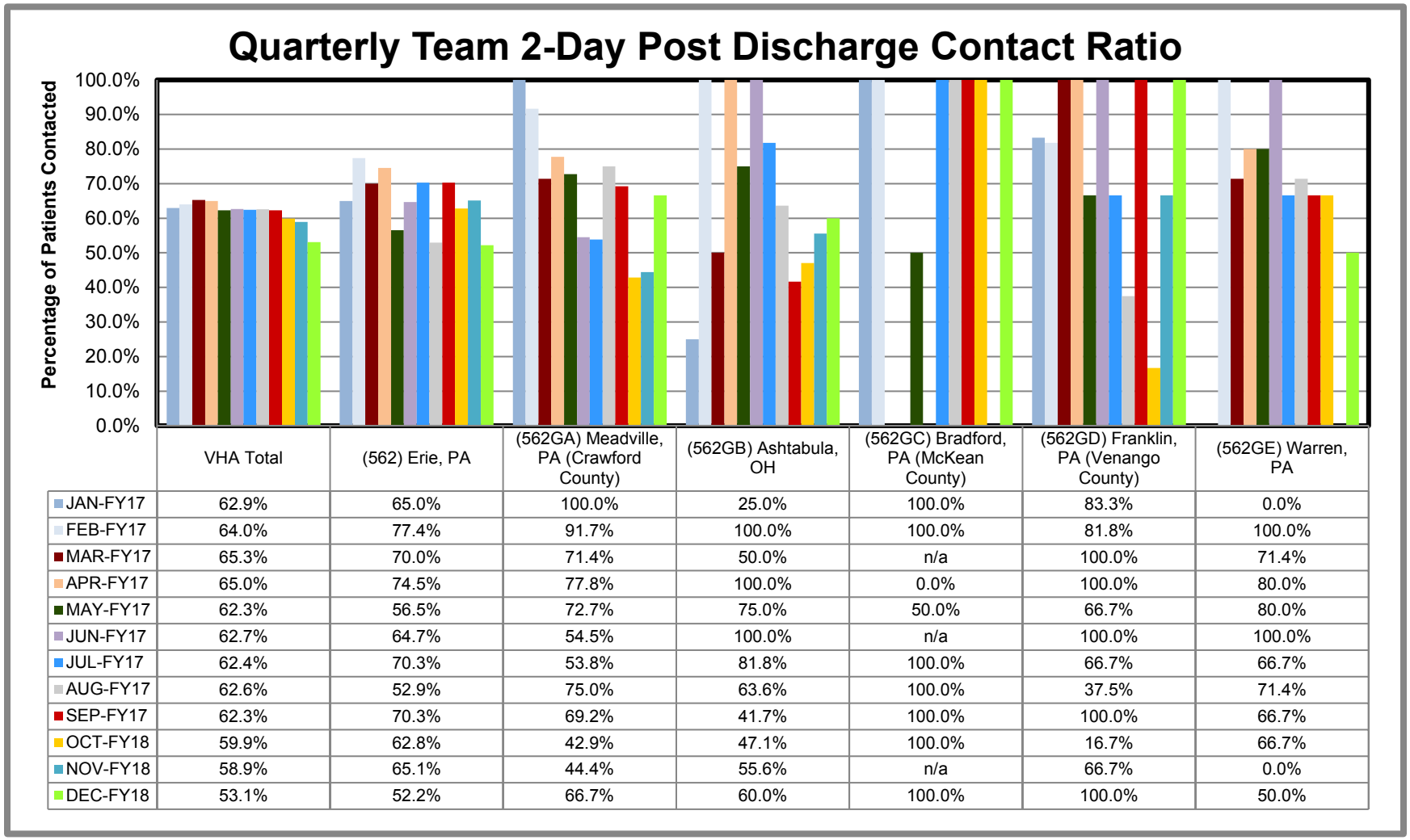



| | VHA Total | (562) Erie, PA | (562GA) Meadville, PA (Crawford County) | (562GB) Ashtabula, OH | (562GC) Bradford, PA (McKean County) | (562GD) Franklin, PA (Venango County) | (562GE) Warren, PA |
|---|---|---|---|---|---|---|---|
| JAN-FY17 | 4.4 | 8.4 | 19.2 | 2.5 | 2.7 | 1.7 | 2.9 |
| FEB-FY17 | 3.9 | 4.8 | 21.2 | 2.7 | 1.5 | 1.5 | 2.2 |
| MAR-FY17 | 3.9 | 2.9 | 9.3 | 2.5 | 1.7 | 1.5 | 2.5 |
| APR-FY17 | 3.9 | 3.1 | 6.4 | 2.6 | 2.2 | 2.3 | 2.7 |
| MAY-FY17 | 4.0 | 3.4 | 6.1 | 1.9 | 1.7 | 2.3 | 2.0 |
| JUN-FY17 | 4.1 | 4.7 | 8.1 | 1.6 | 2.0 | 2.2 | 2.1 |
| JUL-FY17 | 4.1 | 5.4 | 10.2 | 1.8 | 2.4 | 2.3 | 4.0 |
| AUG-FY17 | 4.2 | 4.4 | 11.9 | 2.6 | 1.3 | 1.8 | 3.4 |
| SEP-FY17 | 4.0 | 4.7 | 10.6 | 3.3 | 0.9 | 1.7 | 1.4 |
| OCT-FY18 | 3.7 | 6.1 | 8.4 | 3.8 | 1.0 | 2.4 | 3.2 |
| NOV-FY18 | 4.1 | 7.0 | 9.3 | 5.6 | 0.9 | 3.9 | 4.3 |
| DEC-FY18 | 4.1 | 6.3 | 10.5 | 5.2 | 1.3 | 2.5 | 1.6 |

