DEPARTMENT OF VETERANS AFFAIRS

# OFFICE OF INSPECTOR GENERAL

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

# Comprehensive Healthcare Inspection Program Review of the Central Arkansas Veterans Healthcare System

## Little Rock, Arkansas

CHIP REPORT | REPORT #18-01013-263 | AUGUST 30, 2018


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***Figure 1.*** *Central Arkansas Veterans Healthcare System, Little Rock, Arkansas (Source: https://vaww.va.gov/directory/guide/, accessed on June 22, 2018)*

# Abbreviations

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

# Report Overview

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

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

The OIG's current areas of focus are

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

This review was conducted during an unannounced visit made during the week of April 23, 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), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with the Joint Leadership Council having oversight for groups, such as Medical Executive; Quality, Safety Value; Strategic Direction/Resources; Veterans Experience; and Workforce Boards. The leaders are members of the Joint Leadership Council through which they track, trend, and monitor quality of care and patient outcomes. The Facility leaders have worked together since November 2016.

In the review of selected employee satisfaction and patient experience survey results regarding Facility leaders, the OIG noted generally satisfied employees, while opportunities exist to improve patient experiences.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[1] Although the leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current "2-Star" rating.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[2] disclosures of adverse patient events, and Patient Safety Indicator data and did not identify any substantial organizational risk factors.

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

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

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

## Quality, Safety, and Value

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

## Environment of Care

The OIG found general compliance with cleanliness, safety, and emergency management requirements at the parent Facility in Little Rock. However, the OIG identified deficiencies with panic alarm testing at the representative community based outpatient clinic and in the locked mental health unit.

## Medication Management

The OIG found general compliance with requirements for most of the performance indicators evaluated, including annual physical security surveys, ordering procedures, and Controlled Substances (CS) Coordinator and inspector assignments and training. However, the OIG identified deficiencies with the monthly summary reports, reconciliation of CS distribution and returns to pharmacy stock, verification of written CS orders, and emergency drug cache inspections.

## Mental Health Care

The OIG found general 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.

## Long-term Care

The OIG noted general compliance with provision of clinical care and implementation of interventions when indicated. However, the OIG identified a deficiency with program oversight and evaluation.

## Summary

In the review of key care processes, the OIG issued nine 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 CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 58–59, and the responses within the body of the report for the full text of the Directors' comments.) The OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
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 Central Arkansas Veterans Healthcare System (Facility) through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of healthcare services to veterans and to share findings with Facility leaders so that informed decisions can be made to improve care.

## Scope

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

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

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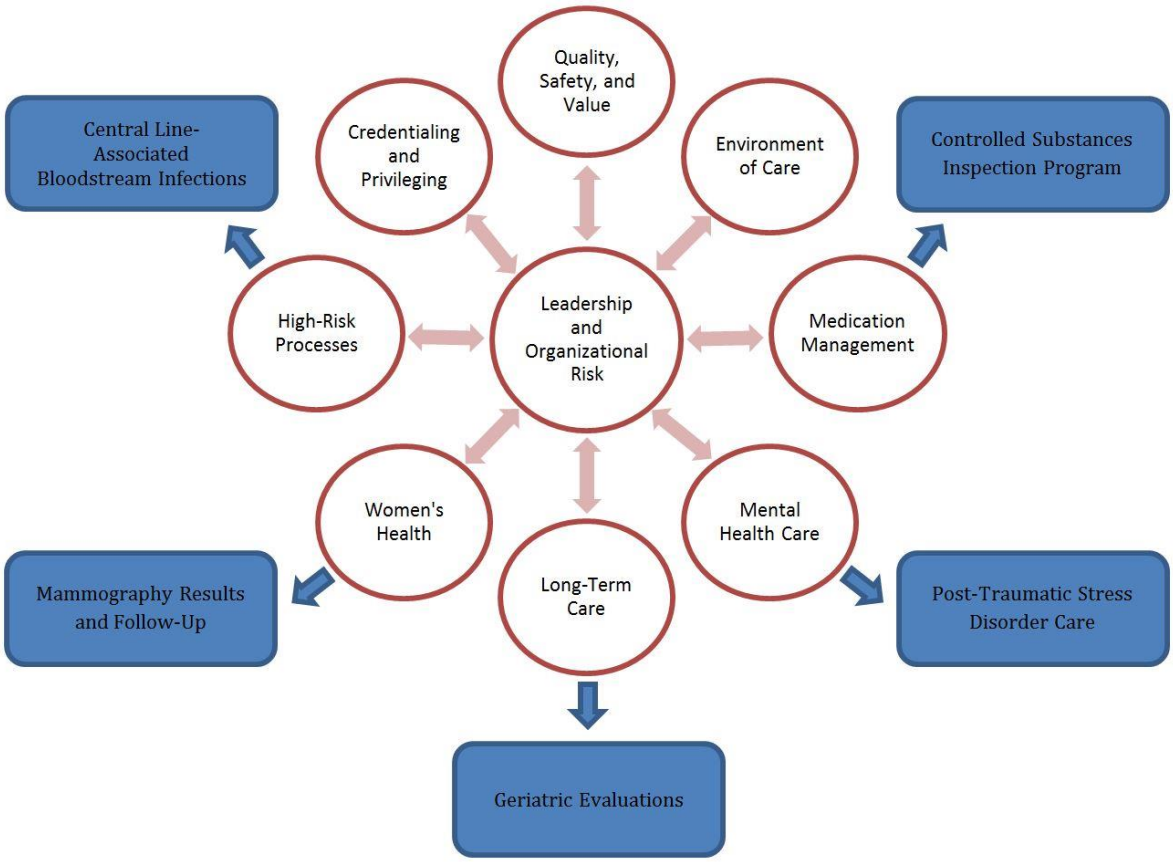
[3] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

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

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

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

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




*Source: VA OIG*

# Methodology

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

The review covered operations for August 19, 2015,[8] through April 23, 2018, the date when an unannounced week-long site visit commenced.

This report's recommendations for improvement target problems that can impact the quality of patient care significantly enough to warrant OIG follow-up until the Facility completes corrective actions. The 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.

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

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

# Results and Recommendations

## Leadership and Organizational Risks

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

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

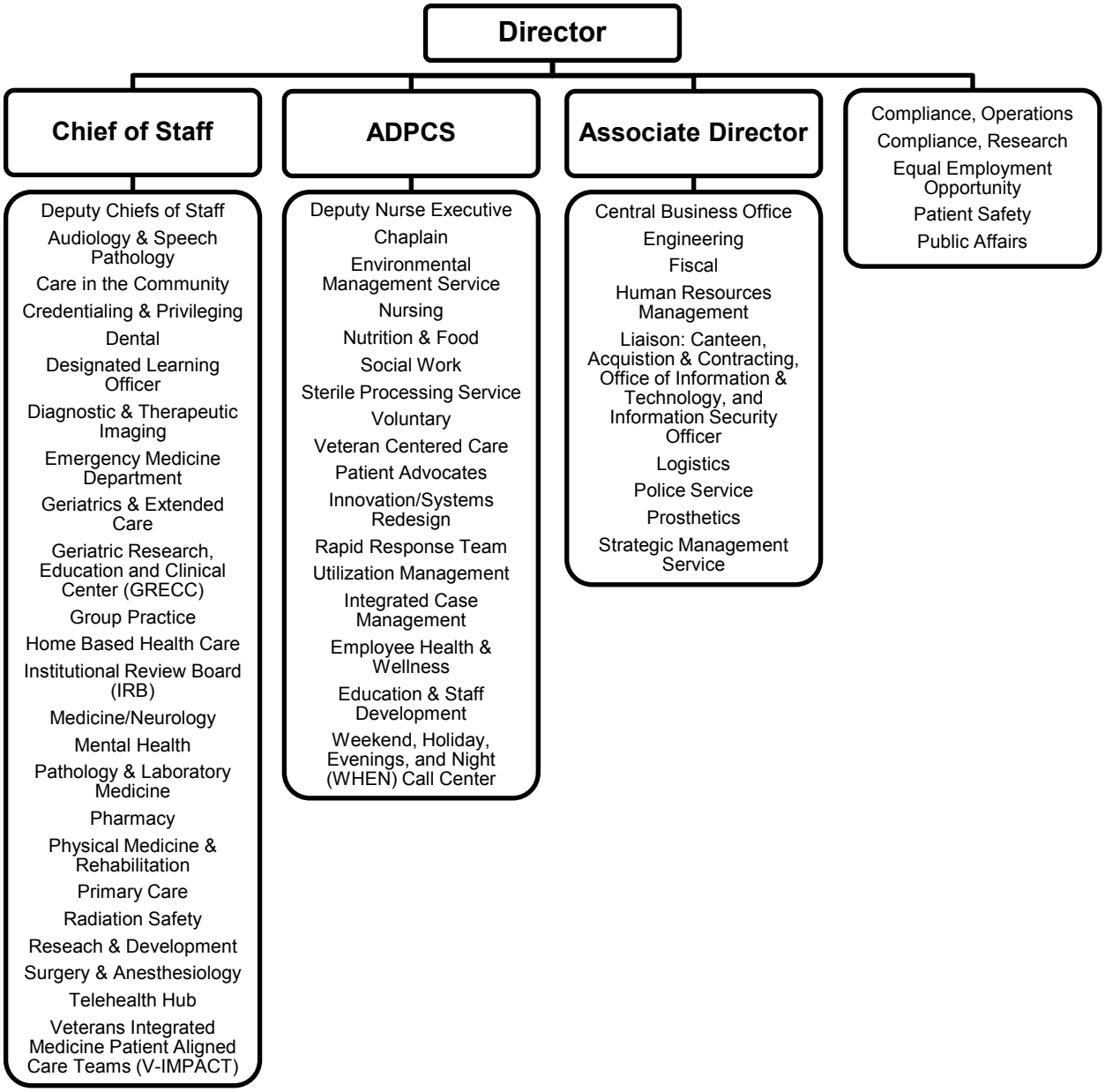
### Executive Leadership Stability and Engagement

Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ among facilities. Figure 3 illustrates the Facility's reported organizational structure.

