



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

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare  
Inspection Program Review  
of the Louis A. Johnson VA  
Medical Center

Clarksburg, West Virginia



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**Figure 1.** *Louis A. Johnson VA Medical Center, Clarksburg, West Virginia (Source: <https://vaww.va.gov/directory/guide/>, accessed on July 18, 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
PSM	Patient Safety Manager
PTSD	posttraumatic stress disorder
QSV	quality, safety, and value
RCA	root cause analysis
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Report Overview

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

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

The OIG's current areas of focus are

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

This review was conducted during an unannounced visit made during the week of May 7, 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. At the time of the OIG site visit, the leadership team had been working together for nine months.

Organizational communication and accountability are carried out through a committee reporting structure, with the Executive Leadership Board having oversight for groups such as the Medical Executive, Administrative Executive, and Patient Care Executive Councils. The Facility reinstated the Quality Executive Council in November 2017 where performance data, quality of care, and patient outcomes are reviewed and corresponding actions are followed. However, the OIG noted that the Director is not the chair or co-chair and that the Council had not met quarterly as required by VHA policy.<sup>1</sup> Further, at the time of the onsite visit, the ADPCS was the only executive team member of the Quality Executive Council.

In the review of selected satisfaction survey results regarding Facility leaders, the OIG noted generally satisfied employees and patients.

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.<sup>2</sup> Although the leadership team appeared 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 “4-Star” rating.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,<sup>3</sup> disclosures of adverse patient events, and Patient Safety Indicator data and identified the presence of organizational risk factors that may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored.

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<sup>1</sup> VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, And Value*, August 2, 2013.

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

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

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, ADPCS, and Associate Director. These are briefly described below.

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

The OIG found general compliance with requirements for protected peer reviews and patient safety. The OIG noted inconsistent entry of all patient safety events into the VHA Patient Safety Information System in the one-year timeframe prior to implementing a new system. The OIG also identified deficiencies with utilization management<sup>4</sup> that warranted recommendations for improvement.

### **Credentialing and Privileging**

The OIG found general compliance with requirements for credentialing and Focused Professional Practice Evaluations. However, the OIG identified deficiencies in Ongoing Professional Practice Evaluation processes.

### **Environment of Care**

The OIG noted a safe and clean environment of care with the exception of one inpatient unit with soiled floors. The OIG did not note any issues with the availability of medical equipment and supplies, and the representative community based outpatient clinic generally met the performance indicators evaluated. However, the OIG identified deficiencies with damaged furniture in patient rooms and documentation of emergency generator inspections.

### **Medication Management**

The OIG found general compliance with requirements for Controlled Substances Coordinator (CSC) reports, pharmacy operations, and CSCs and Controlled Substances Inspectors having no conflicts of interest and completing required training. However, the OIG found deficiencies with reconciliation of one day's dispensing and verification of controlled substances orders during monthly area inspections.

### **High-Risk Processes**

Generally, the OIG noted that the Facility has current policies on the use and care of central lines. An annual risk assessment was completed, and data and prevention outcome measures were reported and discussed in appropriate committees. The Facility also used a checklist for

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<sup>4</sup> VHA Directive 1117, *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

central line insertion and maintenance and had educational materials for patients and families. However, the OIG identified a deficiency in staff training.

## Summary

In the review of key care processes, the OIG issued nine recommendations that are attributable to the Director, Chief of Staff, ADPCS, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this Facility. The intent is for Facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

## Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the Comprehensive Healthcare Inspection Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 60–61, for the full text of the Directors' comments.) We consider Recommendation 5 closed. We will follow up on the planned actions for the open recommendations until they are completed.



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## Purpose and Scope

### Purpose

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

### Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.<sup>5,6</sup> Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.<sup>7</sup> Figure 2 shows the direct relationship leadership and organizational risks have with the processes used to deliver health care to veterans.

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management; Controlled Substances (CS) Inspection Program; Mental Health: Posttraumatic Stress Disorder (PTSD) Care; Long-term Care: Geriatric Evaluations; Women’s Health: Mammography Results and Follow-up; and High-Risk Processes: Central Line-Associated Bloodstream Infections (CLABSI) (see Figure 2).<sup>8</sup>