*Source: VHA Support Service Center*

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

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

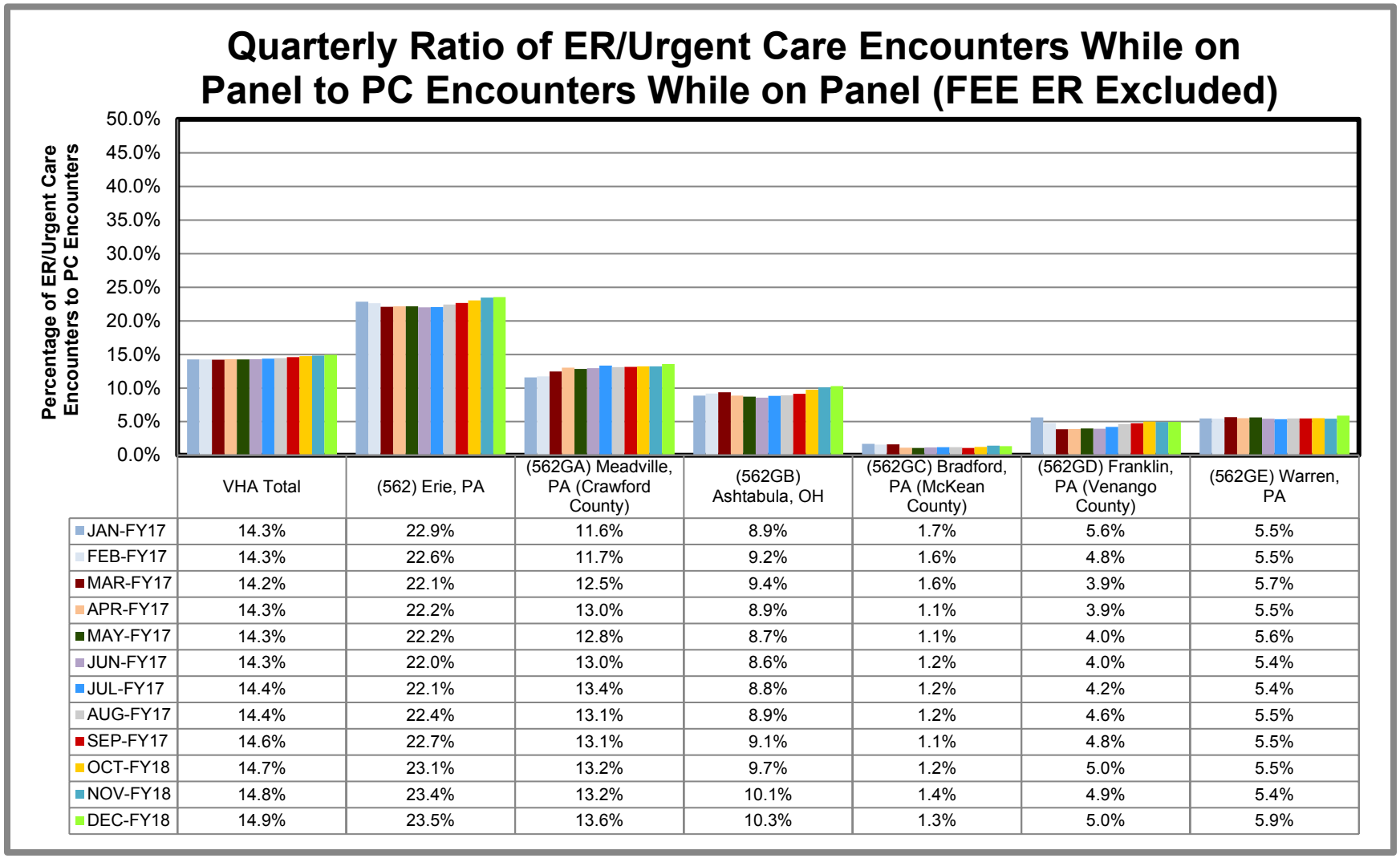



| | VHA Total | (562) Erie, PA | (562GA) Meadville, PA (Crawford County) | (562GB) Ashtabula, OH | (562GC) Bradford, PA (McKean County) | (562GD) Franklin, PA (Venango County) | (562GE) Warren, PA |
|---|---|---|---|---|---|---|---|
| JAN-FY17 | 62.9% | 65.0% | 100.0% | 25.0% | 100.0% | 83.3% | 0.0% |
| FEB-FY17 | 64.0% | 77.4% | 91.7% | 100.0% | 100.0% | 81.8% | 100.0% |
| MAR-FY17 | 65.3% | 70.0% | 71.4% | 50.0% | n/a | 100.0% | 71.4% |
| APR-FY17 | 65.0% | 74.5% | 77.8% | 100.0% | 0.0% | 100.0% | 80.0% |
| MAY-FY17 | 62.3% | 56.5% | 72.7% | 75.0% | 50.0% | 66.7% | 80.0% |
| JUN-FY17 | 62.7% | 64.7% | 54.5% | 100.0% | n/a | 100.0% | 100.0% |
| JUL-FY17 | 62.4% | 70.3% | 53.8% | 81.8% | 100.0% | 66.7% | 66.7% |
| AUG-FY17 | 62.6% | 52.9% | 75.0% | 63.6% | 100.0% | 37.5% | 71.4% |
| SEP-FY17 | 62.3% | 70.3% | 69.2% | 41.7% | 100.0% | 100.0% | 66.7% |
| OCT-FY18 | 59.9% | 62.8% | 42.9% | 47.1% | 100.0% | 16.7% | 66.7% |
| NOV-FY18 | 58.9% | 65.1% | 44.4% | 55.6% | n/a | 66.7% | 0.0% |