The Facility has generally stable leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Service (ADPCS), and Associate Director. The Facility's leaders are led by the Director who was appointed to the position in May 2016. The Associate Director, assigned in September 2006, was the most tenured member of the leadership team. The ADPCS and Chief of Staff were assigned in September and November 2016, respectively. The executive 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.

[9] 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: Central Arkansas Veterans Healthcare System (received April 23, 2018)*

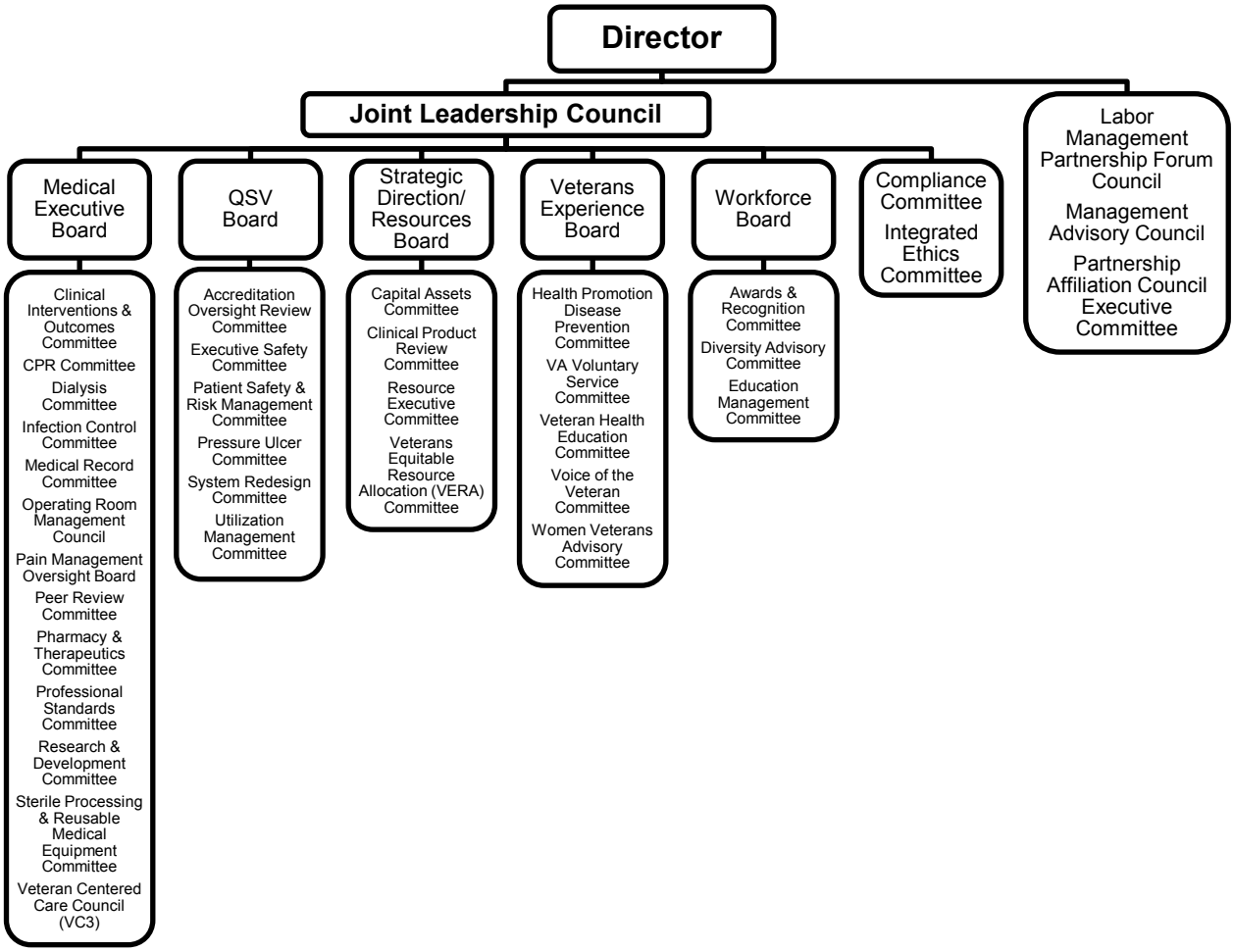
To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Chief of Staff, ADPCS, and acting Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve

performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Joint Leadership Council 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 Joint Leadership Council also oversees various working committees, such as the Medical Executive; Quality, Safety Value (QSV); Strategic Direction/Resources; Veterans Experience; and Workforce Boards. See Figure 4.

**Figure 4. Facility Committee Reporting Structure**




*Source: Central Arkansas Veterans Healthcare System (received April 23, 2018)*
*CPR = cardiopulmonary resuscitation*

## 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 1–3 provide relevant survey results for VHA, the Facility, and selected Facility executive leaders.[10]

Table 1 summarizes employee attitudes toward selected Facility leaders as expressed in VHA's All Employee Survey.[11] The Facility averages for the selected survey questions were similar to or below the VHA average.[12] A similar trend was noted for the members of the leadership team, except for the Director, whose results were higher than the Facility and VHA averages. In all, employees appear generally satisfied with Facility leaders.

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

| Questions/ Survey Items | Scoring | VHA Average | Facility Average | Director Average | Chief of Staff Average | ADPCS Average | Assoc. Director Average |
|---|---|---|---|---|---|---|---|
| All Employee Survey: *Servant Leader Index Composite* | 0–100 where HIGHER scores are more favorable | 67.7 | 66.2 | 84.6 | 68.9 | 63.0 | 67.6 |

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

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

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

| Questions/ Survey Items | Scoring | VHA Average | Facility Average | Director Average | Chief of Staff Average | ADPCS Average | Assoc. Director Average |
|---|---|---|---|---|---|---|---|
| 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 | 3.2 | 4.5 | 3.2 | 3.1 | 3.5 |

*Source: VA All Employee Survey (accessed March 23, 2018)*

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

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

| Questions/ Survey Items | Scoring | VHA Average | Facility Average | Director Average | Chief of Staff Average | ADPCS Average | Assoc. Director Average |
|---|---|---|---|---|---|---|---|
| All Employee Survey Q43. *My supervisor encourages people to speak up when they disagree with a decision.* | 1 (Strongly Disagree)–5 (Strongly Agree) | 3.8 | 3.7 | 4.4 | 3.8 | 4.2 | 3.8 |
| All Employee Survey Q44. *I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.* | 1 (Strongly Disagree)–5 (Strongly Agree) | 3.9 | 3.9 | 4.5 | 4.0 | 4.2 | 4.0 |

| Questions/ Survey Items | Scoring | VHA Average | Facility Average | Director Average | Chief of Staff Average | ADPCS Average | Assoc. Director Average |
|---|---|---|---|---|---|---|---|
| All Employee Survey Q75. *I can talk with my direct supervisor about ethical concerns without fear of having my comments held against me.* | 1 (Strongly Disagree)–5 (Strongly Agree) | 3.9 | 3.8 | 4.4 | 3.9 | 4.3 | 3.8 |

*Source: VA All Employee Survey (accessed March 23, 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 (see Table 3). For this Facility, all four patient survey results reflected lower care ratings than the VHA average. Opportunities appear to exist to improve patient satisfaction with care provided.

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

| Questions | Scoring | VHA Average | Facility Average |
|---|---|---|---|
| Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?* | The response average is the percent of "Definitely Yes" responses. | 66.7 | 63.0 |
| 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 | 80.4 |
| 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 | 73.0 |

| Questions | Scoring | VHA Average | Facility Average |
|---|---|---|---|
| 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 | 72.2 |

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

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

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 4 summarizes the relevant Facility inspections most recently performed by the OIG and The Joint Commission (TJC).[14] Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 4.[15]

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[16] and College of American Pathologists,[17] 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.[18]

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

[14] 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.