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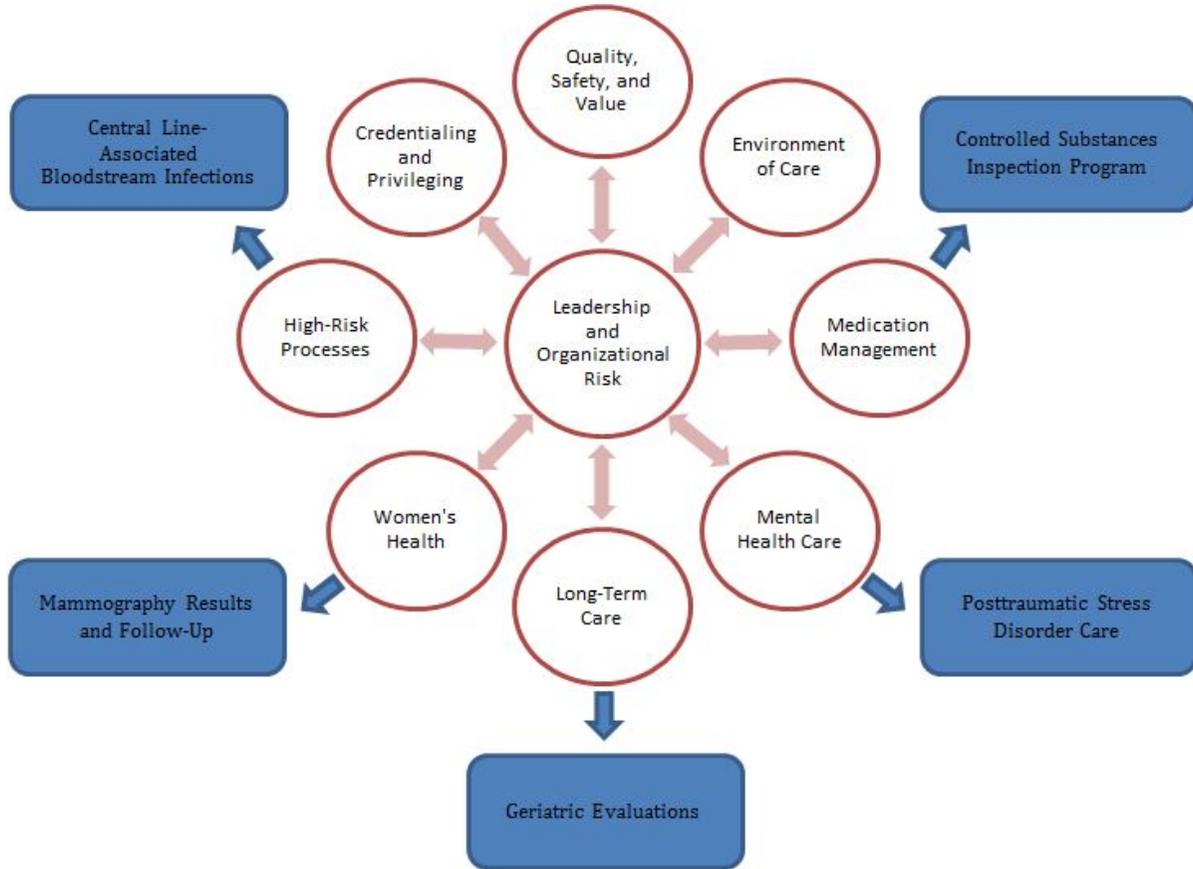
<sup>5</sup> Carol Stephenson, “The role of leadership in managing risk,” *Ivey Business Journal*, November/December 2010. <https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/>. (Website accessed on March 1, 2018.)

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

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

<sup>8</sup> CHIP reviews address these processes during fiscal year (FY) 2018 (October 1, 2017, through September 30, 2018).

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



Source: VA OIG

## Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the EOC, the OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;<sup>9</sup> and discussed processes and validated findings with managers and employees. The OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for September 21, 2015,<sup>10</sup> through May 7, 2018, the date when an unannounced week-long site visit commenced.

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

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

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

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

## Results and Recommendations

### Leadership and Organizational Risks

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

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

### Executive Leadership Stability and Engagement

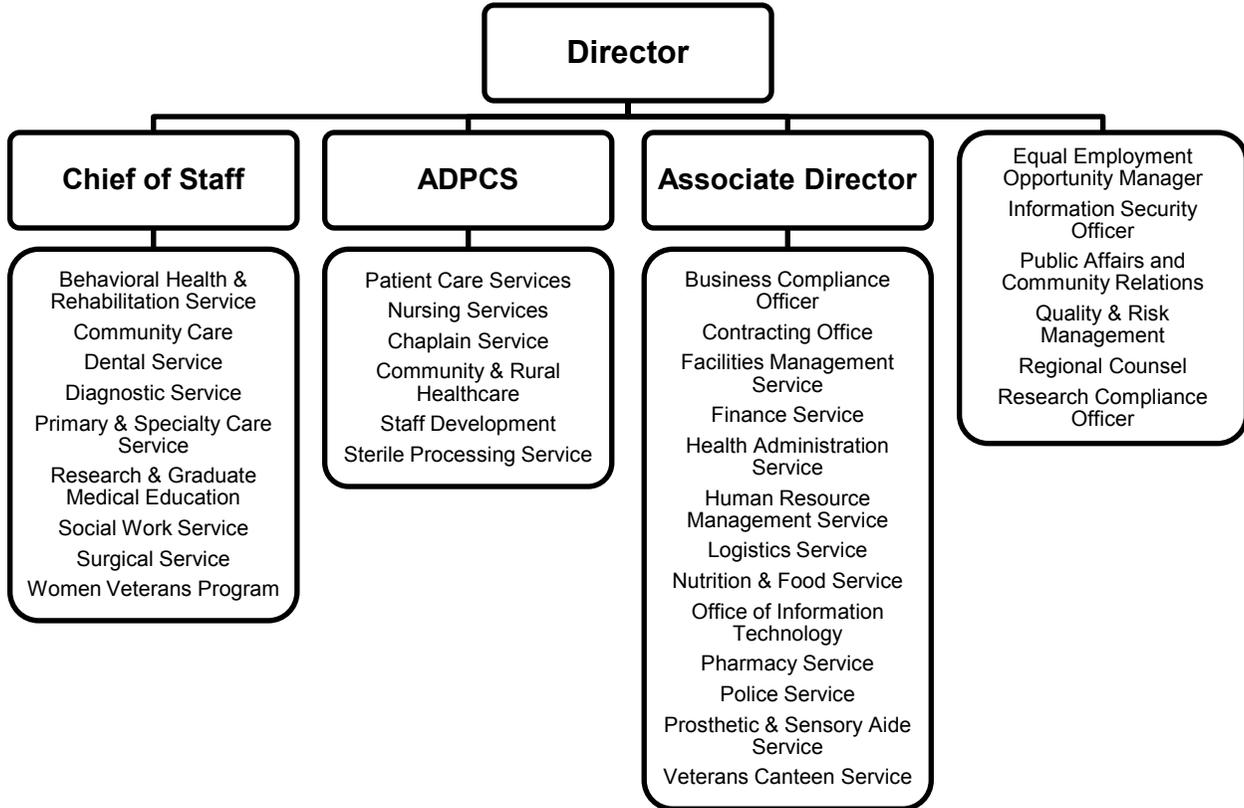
Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ among facilities. Figure 3 illustrates the Facility's reported organizational structure. The Facility has a leadership team consisting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