| DEC-FY18 | 53.1% | 52.2% | 66.7% | 60.0% | 100.0% | 100.0% | 50.0% |

*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."*




| | VHA Total | (562) Erie, PA | (562GA) Meadville, PA (Crawford County) | (562GB) Ashtabula, OH | (562GC) Bradford, PA (McKean County) | (562GD) Franklin, PA (Venango County) | (562GE) Warren, PA |
|---|---|---|---|---|---|---|---|
| JAN-FY17 | 14.3% | 22.9% | 11.6% | 8.9% | 1.7% | 5.6% | 5.5% |
| FEB-FY17 | 14.3% | 22.6% | 11.7% | 9.2% | 1.6% | 4.8% | 5.5% |
| MAR-FY17 | 14.2% | 22.1% | 12.5% | 9.4% | 1.6% | 3.9% | 5.7% |
| APR-FY17 | 14.3% | 22.2% | 13.0% | 8.9% | 1.1% | 3.9% | 5.5% |
| MAY-FY17 | 14.3% | 22.2% | 12.8% | 8.7% | 1.1% | 4.0% | 5.6% |
| JUN-FY17 | 14.3% | 22.0% | 13.0% | 8.6% | 1.2% | 4.0% | 5.4% |
| JUL-FY17 | 14.4% | 22.1% | 13.4% | 8.8% | 1.2% | 4.2% | 5.4% |
| AUG-FY17 | 14.4% | 22.4% | 13.1% | 8.9% | 1.2% | 4.6% | 5.5% |
| SEP-FY17 | 14.6% | 22.7% | 13.1% | 9.1% | 1.1% | 4.8% | 5.5% |
| OCT-FY18 | 14.7% | 23.1% | 13.2% | 9.7% | 1.2% | 5.0% | 5.5% |
| NOV-FY18 | 14.8% | 23.4% | 13.2% | 10.1% | 1.4% | 4.9% | 5.4% |
| DEC-FY18 | 14.9% | 23.5% | 13.6% | 10.3% | 1.3% | 5.0% | 5.9% |