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

[16] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA's commitment is supported through a system-wide, long-term collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

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

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

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

| Accreditation or Inspecting Agency | Date of Visit | Number of Findings | Number of Recommendations Remaining Open |
|---|---|---|---|
| OIG (*Combined Assessment Program Review of the Central Arkansas Veterans Healthcare System, Little Rock, Arkansas, October 19, 2015*) | August 2015 | 16 | 0 |
| OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Central Arkansas Veterans Healthcare System, Little Rock, Arkansas, September 30, 2015*) | August 2015 | 9 | 0 |
| OIG (*Healthcare Inspection – Quality of Care Concerns of a Surgical Patient, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas, May 17, 2017*) | August 2015 | 3 | 0 |
| TJC | July 2017 | | |
| • Hospital Accreditation | | 54 | 0 |
| • Behavioral Health Care Accreditation | | 1 | 0 |
| • Home Care Accreditation | | 1 | 0 |

*Sources: OIG and TJC (Inspection/survey results verified with the Director on April 25, 2018)*

## Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 5 summarizes key indicators of risk since the OIG's previous August 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of April 23, 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 Central Arkansas Veterans Healthcare System is a highest complexity (1a) Facility as described in Appendix B.)

**Table 5. Summary of Selected Organizational Risk Factors (August 2015 to April 23, 2018)**

| Factor | Number of Occurrences |
|---|---|
| Sentinel Events[20] | 6 |
| Institutional Disclosures[21] | 16 |
| Large-Scale Disclosures[22] | 0 |

*Source: Central Arkansas Veterans Healthcare System's Patient Safety Manager (received April 25, 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 6 summarizes Patient Safety Indicator data from October 1, 2015, through September 30, 2017.

**Table 6. 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 | 2.29 |
| Death among surgical inpatients with serious treatable conditions | 100.97 | 85.80 | 66.04 |
| Iatrogenic pneumothorax | 0.19 | 0.21 | 0.39 |
| Central venous catheter-related bloodstream infection | 0.15 | 0.14 | 0.00 |
| In-hospital fall with hip fracture | 0.08 | 0.02 | 0.00 |

[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 16 | Facility |
| Perioperative hemorrhage or hematoma | 1.94 | 1.86 | 2.54 |
| Postoperative acute kidney injury requiring dialysis | 0.88 | 1.00 | 1.77 |
| Postoperative respiratory failure | 5.55 | 2.65 | 3.28 |
| Perioperative pulmonary embolism or deep vein thrombosis | 3.29 | 3.61 | 2.45 |
| Postoperative sepsis | 4.00 | 4.84 | 7.95 |
| Postoperative wound dehiscence | 0.52 | 0.00 | 0.00 |
| Unrecognized abdominopelvic accidental puncture/laceration | 0.53 | 0.65 | 1.66 |

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

Six of the 12 Patient Safety Indicator measures (pressure ulcers, iatrogenic pneumothorax, perioperative hemorrhage or hematoma, postoperative acute kidney injury requiring dialysis, postoperative sepsis, and unrecognized abdominopelvic accidental puncture/laceration) show a higher observed rate than VHA and Veterans Integrated Service Network (VISN) 16. Facility managers reported that multidisciplinary teams reviewed each case individually and collectively, developed processes for improvement as indicated, and monitored the indicators on an ongoing basis. Examples of improvement actions taken include staff re-education on pressure ulcer management, sepsis protocol implementation, coding accuracy training, and daily reviews.

## Veterans Health Administration Performance Data

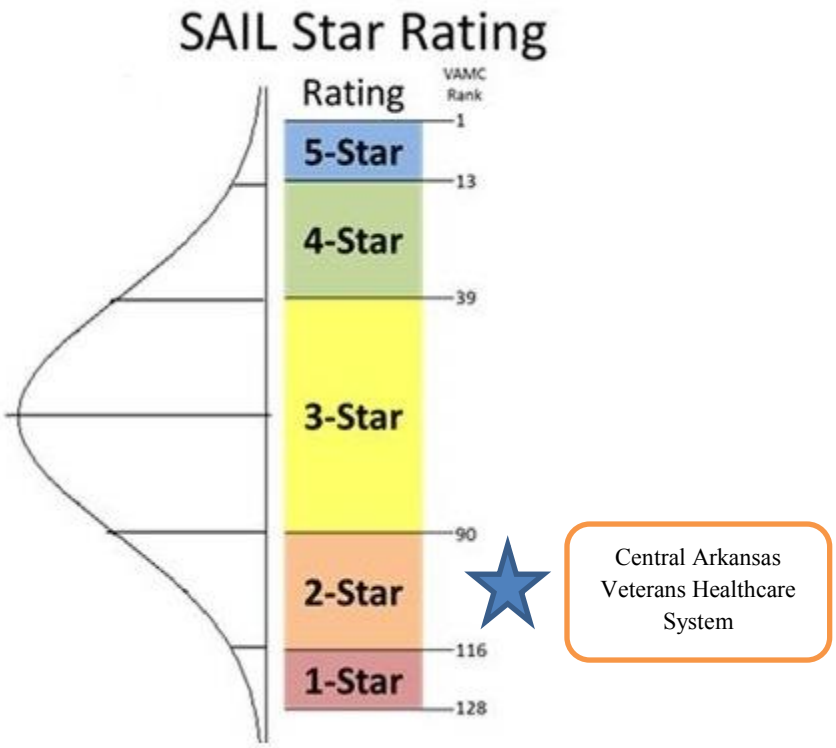
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[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 was rated at "2-Star" for overall quality.

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

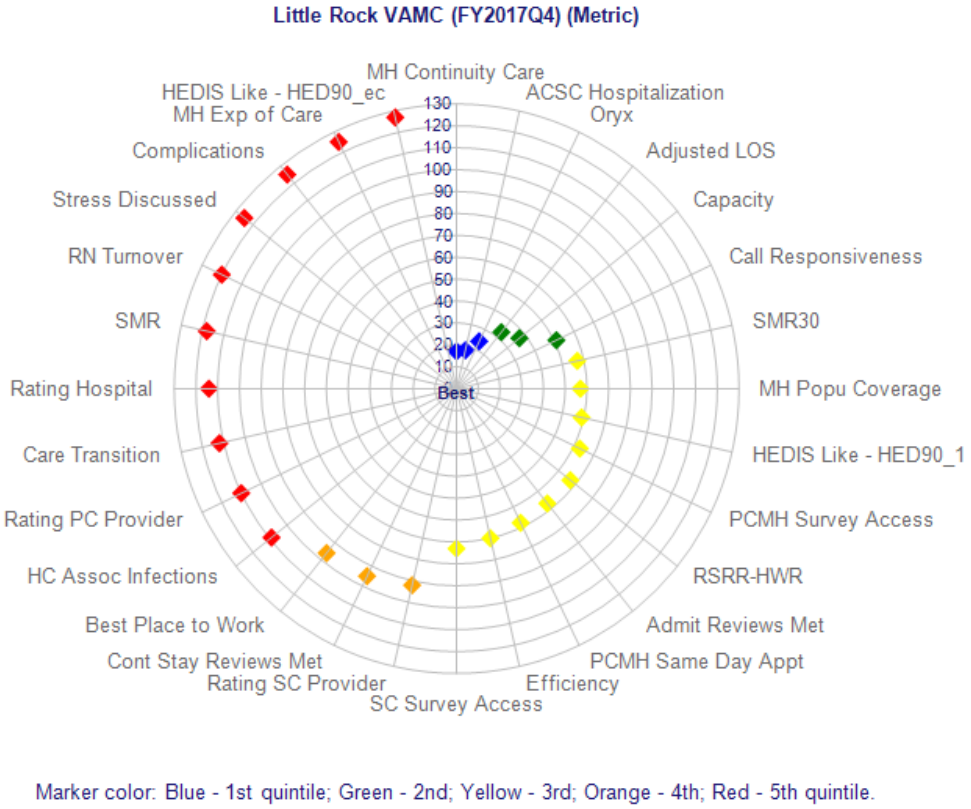



*Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed March 23, 2018)*

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of September 30, 2017. Of note, Figure 6 shows blue and green data points to indicate high performance (for example, Mental Health (MH) Continuity (of) Care, Adjusted Length of Stay (LOS), and Capacity). Metrics that need improvement are denoted in orange and red (for example, Rating (of) Specialty Care (SC) Provider, Healthcare-Associated (HC Assoc) Infections, Registered Nurse (RN) Turnover, and Complications).

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

**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 generally stable executive leadership and active engagement with employees as evidenced by satisfaction scores. However, opportunities exist to improve patient experiences. Facility leaders appear to support 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). The OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors. The leadership team was knowledgeable about selected SAIL metrics but should continue to take actions to improve performance of Quality of Care and Efficiency metrics likely contributing to the current "2-Star" rating.

## Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.[26] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[27]

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

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

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

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

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

[29] According to VHA Directive 1117, *Utilization Management Program*, July 9, 2014, UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

[30] According to VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011, VHA has implemented approaches to improve patient safety, including the reporting of patient safety incidents to 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.