It is important to note that the Director and Chief of Staff have been in their positions since March 2016 and September 2016, respectively. The ADPCS served in an interim capacity from August 7, 2017, through March 31, 2017, and was permanently assigned on April 1, 2018. The Associate Director was permanently assigned August 7, 2017. Prior to this assignment, the position had been vacant since April 2016 and was filled by 10 different interim appointees, including the permanent Associate Director who served as interim from April 29, 2017, through July 20, 2017. At the time of the OIG site visit, the leadership team had been working together for nine months.

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

**Figure 3. Facility Organizational Chart**



Source: Louis A. Johnson VA Medical Center (received May 7, 2018)

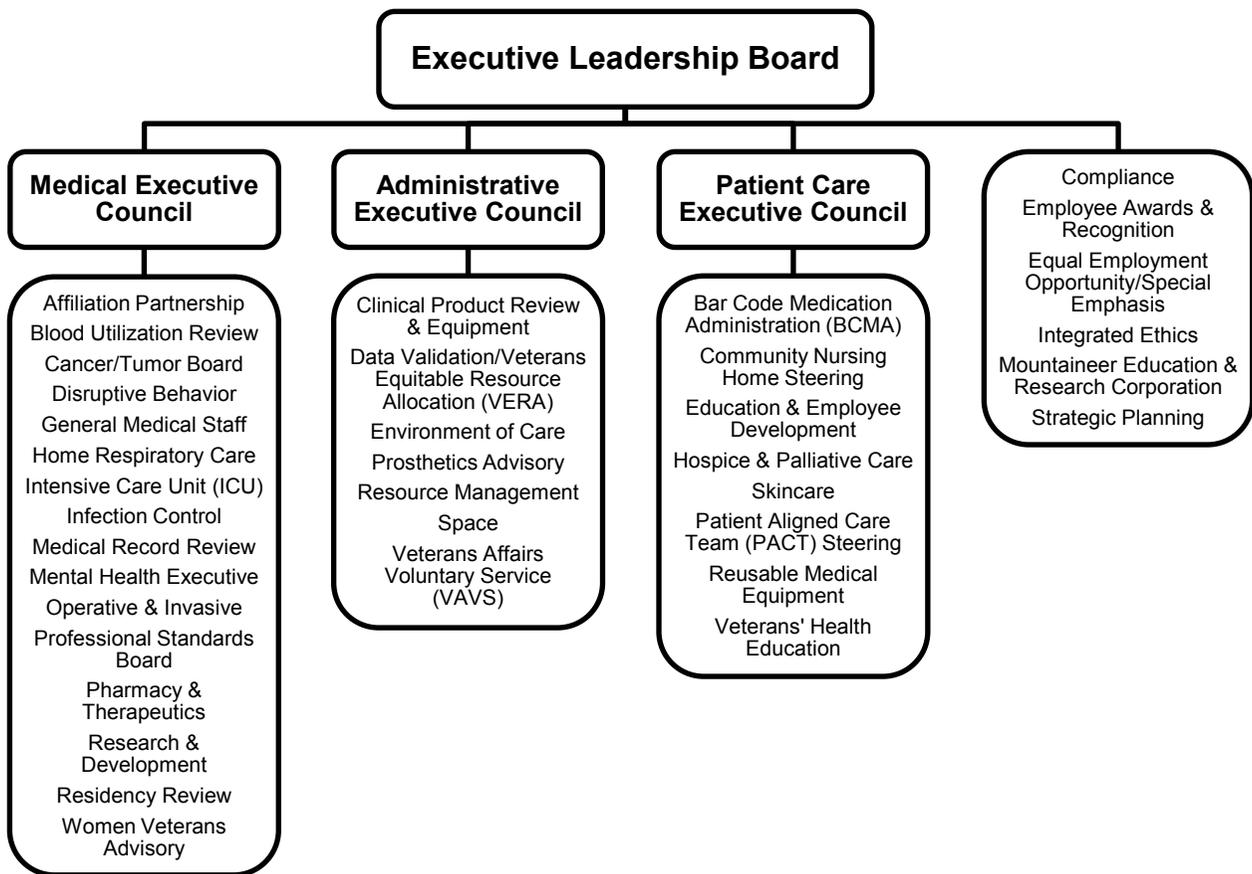
To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members, generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. The Director serves as the chairperson of the Executive Leadership Board with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board also oversees various working groups, such as the Medical Executive, Administrative Executive, and Patient Care Executive Councils. During the 2017 Veterans Integrated Service Network (VISN) 5 Quality review of the Facility’s Quality Management and Patient Safety program, several improvement opportunities were identified, including the development of a comprehensive policy or plan that