*Source: VHA Support Service Center*

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

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

# Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[92]

| 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 |

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

| Measure | Definition | Desired Direction |
|---|---|---|
| Efficiency | Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis) | A higher value is better than a lower value |
| Efficiency/Capacity | Efficiency and Physician Capacity | A higher value is better than a lower value |
| Employee Satisfaction | Overall satisfaction with job | A higher value is better than a lower value |
| HC Assoc Infections | 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 |

| Measure | Definition | Desired Direction |
|---|---|---|
| PSI | Patient safety indicator (observed to expected ratio) | A lower value is better than a higher value |
| Rating Hospital | Overall rating of hospital stay (inpatient only) | A higher value is better than a lower value |
| Rating PC Provider | Rating of PC providers (PCMH) | A higher value is better than a lower value |
| Rating SC Provider | Rating of specialty care providers (specialty care) | A higher value is better than a lower value |
| RN Turnover | Registered nurse turnover rate | A lower value is better than a higher value |
| RSMR-AMI | 30-day risk standardized mortality rate for acute myocardial infarction | A lower value is better than a higher value |
| RSMR-CHF | 30-day risk standardized mortality rate for congestive heart failure | A lower value is better than a higher value |
| RSMR-COPD | 30-day risk standardized mortality rate for COPD | A lower value is better than a higher value |
| RSMR-Pneumonia | 30-day risk standardized mortality rate for pneumonia | A lower value is better than a higher value |
| RSRR-AMI | 30-day risk standardized readmission rate for acute myocardial infarction | A lower value is better than a higher value |
| RSRR-Cardio | 30-day risk standardized readmission rate for cardiorespiratory patient cohort | A lower value is better than a higher value |
| RSRR-CHF | 30-day risk standardized readmission rate for congestive heart failure | A lower value is better than a higher value |
| RSRR-COPD | 30-day risk standardized readmission rate for COPD | A lower value is better than a higher value |
| RSRR-CV | 30-day risk standardized readmission rate for cardiovascular patient cohort | A lower value is better than a higher value |
| RSRR-HWR | Hospital wide readmission | A lower value is better than a higher value |
| RSRR-Med | 30-day risk standardized readmission rate for medicine patient cohort | A lower value is better than a higher value |
| RSRR-Neuro | 30-day risk standardized readmission rate for neurology patient cohort | A lower value is better than a higher value |
| RSRR-Pneumonia | 30-day risk standardized readmission rate for pneumonia | A lower value is better than a higher value |

| Measure | Definition | Desired Direction |
|---|---|---|
| RSRR-Surg | 30-day risk standardized readmission rate for surgery patient cohort | A lower value is better than a higher value |
| SC Routine Care Appt | Timeliness in getting a SC routine care appointment (Specialty Care) | A higher value is better than a lower value |
| SC Survey Access | Timely Appointment, care and information (Specialty Care) | A higher value is better than a lower value |
| SC Urgent Care Appt | Timeliness in getting a SC urgent care appointment (Specialty Care) | A higher value is better than a lower value |
| SMR | Acute care in-hospital standardized mortality ratio | A lower value is better than a higher value |
| 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 23, 2018

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

Subj: CHIP Review of the Erie VA Medical Center, PA

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

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

I have reviewed the responses provided by the Erie VA Medical Center, Erie, PA. I am submitting to your office as requested. I concur with their responses.

*(Original signed by:)*

Michael D. Adelman, MD

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

# Appendix F: Facility Director Comments

## Department of Veterans Affairs Memorandum

Date: July 18, 2018

From: Director, Erie VA Medical Center (562/00)

Subj: CHIP Review of the Erie VA Medical Center, PA

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

I have reviewed the draft report of the Office of Inspector General Comprehensive Inspection Program Review of the Erie VA Medical Center. I concur with the findings outlined in this report and have included corrective action plans for each recommendation.

*(Original signed by:)*

Dorene M. Sommers, Associate Director for Patient Care Services
For John A. Gennaro, Medical Center Director

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

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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