[31] VHA Handbook 1050.01.

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

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

## Conclusion

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

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

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

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

## Utilization Management Documentation

VHA requires that Physician UM Advisors document their decisions in the National UM Integration database regarding appropriateness of patient admissions and continued stays for 75 percent of all inpatient stays.[35] This allows for national level UM data to be available for review by an interdisciplinary group to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes. From July1, 2017, through March 31, 2018, advisors documented only 66 percent of their decisions in the database, resulting in incomplete reviews. Program managers and leaders cited position vacancies, clinical responsibilities, and challenges with the database program as the reasons for noncompliance.

## Recommendation 1

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

Facility Concurred.

Target date for completion: August 31, 2018

Facility response: The Physician Utilization Management Advisors (PUMA) at Central Arkansas Veterans Healthcare System (CAVHS) now utilizes the reminder functions within the National Utilization Management Integration (NUMI) database to improve consistency with documenting their decision. The reminders notify advisors when new decision documentation is required and continues the reminder during the 14-day window when the documentation can be completed.

Compliance will be monitored by conducting audits monthly until three consecutive months of at least 90% compliance is achieved. The numerator will be the number of decisions documented during a calendar month. The denominator is the total number of decisions required to be completed during a calendar month.

[35] VHA Directive 1117.

## 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).[36]

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.[37]

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.[38]

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,[39] and 20 LIPs who were re-privileged within 12 months prior to the visit.[40] The OIG evaluated the following performance indicators:

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

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

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] The 18-month period was from October 23, 2016, through April 23, 2018.

[40] The 12-month review period was from April 23, 2017, through April 23, 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

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

## 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.[41]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG also determined whether the Facility met requirements in selected areas that are often associated with higher risks of harm to patients in the locked MH Unit and with Emergency Management processes.[42]

VHA requires managers to ensure capacity for MH services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting to ensure safety and to provide the type and intensity of clinical intervention necessary to treat the patient. Such care needs to be well integrated with the full continuum of care to support safety and effective management during periods of such severe difficulty. Inpatient MH settings must also provide a healing, recovery-oriented environment.[43]

VHA requires managers to establish a comprehensive Emergency Management program to ensure continuity of patient care and hospital operations in the event of a disaster or emergency, which includes conducting a Hazard Vulnerability Analysis (HVA) and developing an Emergency Operations Plan (EOP).[44] These requirements allow the identification and minimization of impacts from potential hazards, threats, incidents, and events on health care and other essential services provided by facilities. VHA also requires managers to develop Utility Management Plans to ensure reliability and reduce failures of electrical power distribution systems in accordance with TJC,[45] Occupational Safety and Health Administration,[46] and

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

[42] 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).

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

[44] VHA Directive 0320.01, *Comprehensive Emergency Management Program Procedures*, April 6, 2017.

[45] TJC. EOC standard EC.02.05.07.

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

National Fire Protection Association standards.[47] The provision of sustained electrical power during disasters or emergencies is critical to continued operations of a healthcare facility.

In all, the OIG team inspected nine patient care areas. At the Little Rock campus, the OIG inspected medical/surgical 6D and 4C, surgical intensive care, and pre-operative and recovery units; the neurology clinic; and the Emergency Department. At the North Little Rock campus, OIG staff inspected Community Living Center 1 Bravo, primary care clinic 2D, and the locked MH unit 3K. The team also inspected the Hot Springs CBOC. The OIG reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent Facility
  - EOC rounds
  - EOC deficiency tracking
  - Infection prevention
  - General safety
  - Environmental cleanliness
  - General privacy
  - Women veterans' exam room privacy
  - Availability of medical equipment and supplies
- Community Based Outpatient Clinic
  - General safety
  - Medication safety and security
  - Infection prevention
  - Environmental cleanliness
  - General privacy
  - Exam room privacy
  - Availability of medical equipment and supplies
- Locked MH Unit
  - Bi-annual MH EOC Rounds

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

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

## Conclusion

General safety and privacy measures were in place at the parent Facility in Little Rock. The OIG did not note any issues with the availability of medical equipment and supplies, and Emergency Management program met all requirements. However, the OIG identified deficiencies with general safety at the Hot Springs CBOC and in the North Little Rock locked MH unit that warranted recommendations for improvement.

## Hot Springs CBOC Panic Alarm Testing

VHA requires Police and Security Operations to regularly test appropriate physical security precautions and equipment, including panic alarms in high-risk outpatient areas.[48] Regular testing of alarm systems ensures patient and staff safety. At the Hot Springs CBOC, the OIG found no evidence that all computer-based panic alarm systems were tested. The VA Police Chief was aware of requirements and stated that they had recently implemented a new computer-based panic alarm testing system at the CBOC but staff training on the new system had not yet been completed.

## Recommendation 2

2. The Associate Director ensures the VA Police regularly test panic alarms at the Hot Springs community based outpatient clinic and monitors compliance.

[48] VHA Directive 2012-026, *Sexual Assaults and other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

Facility concurred.

Target date for completion: February 28, 2019

Facility response: Beginning in July 2018, all the computers in the Hot Springs community based outpatient clinic (CBOC) are now being tested monthly through the Lynx Duress System. To monitor that the panic alarm tests are occurring, staff are required to log into each computer at the CBOC and acknowledge the internal panic alarm test generated through the Lynx software prior to the last calendar day of each month.

Compliance will be monitored by conducting audits monthly until three consecutive months of at least 90% compliance is achieved. The numerator will be those computers where compliant acknowledgements to the panic alarm test are made by the last day of the calendar month. The denominator is the number of computers within the CBOC.

## Locked Mental Health Unit Panic Alarms

VHA requires Police and Security Operations to periodically test and document response time to panic alarms in locked MH units to ensure patient, visitor, and staff safety.[49] At the North Little Rock locked MH unit, the OIG did not find evidence that all computer-based panic alarm systems were tested, and for those that were tested, VA Police response times were not documented. The VA Police Chief was aware of requirements to test all panic alarms and cited lack of oversight as the reason for noncompliance. The VA Police Chief was not aware of requirements to document response time for panic alarm testing.

## Recommendation 3

3. The Associate Director ensures the VA Police test panic alarms and document response time to alarm testing at the locked mental health unit and monitors compliance.

Facility concurred.

Target date for completion: January 31, 2019

Facility response: Beginning in July 2018, CAVHS Police and Mental Health staff conduct quarterly panic alarm tests that include documented police response times to the locked mental health unit.

[49] VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, December 8, 2016.

Compliance will be monitored by conducting audits quarterly until 100% compliance is achieved. The numerator will be the number of tests with a documented response time. The denominator is the number of tests in a quarter for the locked mental health unit (1).

## 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.[50] 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.[51]

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.[52] 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.[53] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[54] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[55] CS inspection quarterly trend reports for the prior four quarters;[56] 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

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

[51] 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.

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

[53] 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.

[54] The review period was October 2017 through March 2018.

[55] The review period was April 2017 through March 2018.

[56] The four quarters were from April 2017 through March 2018.

  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transition
  - Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from conflicts of interest
  - Appointed in writing by the Director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSIs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated
  - Security and documentation of drugs held for destruction[57]

[57] 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 requirements for most of the performance indicators evaluated, including annual physical security surveys, ordering procedures, and the CSC and CSIs having no conflict of interest and completing required training. However, the OIG identified deficiencies with the monthly summary reports, reconciliation of CS distribution and returns to pharmacy stock, verification of written CS orders, and inspection of the emergency drug cache that warranted recommendations for improvement.

## Controlled Substance Coordinator Monthly Summary Reports

VHA requires CSC to provide the Director with a monthly summary of findings, including discrepancies and vulnerabilities, identified during monthly CS inspections.[58] This ensures CS issues are addressed in a timely manner and that appropriate actions are taken and implemented. The OIG noted that the CSC's monthly report to the Director did not include all discrepancies or findings recorded by CSIs in the inspection reports. For example, for the 10 CS monthly area inspection reports reviewed for the two prior completed quarters, the CSIs documented 2 to 5 discrepancies each month, but the monthly summaries did not include all reported discrepancies.[59] Failure to report CS program issues may cause a delay in responding to critical issues and puts the Facility at risk for diversion. Program managers confirmed that the monthly reports did not include all inspection discrepancies or findings. The CSC, appointed on the first day of the OIG visit, acknowledged a lack of program oversight.

## Recommendation 4

4. The Facility Director ensures that the Controlled Substances Coordinator's monthly summary of findings includes all discrepancies from the inspections and monitors compliance.

[58] VHA Directive 1108.02(1).

[59] CS monthly summary of findings from October 2017 through March 2018.

Facility concurred.

Target date for completion: August 31, 2018

Facility response: The Controlled Substances Coordinator's (CSC) monthly summary of findings are now including all discrepancies that occurred during the reporting period including those that were corrected prior to reporting.

Compliance will be monitored by conducting monthly audits until 100% compliance is achieved for three consecutive months. The numerator is the number of discrepancies that were included in the CSC's monthly summary report. The denominator is the number of discrepancies included in all controlled substance inspector's reports.