encompasses all aspects of the Quality Management program, including Risk Management, Patient Safety, and Accreditation. In addition, the opportunity to include detailed discussion of quality concerns in the meeting minutes was identified. In response, the Facility reinstated the Quality Executive Council in November 2017 where performance data, quality of care, and patient outcomes are reviewed and corresponding actions are followed. However, the OIG noted that the Director is not the chair or co-chair and that the Council had not met quarterly as required by VHA policy.<sup>12</sup> Further, at the time of the onsite visit, the OIG noted that the ADPCS was the only executive team member of the Quality Executive Council. See Figure 4.

**Figure 4. Facility Committee Reporting Structure**



Source: Louis A. Johnson VA Medical Center (received May 7, 2018)

## Employee Satisfaction and Patient Experience

The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. Since 2001, the instrument has been refined at several

<sup>12</sup> VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, And Value*, August 2, 2013).

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 survey and patient experience 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.<sup>13</sup>

Table 1 summarizes employee attitudes toward selected Facility leaders as expressed in VHA’s All Employee Survey.<sup>14</sup> The Facility average for both selected survey questions was above the VHA average.<sup>15</sup> The same trend was noted for the members of the executive leadership team, with the exception of the Associate Director, whose results were lower than the Facility and VHA averages. In all, employees appear generally satisfied with Facility leaders.

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<sup>13</sup> Rating is based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, and Associate Director.

<sup>14</sup> 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.

<sup>15</sup> The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

**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: <i>Servant Leader Index Composite</i>	0–100 where HIGHER scores are more favorable	67.7	69.6	91.6	72.0	73.7	59.2
All Employee Survey Q59. <i>How satisfied are you with the job being done by the executive leadership where you work?</i>	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	3.5	4.5	3.6	3.6	3.1

Source: VA All Employee Survey (accessed April 6, 2018)

Table 2 summarizes employee attitudes toward the workplace as expressed in VHA’s All Employee Survey. The Facility averages for the selected survey questions were similar to or higher than the VHA average. With the exception of the Associate Director, the Facility leaders’ averages were higher than the Facility and VHA averages. Opportunities appear to exist for the Associate Director to provide a safe workplace environment where employees feel comfortable with bringing forth issues or ethical concerns, and all members of the executive team verbalized ongoing efforts to improve the culture of the organization.

**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. <i>My supervisor encourages people to speak up when they disagree with a decision.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.8	4.8	3.9	4.0	3.4
All Employee Survey Q44. <i>I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.9	4.0	4.9	4.2	4.2	3.6
All Employee Survey Q75. <i>I can talk with my direct supervisor about ethical concerns without fear of having my comments held against me.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.9	4.0	4.6	4.1	4.2	3.5

Source: VA All Employee Survey (accessed April 6, 2018)

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

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes towards Facility leaders (see Table 3). For this Facility, all four patient survey results reflected higher care ratings than the VHA average. Patients appear generally satisfied with the leadership and care provided.

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

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	66.7	75.3
Survey of Healthcare Experiences of Patients (inpatient): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	83.4	89.7
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	74.9	78.1
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	75.2	81.5

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

### Accreditation/For-Cause Surveys<sup>16</sup> and Oversight Inspections

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

<sup>16</sup> The Joint Commission (TJC) conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

recently performed by the OIG and The Joint Commission (TJC).<sup>17</sup> Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 4.<sup>18</sup>

The OIG also noted the Facility’s current accreditation status with the Commission on Accreditation of Rehabilitation Facilities<sup>19</sup> and College of American Pathologists,<sup>20</sup> which demonstrates the Facility leaders’ commitment to quality care and services. Additionally, the Long Term Care Institute conducted inspections of the Facility’s Community Living Center.<sup>21</sup>

**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 Louis A. Johnson VA Medical Center, Clarksburg, West Virginia, November 23, 2015)	September 2015	10	0
OIG (Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Louis A. Johnson VA Medical Center Clarksburg, West Virginia, December 16, 2015)	September 2015	9	0
TJC	May 2017		
<ul style="list-style-type: none"> <li>• Hospital Accreditation</li> <li>• Nursing Care Center Accreditation</li> <li>• Behavioral Health Care Accreditation</li> <li>• Home Care Accreditation</li> </ul>		21 0 6 4	0 n/a 0 0

*Sources: OIG and TJC (Inspection/survey results verified with the Chief Quality on May 7, 2018)*

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<sup>17</sup> TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VA medical facilities for over 35 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

<sup>18</sup> A closed status indicates that the Facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

<sup>19</sup> The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA’s commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

<sup>20</sup> For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

<sup>21</sup> Since 1999, the Long Term Care Institute has been to over 3,500 healthcare facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

*n/a = not applicable*

## Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms.