### Controlled Substances Area Inspections: Reconciliation of Dispensing and Return of Stock for One Random Day

VHA requires CS program staff to reconcile the restocking/refilling from the pharmacy to every automated dispensing cabinet and the return of stock to pharmacy from every automated dispensing cabinet for one random day during CS area inspections.[60] The reconciliation provides the opportunity to identify potential drug diversion activities and any discrepancies with refilling or returning CS.

The OIG found that reconciliation of the dispensing of CS and returns to pharmacy stock was not conducted in 7 of 10 CS areas for the six months of inspection reports reviewed. However, OIG staff noted that the reconciliation report from pharmacy did include all CS areas, particularly areas with a limited quantity of CS. Pharmacy staff acknowledged that the CSI reconciliation reports did not capture all automated dispensing cabinets with CS. Failure to reconcile CS dispensing and returns in all CS areas may cause delay in identifying any potential drug diversion activities. The CSC and program managers believed that the reconciliation reports from pharmacy met requirements.

## Recommendation 5

5. The Facility Director ensures that reconciliation of controlled substances dispensing from the pharmacy to every automated dispensing cabinet and returns to pharmacy stock is performed during controlled substances inspections and monitors compliance.

[60] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: November 30, 2018

Facility response: Beginning in August 2018, the process for the way the Controlled Substance Inspectors complete the required monthly automated dispensing cabinet reconciliation audit has been adjusted to reconcile drug receipt/return history for each automated dispensing cabinet.

Compliance will be monitored by conducting monthly audits until at least 90% compliance is achieved for three consecutive months. The numerator will be the number of automated dispensing cabinets with controlled substance inspection audit. The denominator will be the number of automated dispensing cabinets in use within the health system.

### Verification of Orders

VHA requires that CSIs verify during CS area inspections that there is evidence of a written CS order for a prescribed number of randomly selected patients.[61] This ensures accountability for all CS. The OIG noted that CS order verifications were completed at the Little Rock Outpatient Pharmacy for the six months of inspection reports reviewed;[62] however, two out of six months were missed at the North Little Rock Outpatient Pharmacy. Failure to verify orders may cause delay in identifying any potential drug diversion activities. Facility managers acknowledged a lack of oversight.

## Recommendation 6

6. The Facility Director ensures that controlled substances inspectors verify written controlled substance orders during monthly area inspections and monitors compliance.

Facility concurred.

Target date for completion: November 30, 2018

Facility response: Beginning in August 2018, the revised controlled substance inspection form used by the controlled substance inspectors includes written controlled substance order verification.

Compliance will be monitored by conducting monthly audits until at least 90% compliance is achieved for three consecutive months. The numerator will be the number of controlled substance inspection forms that include written order verification. The denominator will be the number of controlled substance inspection forms with required written order verification.

[61] VHA Directive 1108.02.

[62] CS monthly summary of findings from October 2017 through March 2018.

## Emergency Drug Cache Inspections

VHA requires CSIs to complete a quarterly physical inventory of the CS in the emergency drug cache by breaking the locks and physically counting all CS. In each of the two months of the quarter in which the physical inventory does not occur, the CSI must check the locks for any evidence of tampering and verify the lock numbers.[63] This ensures there is no evidence of tampering with the emergency drug cache and that the cache does not contain expired CS in case of any disaster or emergency.

The OIG found that CSIs did not inspect the emergency drug cache in four out of six months of inspection reports reviewed. Failure to perform required inspections delays the replacing of expired CS and compromises the Facility's emergency readiness. Pharmacy managers reported that miscommunication between the inpatient and outpatient pharmacy CSIs resulted in missed inspections.

## Recommendation 7

7. The Facility Director ensures controlled substances inspectors complete emergency drug cache inspections and monitors compliance.

Facility concurred.

Target date for completion: November 30, 2018

Facility response: In July 2018, training was completed for all controlled substance inspectors and responsible pharmacist responsible for completing emergency drug cache inspections each month.

Compliance will be monitored by conducting monthly audits until 100% compliance is achieved for three consecutive months. The numerator will be the number of completed emergency drug cache inspection forms turned in each month. The denominator will be the required emergency drug cache inspections due each month (1).

[63] VHA Directive 1108.02.

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

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

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed.[66] VHA[67] 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.

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 48 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

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

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

[65] VHA Handbook 1160.03.

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

[67] 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 general compliance with the offer of, referral for, and completion of further diagnostic evaluations by providers. However, the OIG identified a deficiency in timely completion of suicide risk assessments that warranted a recommendation for improvement.

## Suicide Risk Assessment

VHA requires that appropriate providers assess patients with positive PTSD screen by the end of the next business day to ensure immediate safety risks are identified and addressed.[68] The OIG estimated that providers completed suicide risk assessments by the end of the next business day in 73 percent of the EHRs reviewed; and 95 percent of the time, the true compliance rate is between 60.5 and 85.5 percent, which is statistically significantly below the 90 percent benchmark. As a result, patients who were not assessed for suicide were potentially placed at risk because staff did not confirm the severity of the patients' condition and their clinical needs. Program managers attributed this noncompliance to inadequate communication of patients' positive screens between clinic staff and providers.

## Recommendation 8

8. The Chief of Staff ensures providers complete suicide risk assessments within the required timeframe for patients with positive post-traumatic stress disorder screens and monitors compliance.

Facility concurred.

Target date for completion: March 31, 2019

Facility response: Education for providers in the primary care and mental health services regarding use of clinical reminders for PTSD screening was developed and shared with providers during FY18. The goal for the education was to increase compliance with the completion of suicide risk assessments within the required timeframe for patients with a positive PTSD screen. The actions taken have been value added as evidenced by the facility's External Peer Review Program (EPRP) Suicide Risk Evaluation-1 (SRE-1) score during the current fiscal year. The quarterly compliance averages in the EPRP SRE-1 for providing a suicide risk assessment within 24-hours for Veterans with a positive PTSD or depression screen are as follows: 1QFY18: 90%; 2QFY18: 86%; 3QFY18: 92%.

[68] VHA Handbook 1160.03.

Compliance will be monitored by conducting monthly audits until at least 90% compliance is achieved for three consecutive months. Twenty-five (25) patients with a positive PTSD screen during an outpatient visit will be randomly selected each month. The numerator will be the number of suicide risk assessments completed within 24-hours of a positive PTSD screen. The denominator will be 25.

## 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 geriatric evaluation, OIG staff reviewed relevant documents and interviewed key employees and managers.[75] Additionally, the team reviewed the EHRs of 40 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

[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.

[75] Home Health Care Service Education/Performance Improvement/Administrative meeting minutes from May 26, 2017, through March 27, 2018.

  - 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 was compliant with provision of clinical care and interventions implementation. However, the OIG identified a deficiency with program oversight and evaluation that warranted a recommendation.

## Program Oversight and Evaluation

VHA requires the leadership board responsible for oversight of all performance improvement activities to review and oversee the GE program performance improvement activities at the Facility.[76] This provides the opportunity to identify practice improvements, ensures appropriate actions were taken, and measures the effectiveness of actions on a regular basis. The OIG noted that the GE program's performance improvement activities were reported separately to the Community Living Center (CLC) and the Home Health Care Services Sub-Committees. However, the OIG found that only the activities reported to the Community Living Center Sub-Committee were further reviewed by the Joint Leadership Council. Program managers believed that they met the requirement by submitting Home Health Care Services Sub-Committees performance improvement data to the QSV Committee. As a result, the executive leaders could not maintain effective oversight for all GE program performance improvement efforts.

## Recommendation 9

9. The Facility Director ensures that the Joint Leadership Council maintain oversight of all geriatric evaluation program performance improvement activities and monitors compliance.

[76] VHA Directive 1140.04.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: Beginning in July 2018, the Home Based Primary Care team reports geriatric evaluation performance improvement data on a consistent basis through the Patient Safety Risk Management Committee to the executive leadership team during the Joint Leadership Council (JLC). The performance improvement data includes hand hygiene compliance rates.

Compliance will be monitored by conducting monthly audits until 100% compliance is achieved for three consecutive months. The numerator will be the compliance to the PI data being shared as evidenced by documenting in the JLC minutes and the denominator will be the number of JLC meetings held per month (1).

## 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.[77] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veteran's Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening. [78] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services including mammography services to eligible women veterans.[79]

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Communication with patients must be documented.[80]

The OIG 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 OIG 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

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

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

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

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

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

## Conclusion

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

## High-Risk Processes: Central Line-Associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[81] 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,"[82] 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.[83]

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."[84]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[85] 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.[86]

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 36 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

[81] TJC. Infection Prevention and Control: IC.01.03.01.

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

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

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

[85] 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.