While on site, the OIG requested a list of the Facility's sentinel events from September 2015 through May 7, 2018. Facility managers stated there were no sentinel events identified during this timeframe; however, after the OIG reviewed the Facility's FY 2017 Patient Safety Annual Report,<sup>22</sup> the OIG identified six completed RCAs that appeared to meet criteria for sentinel events;<sup>23</sup> for example, a suicide, malfunction of laser equipment during surgery, and administration of a wrong medication. After the OIG's discussion with Facility managers, the managers re-evaluated the cases and identified one of the six as a sentinel event.

The OIG reviewed the Facility's sentinel event identification process and it appears that the Facility has not consistently applied criteria according to VHA policy to identify sentinel events.<sup>24</sup> In addition, Facility managers did not follow local policy for single identified sentinel events and disclose relevant information to the patient or the patient's representative. The OIG noted that the Facility has opportunities to improve identification of events that require disclosure and sentinel event identification, tracking, and reporting.

Table 5 summarizes key indicators of risk since the OIG's previous September 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of May 7, 2018.<sup>25</sup>

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<sup>22</sup> An end-of-FY Patient Safety Report is submitted to Facility leaders to provide an overview of the program, including sentinel events, aggregate reviews, program successes, etc.

<sup>23</sup> VHA Handbook 1050.01, *National Patient Safety Improvement Handbook*, March 4, 2011.

<sup>24</sup> VHA Handbook 1050.01.

<sup>25</sup> It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the Facility. (Note that the Louis A. Johnson VA Medical Center is a mid-high complexity (1c) affiliated Facility as described in Appendix B.)

**Table 5. Summary of Selected Organizational Risk Factors  
(September 2015 to May 7, 2018)**

Factor	Number of Occurrences
Sentinel Events <sup>26</sup>	1
Institutional Disclosures <sup>27</sup>	2
Large-Scale Disclosures <sup>28</sup>	0

*Sources: Louis A. Johnson VA Medical Center's Patient Safety Manager (received May 8, 2018)*

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.<sup>29</sup> 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.

<sup>26</sup> A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

<sup>27</sup> Institutional disclosure of adverse events (sometimes referred to as “administrative disclosure”) is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or his or her personal representative that an adverse event has occurred during care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.

<sup>28</sup> Large-scale disclosure of adverse events (sometimes referred to as “notification”) is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.

<sup>29</sup> Agency for Healthcare Research and Quality. <https://www.qualityindicators.ahrq.gov/>. (Website accessed on March 8, 2017.)

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 5	Facility
Pressure ulcers	0.60	1.12	0.00
Death among surgical inpatients with serious treatable conditions	100.97	121.02	0.00
Iatrogenic pneumothorax	0.19	0.14	0.00
Central venous catheter-related bloodstream infection	0.15	0.13	0.00
In-hospital fall with hip fracture	0.08	0.03	0.00
Perioperative hemorrhage or hematoma	1.94	1.34	0.00
Postoperative acute kidney injury requiring dialysis	0.88	0.62	0.00
Postoperative respiratory failure	5.55	2.57	0.00
Perioperative pulmonary embolism or deep vein thrombosis	3.29	4.73	3.22
Postoperative sepsis	4.00	2.88	0.00
Postoperative wound dehiscence	0.52	0.00	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.00	0.00

Source: VHA Support Service Center

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

None of the Patient Safety Indicator measures show an observed rate per 1,000 hospital discharges in excess of rates for VISN 5 and VHA.

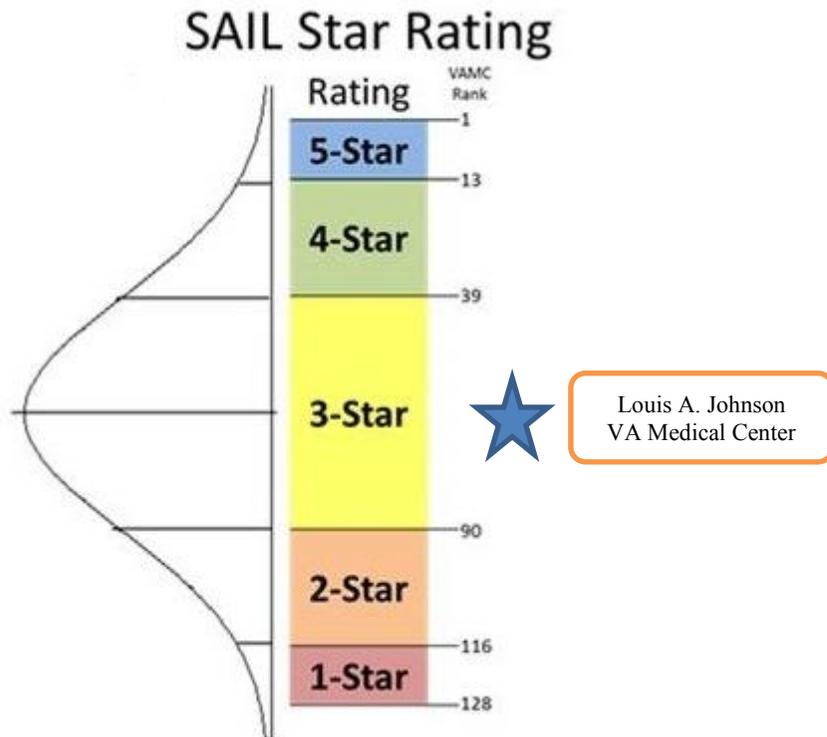
## Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical risk. The data are presented as one “way to understand the similarities and differences between the top and bottom performers” within VHA.<sup>30</sup>

<sup>30</sup> VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146>. (Website accessed on April 16, 2017.)