[86] 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 OIG found general compliance 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 | • 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 | Nine 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 | • Protected peer review of clinical care<br>• UM reviews<br>• Patient safety incident reporting and RCAs | • None | • Physician UM Advisors consistently document their decisions in the National UM Integration database. |
| Credentialing and Privileging | • Medical licenses<br>• Privileges<br>• FPPEs<br>• OPPEs | • None | • 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>• Locked MH Unit<br>  ○ Bi-annual MH EOC rounds<br>  ○ Nursing station security<br>  ○ Public area and general unit safety<br>  ○ Patient room safety<br>  ○ Infection prevention<br>  ○ Availability of medical equipment and supplies<br>• Emergency Management<br>  ○ Hazard Vulnerability Analysis (HVA)<br>  ○ Emergency Operations Plan (EOP)<br>  ○ Emergency power testing and availability | • VA Police regularly test panic alarms at the Hot Springs CBOC.<br>• VA Police test panic alarms and document response time to alarm testing at the locked MH unit. | • 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 | • CSIs consistently conduct emergency drug cache inspections. | • Monthly reports to the Director include all findings and discrepancies from CS inspections.<br>• CS program staff reconcile CS dispensing from the pharmacy to every ADC and returns to pharmacy stock.<br>• CSIs verify written CS orders during monthly area inspections. |
| 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 | • Providers complete suicide risk assessments, within the required timeframe, for patients with positive PTSD screens. | • None |
| Long-Term Care: Geriatric Evaluations | • Provision of or access to geriatric evaluation<br>• Program oversight and evaluation requirements<br>• Geriatric evaluation requirements<br>• Geriatric management requirements | • None | • Joint Leadership Council maintains oversight of all GE program performance improvement activities. |
| 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 |
| High-Risk Processes: Central Line-Associated Bloodstream Infections | • Policy and infection prevention risk assessment<br>• Committee discussion<br>• Infection incidence data | • None | • None |

| Healthcare Processes | Performance Indicators | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|---|---|
| | • Education and educational materials<br>• Policy, procedure, and checklist for insertion and maintenance of central venous catheters | | |

# Appendix B: Facility Profile and VA Outpatient Clinic Profiles

## Facility Profile

The table below provides general background information for this highest complexity (1a)[87] affiliated[88] Facility reporting to VISN 16.

**Table 7. Facility Profile for Little Rock (598)
(October 1, 2014, through September 30, 2017)**

| Profile Element | Facility Data FY 2015[89] | Facility Data FY 2016[90] | Facility Data FY 2017[91] |
|---|---|---|---|
| Total Medical Care Budget in Millions | $575.0 | $589.9 | $601.2 |
| Number of: | | | |
| • Unique Patients | 84,911 | 82,363 | 75,014 |
| • Outpatient Visits | 872,952 | 906,610 | 918,871 |
| • Unique Employees[92] | 2,906 | 2,847 | 2,770 |
| Type and Number of Operating Beds: | | | |
| • Community Living Center | 119 | 152 | 152 |
| • Domiciliary | 119 | 119 | 119 |
| • Medicine | 140 | 140 | 140 |
| • Mental Health | 60 | 60 | 60 |
| • Neurology | 9 | 9 | 9 |
| • Residential Psychology | 25 | 25 | 25 |
| • Surgery | 46 | 46 | 46 |
| Average Daily Census: | | | |
| • Community Living Center | 93 | 97 | 77 |

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

[88] Associated with a medical residency program.

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

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

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

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

| Profile Element | Facility Data FY 2015[89] | Facility Data FY 2016[90] | Facility Data FY 2017[91] |
|---|---|---|---|
| • Domiciliary | 112 | 104 | 105 |
| • Medicine | 93 | 77 | 78 |
| • Mental Health | 40 | 38 | 40 |
| • Neurology | 2 | 0 | 0 |
| • Rehab Medicine | 5 | n/a | n/a |
| • Residential Psychology | 16 | 19 | 15 |
| • Surgery | 26 | 25 | 21 |

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

## VA Outpatient Clinic Profiles[93]

The VA outpatient clinics in communities within the catchment area of the Facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 8 provides information relative to each of the clinics.

**Table 8. VA Outpatient Clinic Workload/Encounters[94] 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[95] Provided | Diagnostic Services[96] Provided | Ancillary Services[97] Provided |
|---|---|---|---|---|---|---|
| Mountain Home, AR | 598GA | 10,033 | 2,034 | Dermatology<br>Endocrinology<br>Infectious Disease<br>Eye | Radiology | Pharmacy<br>Weight Management<br>Nutrition |
| El Dorado, AR | 598GB | 5,771 | 1,597 | Dermatology<br>Infectious Disease | n/a | Pharmacy<br>Nutrition |

[93] Includes all outpatient clinics in the community that were in operation as of August 15, 2018. The OIG omitted Little Rock, AR (598QA), as no workload/encounters or services were reported.

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

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

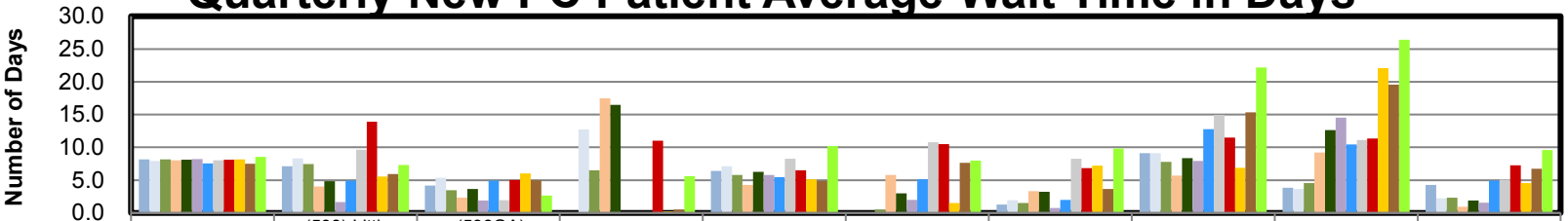
[96] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

[97] 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[95] Provided | Diagnostic Services[96] Provided | Ancillary Services[97] Provided |
|---|---|---|---|---|---|---|
| Hot Springs, AR | 598GC | 12,080 | 3,995 | Infectious Disease | Laboratory & Pathology<br>Radiology | Alternative Nutrition<br>Pharmacy |
| Mena, AR | 598GD | 4,431 | 1,370 | Dermatology<br>Infectious Disease | n/a | Pharmacy<br>Weight Management<br>Nutrition |
| Pine Bluff, AR | 598GE | 7,158 | 2,894 | Endocrinology | Radiology | Nutrition<br>Pharmacy<br>Weight Management |
| Searcy, AR | 598GF | 7,690 | 4,148 | Dermatology<br>Endocrinology<br>Infectious Disease | Laboratory & Pathology<br>Radiology | Alternative Nutrition<br>Pharmacy<br>Weight Management |
| Conway, AR | 598GG | 10,660 | 3,434 | Infectious Disease<br>Eye | Laboratory & Pathology<br>Radiology | Alternative Nutrition<br>Pharmacy |
| Russellville, AR | 598GH | 5,050 | 2,245 | Dermatology<br>Endocrinology | Laboratory & Pathology<br>Radiology | Alternative Nutrition<br>Pharmacy |

*Source: VHA Support Service Center and VA Corporate Data Warehouse*
*n/a = not applicable*

# Appendix C: Patient Aligned Care Team Compass Metrics[98,99]




| | VHA Total | (598) Little Rock, AR (John L. McClellan) | (598GA) Mountain Home, AR | (598GB) El Dorado, AR | (598GC) Hot Springs, AR | (598GD) Mena, AR | (598GE) Pine Bluff, AR | (598GF) Searcy, AR | (598GG) Conway, AR | (598GH) Russellville, AR |
|---|---|---|---|---|---|---|---|---|---|---|
| APR-FY17 | 8.2 | 7.1 | 4.2 | 0.0 | 6.4 | 0.0 | 1.3 | 9.1 | 3.9 | 4.3 |
| MAY-FY17 | 7.9 | 8.3 | 5.4 | 12.8 | 7.1 | 0.1 | 2.0 | 9.1 | 3.6 | 2.2 |
| JUN-FY17 | 8.2 | 7.4 | 3.5 | 6.5 | 5.8 | 0.5 | 1.5 | 7.8 | 4.6 | 2.3 |
| JUL-FY17 | 8.0 | 4.1 | 2.3 | 17.5 | 4.3 | 5.8 | 3.3 | 5.7 | 9.2 | 0.9 |
| AUG-FY17 | 8.1 | 4.9 | 3.6 | 16.5 | 6.2 | 3.0 | 3.3 | 8.3 | 12.7 | 1.9 |
| SEP-FY17 | 8.2 | 1.7 | 1.9 | 0.0 | 5.8 | 2.0 | 0.8 | 7.9 | 14.5 | 1.6 |
| OCT-FY18 | 7.5 | 4.9 | 4.9 | 0.0 | 5.4 | 5.1 | 2.0 | 12.8 | 10.5 | 4.9 |
| NOV-FY18 | 8.0 | 9.6 | 2.0 | 0.0 | 8.3 | 10.8 | 8.3 | 15.0 | 11.1 | 5.1 |
| DEC-FY18 | 8.1 | 13.9 | 5.0 | 11.0 | 6.5 | 10.5 | 6.8 | 11.5 | 11.3 | 7.3 |
| JAN-FY18 | 8.2 | 5.5 | 6.0 | 0.3 | 5.1 | 1.5 | 7.2 | 6.9 | 22.1 | 4.6 |
| FEB-FY18 | 7.5 | 6.0 | 5.0 | 0.5 | 4.9 | 7.7 | 3.7 | 15.3 | 19.6 | 6.8 |
| MAR-FY18 | 8.6 | 7.3 | 2.7 | 5.6 | 10.2 | 8.0 | 9.8 | 22.2 | 26.4 | 9.6 |

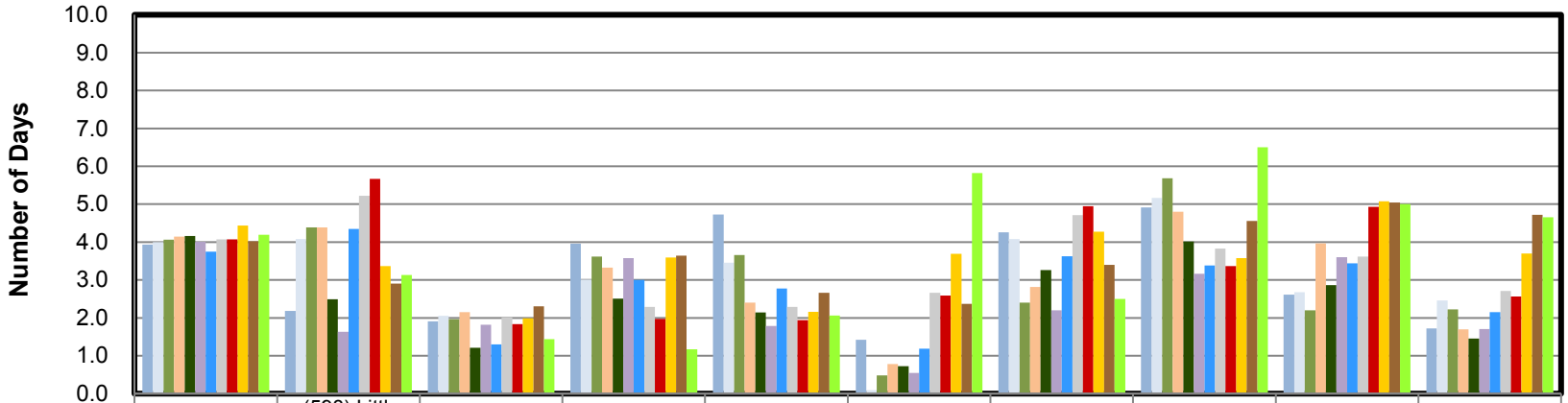
*Source: VHA Support Service Center*

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

***Data Definition**: The average number of calendar days between 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.*

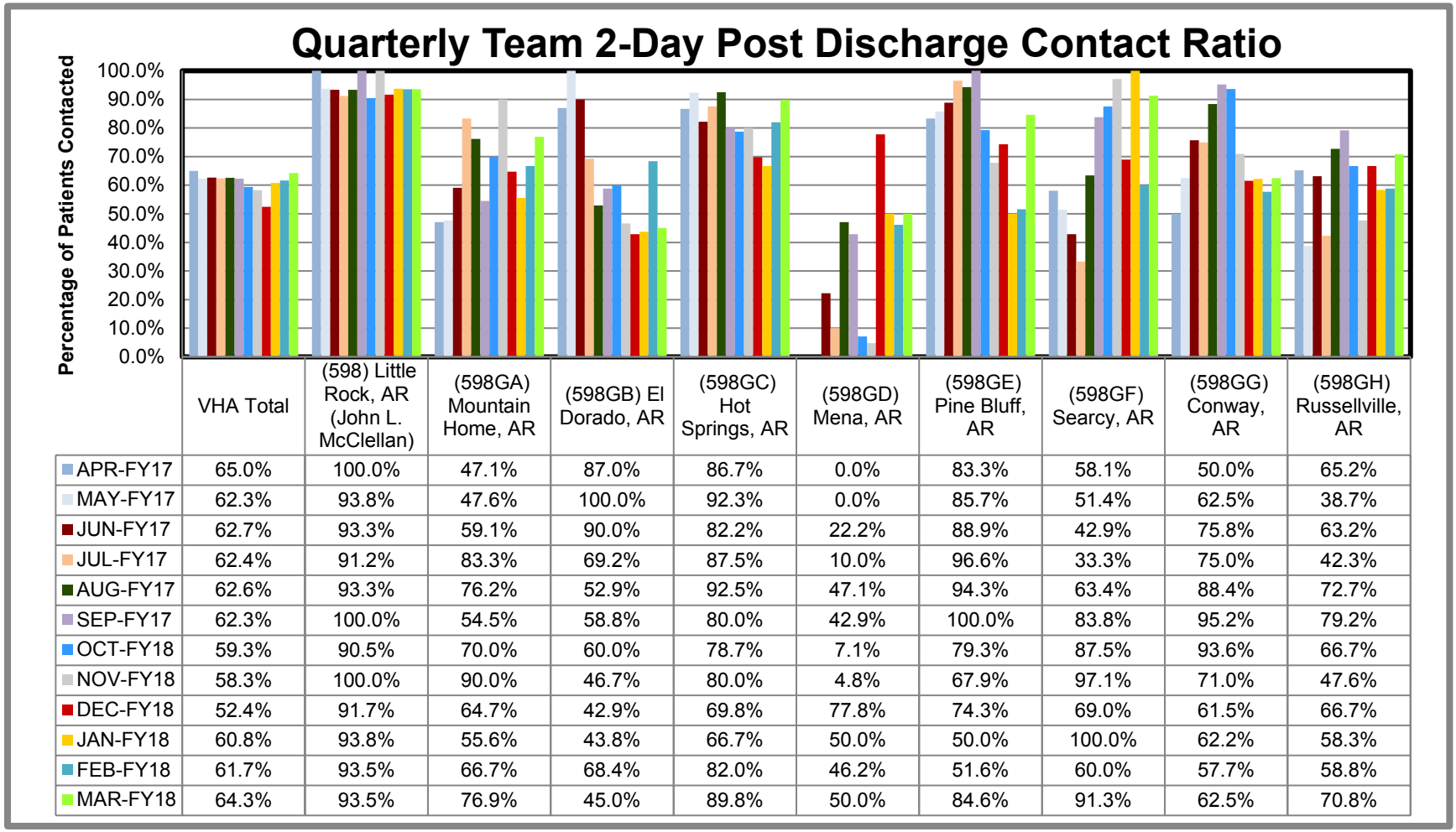
[98] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.

[99] The OIG omitted Little Rock, AR (598QA), as no data was reported.




| | VHA Total | (598) Little Rock, AR (John L. McClellan) | (598GA) Mountain Home, AR | (598GB) El Dorado, AR | (598GC) Hot Springs, AR | (598GD) Mena, AR | (598GE) Pine Bluff, AR | (598GF) Searcy, AR | (598GG) Conway, AR | (598GH) Russellville, AR |
|---|---|---|---|---|---|---|---|---|---|---|
| APR-FY17 | 3.9 | 2.2 | 1.9 | 4.0 | 4.7 | 1.4 | 4.3 | 4.9 | 2.6 | 1.7 |
| MAY-FY17 | 4.0 | 4.1 | 2.1 | 3.0 | 3.5 | 0.1 | 4.1 | 5.2 | 2.7 | 2.5 |
| JUN-FY17 | 4.1 | 4.4 | 2.0 | 3.6 | 3.7 | 0.5 | 2.4 | 5.7 | 2.2 | 2.2 |
| JUL-FY17 | 4.1 | 4.4 | 2.1 | 3.3 | 2.4 | 0.8 | 2.8 | 4.8 | 4.0 | 1.7 |
| AUG-FY17 | 4.2 | 2.5 | 1.2 | 2.5 | 2.1 | 0.7 | 3.3 | 4.0 | 2.9 | 1.5 |
| SEP-FY17 | 4.0 | 1.6 | 1.8 | 3.6 | 1.8 | 0.5 | 2.2 | 3.2 | 3.6 | 1.7 |
| OCT-FY18 | 3.7 | 4.3 | 1.3 | 3.0 | 2.8 | 1.2 | 3.6 | 3.4 | 3.4 | 2.1 |
| NOV-FY18 | 4.1 | 5.2 | 2.0 | 2.3 | 2.3 | 2.7 | 4.7 | 3.8 | 3.6 | 2.7 |
| DEC-FY18 | 4.1 | 5.7 | 1.8 | 2.0 | 1.9 | 2.6 | 4.9 | 3.4 | 4.9 | 2.6 |
| JAN-FY18 | 4.4 | 3.4 | 2.0 | 3.6 | 2.2 | 3.7 | 4.3 | 3.6 | 5.1 | 3.7 |
| FEB-FY18 | 4.0 | 2.9 | 2.3 | 3.6 | 2.7 | 2.4 | 3.4 | 4.6 | 5.0 | 4.7 |
| MAR-FY18 | 4.2 | 3.1 | 1.4 | 1.2 | 2.1 | 5.8 | 2.5 | 6.5 | 5.0 | 4.7 |