VA also uses a star-rating system where facilities with a “5-Star” rating are performing within the top 10 percent of facilities and “1-Star” facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.<sup>31</sup> As of June 30, 2017, the Facility was rated at “3-Star” for overall quality. Updated data as of June 30, 2018, indicates that the Facility has improved to “4-Star” for overall quality.

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



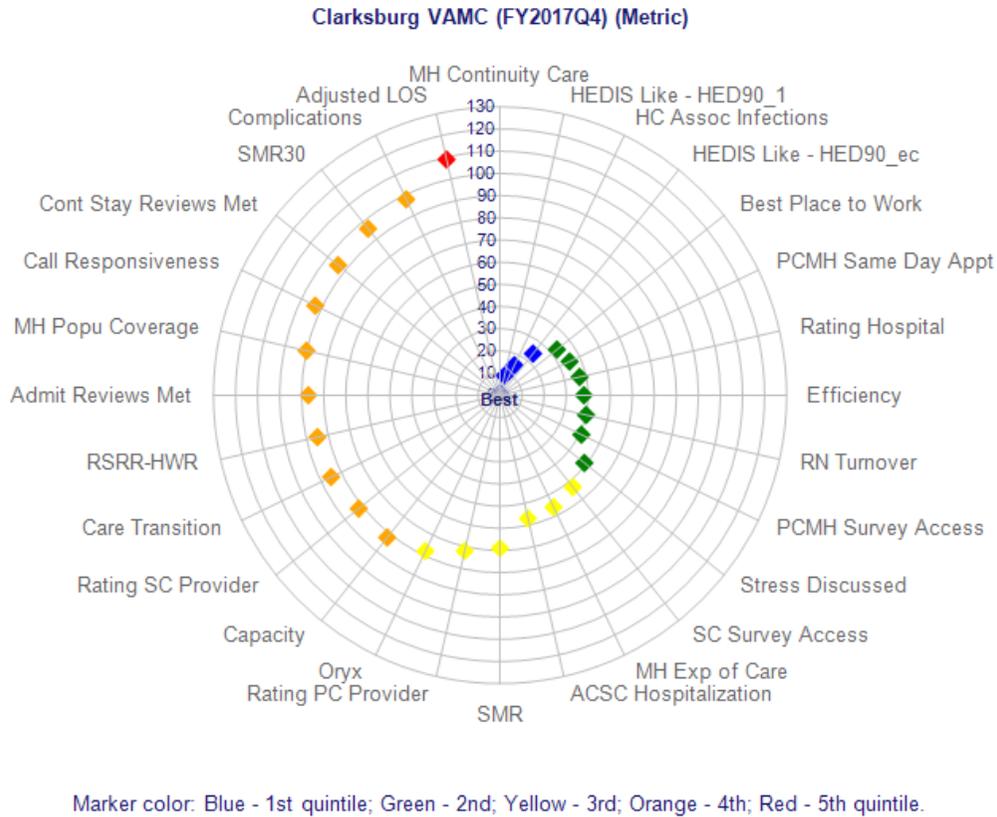
*Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed April 6, 2018)*

Figure 6 illustrates the Facility’s Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of June 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example Mental Health (MH) Continuity (of) Care, Healthcare (HC) Associated (Assoc) Infections, and Rating (of) Hospital).<sup>32</sup> Metrics that need improvement are denoted in orange and red (for example, Capacity, Call Responsiveness, Complications, and Adjusted Length of Stay (LOS)).

<sup>31</sup> Based on normal distribution ranking quality domain of 128 VA Medical Centers.

<sup>32</sup> For data definitions of acronyms in the SAIL metrics, please see Appendix D.

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



Source: VHA Support Service Center

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

## Conclusion

Although all leadership positions were permanently assigned, two of four positions had been filled by interim staff during the year prior to the OIG's on-site visit. The Associate Director position had 10 different interim appointees from April 25, 2016, until the position was filled permanently on August 7, 2017. The interim ADPCS served from August 7, 2017, through March 31, 2018, until permanently selected for the position on April 1, 2018. The OIG noted that Facility leaders were generally engaged with employees and patients and were working to improve employee satisfaction scores. Organizational leaders appeared to support efforts related to patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the Facility through active stakeholder engagement). However, the presence of organizational risk factors—lack of identification, tracking, and reporting of sentinel events and disclosure of adverse events—may contribute to future issues of

noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored. Although the leadership team appeared knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve care and maintain performance of selected Quality of Care and Efficiency metrics that are likely contributing to the current “4-Star” rating.

## Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.<sup>33</sup> VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.<sup>34</sup>

VHA requires that its facilities operate a Quality, Safety, and Value (QSV) program to monitor the quality of patient care and performance improvement activities. The purpose of the OIG review was to determine whether the Facility implemented and incorporated selected key functions of VHA's Enterprise Framework for QSV into local activities. To assess this area of focus, the OIG evaluated the following: protected peer reviews of clinical care,<sup>35</sup> utilization management (UM) reviews,<sup>36</sup> and patient safety incident reporting with related root cause analyses (RCAs).<sup>37</sup>

VHA has implemented approaches to improving patient safety, including the reporting of patient safety incidents to its National Center of Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required RCAs help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the organization.<sup>38</sup>

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<sup>33</sup> VHA Directive 1026.

<sup>34</sup> Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

<sup>35</sup> According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff. (Due for recertification June 30, 2015, but has not been updated.)

<sup>36</sup> According to VHA Directive 1117, UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

<sup>37</sup> According to VHA Handbook 1050.01, VHA has implemented approaches to improve patient safety, including the reporting of patient safety incidents to the VHA National Center for Patient Safety, in order for VHA to learn about system vulnerabilities and how to address them as well as the requirement to implement RCA (a widely-used methodology for dealing with safety-related issues) to allow for more accurate and rapid communication throughout an organization of potential and actual causes of harm to patients.

<sup>38</sup> VHA Handbook 1050.01.

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:<sup>39</sup>

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Entry of all reported patient incidents into VHA's patient safety reporting system<sup>40</sup>
  - Annual completion of a minimum of eight RCAs<sup>41</sup>
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

## Conclusion

The OIG found general compliance with requirements for protected peer reviews and patient safety. However, the OIG noted that all patient safety events were not entered into WebSPOT, the previous software interface for the VHA Patient Safety Information System, for the one year

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<sup>39</sup> For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

<sup>40</sup> 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.

<sup>41</sup> According to VHA Handbook 1050.01, 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.

timeframe prior to implementing Joint Patient Safety Reporting System.<sup>42,43</sup> The OIG also identified deficiencies with UM, which warranted recommendations for improvement.

## Utilization Management: Documentation of Physician UM Advisors' Decisions

VHA requires that Physician UM Advisors document their decisions in the National UM Integration database regarding appropriateness of patient admissions and continued stays.<sup>44</sup> This allows for national level UM data to be available for review by an interdisciplinary group to set benchmarks, identify trends and actions, and determine opportunities to improve efficiency. The OIG found no evidence that advisors documented their decisions in the database for 58 of 104 cases (56 percent) referred to the physician advisors from December 1, 2017, through April 30, 2018, resulting in incomplete reviews. Facility managers stated that although the documentation was inconsistent, the patient admissions and continued stays were discussed with the advisors. Facility managers also stated clinical responsibilities and lack of confidence in the value of the database documentation contributed to 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: December 31, 2018

Facility response: Effective May 11, 2018, Physician Utilization Management Advisors were re-educated on the requirements of completing mandatory documentation. Compliance for this recommendation will be monitored for three consecutive months of exceeding the minimum requirement of 75% of the total Physician Utilization Management Advisor reviews. June 2018 review was 100%, July 2018 review was 93.9% August 2018 review was 100% and current

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<sup>42</sup> The one-year period was August 1, 2016, through July 31, 2017.

<sup>43</sup> The joint patient safety effort was initiated in response to a congressional mandate requiring the Department of Defense (DoD) and Veterans Health Administration (VHA) to develop processes for sharing information regarding error tracking as it relates to patient care.  
[https://www.patientsafety.va.gov/docs/TIPS/2017\\_April\\_May\\_June\\_TIPS\\_Internet\\_FINAL.pdf](https://www.patientsafety.va.gov/docs/TIPS/2017_April_May_June_TIPS_Internet_FINAL.pdf). (Website accessed on August 9, 2018.)

<sup>44</sup> VHA Directive 1117. *Utilization Management Program* (amended January 18, 2018). The amendment to this directive adds clarity to the responsibility section of the Medical Facility Director, by establishing a Physician UM Advisors target and an expectation of 75 percent compliance for Physician UM Advisors to document outcomes in the National UM Integration database.

overall Physician Utilization Management Advisors completion rate is 82.6% for the fiscal year to date.

For sustainment, reports will be sent quarterly to the Quality Executive Council through Utilization Management.

## Utilization Management: Data Review

VHA requires that an interdisciplinary facility group review UM data. This group should include, but not be limited to, representatives from UM, medicine, nursing, social work, case management, MH, and Chief Business Office revenue utilization review.<sup>45</sup> This ensures that an interdisciplinary approach is taken when reviewing UM data for performance improvement.<sup>46</sup>

Facility managers stated they did not have a UM Committee, so minutes were not available for review. The OIG requested other committee minutes that would demonstrate discussion of UM data, and the managers provided the Quality Executive Council minutes from January 2018 to March 2018. Facility managers were not able to provide committee minutes that showed ongoing review of UM data, resulting in a lack of UM review. Facility managers stated they were aware of the requirement but had not established a regular reporting structure for UM because of minimal staffing devoted to this function.

## Recommendation 2

2. The Facility Director ensures the interdisciplinary group or committee that reviews utilization management data includes required representatives and meets regularly and monitors compliance.

Facility concurred.