*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.*



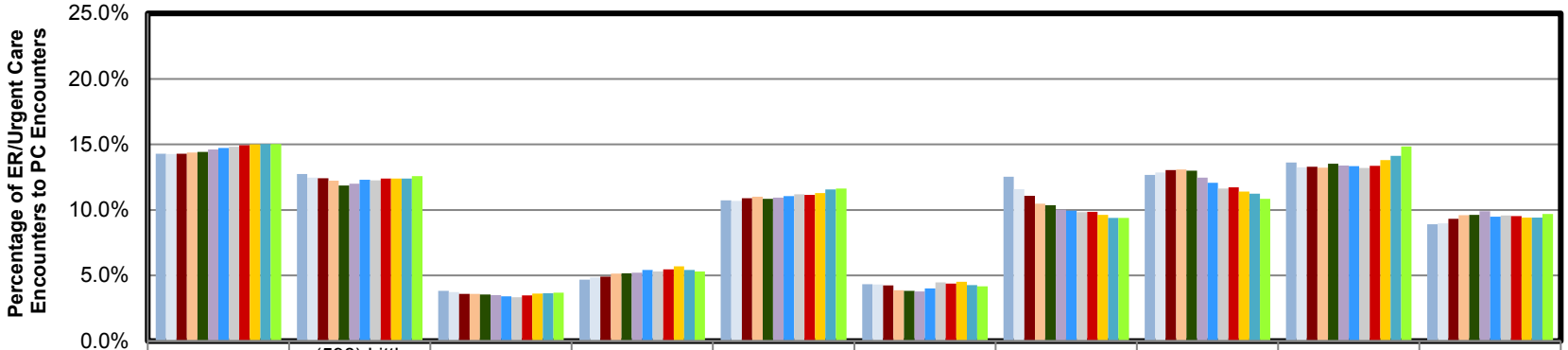

| | VHA Total | (598) Little Rock, AR (John L. McClellan) | (598GA) Mountain Home, AR | (598GB) El Dorado, AR | (598GC) Hot Springs, AR | (598GD) Mena, AR | (598GE) Pine Bluff, AR | (598GF) Searcy, AR | (598GG) Conway, AR | (598GH) Russellville, AR |
|---|---|---|---|---|---|---|---|---|---|---|
| APR-FY17 | 65.0% | 100.0% | 47.1% | 87.0% | 86.7% | 0.0% | 83.3% | 58.1% | 50.0% | 65.2% |
| MAY-FY17 | 62.3% | 93.8% | 47.6% | 100.0% | 92.3% | 0.0% | 85.7% | 51.4% | 62.5% | 38.7% |
| JUN-FY17 | 62.7% | 93.3% | 59.1% | 90.0% | 82.2% | 22.2% | 88.9% | 42.9% | 75.8% | 63.2% |
| JUL-FY17 | 62.4% | 91.2% | 83.3% | 69.2% | 87.5% | 10.0% | 96.6% | 33.3% | 75.0% | 42.3% |
| AUG-FY17 | 62.6% | 93.3% | 76.2% | 52.9% | 92.5% | 47.1% | 94.3% | 63.4% | 88.4% | 72.7% |
| SEP-FY17 | 62.3% | 100.0% | 54.5% | 58.8% | 80.0% | 42.9% | 100.0% | 83.8% | 95.2% | 79.2% |
| OCT-FY18 | 59.3% | 90.5% | 70.0% | 60.0% | 78.7% | 7.1% | 79.3% | 87.5% | 93.6% | 66.7% |
| NOV-FY18 | 58.3% | 100.0% | 90.0% | 46.7% | 80.0% | 4.8% | 67.9% | 97.1% | 71.0% | 47.6% |
| DEC-FY18 | 52.4% | 91.7% | 64.7% | 42.9% | 69.8% | 77.8% | 74.3% | 69.0% | 61.5% | 66.7% |
| JAN-FY18 | 60.8% | 93.8% | 55.6% | 43.8% | 66.7% | 50.0% | 50.0% | 100.0% | 62.2% | 58.3% |
| FEB-FY18 | 61.7% | 93.5% | 66.7% | 68.4% | 82.0% | 46.2% | 51.6% | 60.0% | 57.7% | 58.8% |
| MAR-FY18 | 64.3% | 93.5% | 76.9% | 45.0% | 89.8% | 50.0% | 84.6% | 91.3% | 62.5% | 70.8% |

*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."*

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




| | VHA Total | (598) Little Rock, AR (John L. McClellan) | (598GA) Mountain Home, AR | (598GB) El Dorado, AR | (598GC) Hot Springs, AR | (598GD) Mena, AR | (598GE) Pine Bluff, AR | (598GF) Searcy, AR | (598GG) Conway, AR | (598GH) Russellville, AR |
|---|---|---|---|---|---|---|---|---|---|---|
| APR-FY17 | 14.3% | 12.7% | 3.8% | 4.7% | 10.7% | 4.3% | 12.5% | 12.7% | 13.6% | 8.9% |
| MAY-FY17 | 14.3% | 12.5% | 3.8% | 4.8% | 10.7% | 4.3% | 11.6% | 12.9% | 13.2% | 9.0% |
| JUN-FY17 | 14.3% | 12.4% | 3.6% | 4.9% | 10.9% | 4.2% | 11.1% | 13.0% | 13.3% | 9.3% |
| JUL-FY17 | 14.4% | 12.2% | 3.6% | 5.1% | 11.0% | 3.9% | 10.5% | 13.1% | 13.2% | 9.6% |
| AUG-FY17 | 14.4% | 11.9% | 3.6% | 5.2% | 10.8% | 3.8% | 10.4% | 13.0% | 13.5% | 9.6% |
| SEP-FY17 | 14.6% | 12.0% | 3.5% | 5.2% | 10.9% | 3.8% | 10.0% | 12.5% | 13.4% | 9.9% |
| OCT-FY18 | 14.7% | 12.3% | 3.4% | 5.4% | 11.1% | 4.0% | 9.9% | 12.1% | 13.4% | 9.5% |
| NOV-FY18 | 14.8% | 12.3% | 3.4% | 5.3% | 11.2% | 4.5% | 9.8% | 11.6% | 13.2% | 9.6% |
| DEC-FY18 | 14.9% | 12.4% | 3.5% | 5.5% | 11.2% | 4.4% | 9.9% | 11.7% | 13.4% | 9.5% |
| JAN-FY18 | 15.0% | 12.4% | 3.6% | 5.7% | 11.3% | 4.5% | 9.6% | 11.4% | 13.8% | 9.4% |
| FEB-FY18 | 15.0% | 12.4% | 3.6% | 5.4% | 11.6% | 4.3% | 9.4% | 11.2% | 14.1% | 9.4% |
| MAR-FY18 | 15.0% | 12.6% | 3.7% | 5.3% | 11.6% | 4.2% | 9.4% | 10.9% | 14.8% | 9.7% |

*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[100]

| 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 |

[100] 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 24, 2018

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

Subj: CHIP Review of the Central Arkansas Veterans Healthcare System

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

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

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the recommendations and the facility's response to the draft CHIP report for the Central Arkansas Veterans Healthcare System, Little Rock, AR.

*(Original signed by:)*

Shannon A. Novotny, Acting Network Director

*On behalf of*
Skye McDougall, PhD

*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 24, 2018

From: Director, Central Arkansas Veterans Healthcare System (598/00)

Subj: CHIP Review of the Central Arkansas Veterans Healthcare System, Little Rock, AR

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

I have reviewed and concur with the action plans regarding the Comprehensive Healthcare Inspection Program Review conducted at Central Arkansas Veterans Healthcare System.

*(Original signed by:)*

Catina McClain, MD
Chief of Staff

*for* Margie A. Scott, MD
Medical Center Director
Central Arkansas Veterans Healthcare System (598/00)

*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

| | |
|---|---|
| **Contact** | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
| **Review Team** | Shelia Farrington-Sherrod, MSN, RN, Team Leader<br>Rose Griggs, MSW, LCSW<br>Avisa Hwang, MPH, RN<br>Yoonhee Kim, PharmD<br>Meredith Magner-Perlin, MPH<br>Kathleen Shimoda, BSN, RN |
| **Other Contributors** | Daisy Arugay-Rittenberg, MT<br>Limin Clegg, PhD<br>Justin Hanlon, BS<br>Henry Harvey, MS<br>LaFonda Henry, MSN, RN-BC<br>Scott McGrath, BS<br>Larry Ross, Jr., MS<br>Marilyn Stones, BS<br>Mary Toy, RN, MSN<br>Robert Wallace, ScD, MPH |

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