Target date for completion: February 28, 2019

Facility response: The Utilization Review Coordinator will include all required representatives to meet and or provide input regularly as required. Representatives from utilization management, medicine, nursing, social work, case management and mental health are included and meeting daily as these are employees of the medical center. As an ongoing process, the Chief Business Office Revenue- Utilization Review Nurse or designee will be included in the Quality Executive Council for utilization management data reporting. Monitoring will continue for three consecutive months for compliance and reports will be required quarterly by the Quality Executive Council for sustainment purposes.

<sup>45</sup> VHA Directive 1117.

<sup>46</sup> 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).<sup>47</sup>

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This systematic process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.<sup>48</sup>

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual’s license. Clinical privileges need to be specific, based on the individual’s clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.<sup>49</sup>

The purpose of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of 10 LIPs who were hired within 18 months prior to the on-site visit,<sup>50</sup> and 20 LIPs who were re-privileged within 12 months prior to the visit.<sup>51</sup> The OIG evaluated the following performance indicators:

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

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<sup>47</sup> VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)

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

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

<sup>50</sup> The 18-month period was from November 8, 2016, through May 7, 2018.

<sup>51</sup> The 12-month review period was from May 8, 2017, through May 7, 2018.

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

## Conclusion

The OIG found general compliance with requirements for credentialing and FPPEs. However, the OIG identified deficiencies in OPPE processes.

## Ongoing Professional Practice Evaluations: Re-Privileging

VHA requires that at the time of reprivileging, service chiefs consider relevant, service- and practitioner-specific data utilizing defined criteria when recommending the continuation of LIPs privileges to the Medical Executive Council. Such data is maintained as part of the practitioner's provider profile and may include direct observation, clinical discussions, and clinical reviews. This OPPE is essential to confirm the quality of care delivered and allows the Facility to identify professional practice trends that impact the quality of care and patient safety. VHA also requires the Medical Executive Council to consider all information available prior to making the recommendation for the granting of privileges to the Director and clearly document the

deliberation in the minutes. This ensures that an oversight committee has reviewed the OPPE evidence supporting renewal of privileges.<sup>52</sup>

For 15 of 20 LIPs who were re-privileged, the Facility's Medical Executive Council recommended continuation of privileges without the required OPPE data available for review. Additionally, for three of the five LIPs re-privileged based on complete OPPE results, the OIG did not find evidence that the Medical Executive Council reviewed and discussed these OPPE results. This resulted in providers continuing to deliver care without a thorough evaluation of their practice. Facility managers and key staff stated they did not consistently complete and document OPPEs due to inadequate support from the previous leader in Quality & Risk Management, confusion about requirements for completion of OPPE, frequent turnover among providers, and providers being responsible for administrative tasks along with clinical duties. Facility managers and key staff reported not consistently documenting discussion of OPPE results in the Medical Executive Council meeting minutes due to a shortage in administrative support personnel.

### **Recommendation 3**

3. The Chief of Staff ensures clinical managers consistently collect and review Ongoing Professional Practice Evaluation data and monitors compliance.

Facility concurred.

Target date for completion: February 28, 2019

Facility response: The Chief of Staff provided education to Service Chiefs and Administrative Officers on local policy Memorandum 11-30 Professional Practice Evaluation in May 2018. The Credentialing Coordinator began to send out reminders to services for upcoming reappointments in August 2018. Internal audits will begin in October 2018 and show 90% compliance for three consecutive months. The Credentialing Coordinator will submit monthly reports to the Medical Executive Council which is chaired by the facility Chief of Staff for sustainment purposes.

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<sup>52</sup> VHA Handbook 1100.19.

## Recommendation 4

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

Facility concurred.

Target date for completion: February 28, 2019

Facility response: The Chief of Staff provided education to Service Chiefs and Administrative Officers on local policy Memorandum 11-30 Professional Practice Evaluation in May 2018. The Credentialing Coordinator began to send out reminders to services for upcoming reappointments in August 2018. The Chief of Staff or designee will complete random audits of the Medical Executive Council minutes for three consecutive months at 90% compliance to validate the use of Ongoing Professional Practice Evaluations in determining recommendations for continuation of licensed independent practitioner privileges. Results will be reported monthly to the Medical Executive Council chaired by the Chief of Staff.

## Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.<sup>53</sup>

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements. 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.<sup>54</sup>

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.<sup>55</sup>

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).<sup>56</sup> 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,<sup>57</sup> Occupational Safety and Health Administration,<sup>58</sup> and

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<sup>53</sup> VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

<sup>54</sup> Applicable requirements include various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

<sup>55</sup> VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

<sup>56</sup> VHA Directive 0320.01, *Comprehensive Emergency Management Program Procedures*, April 6, 2017.

<sup>57</sup> TJC. Environment of Care standard EC.02.05.07.

<sup>58</sup> 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.<sup>59</sup> 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 five inpatient units (Community Living Center, intensive care, medical-surgical, locked MH, and post-anesthesia care) in addition to the Emergency Department and Women's Health, surgical, specialty, and primary care clinics. The team also inspected the Wood County CBOC and reviewed the Emergency Management Program. 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
  - Nursing station security

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<sup>59</sup> 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.

- 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. The representative CBOC generally met the performance indicators evaluated. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG noted one inpatient unit had soiled floors.<sup>60</sup> The OIG also identified deficiencies with damaged furniture in patient rooms and documentation of emergency generator inspections that warranted recommendations for improvement.

### Parent Facility: General Safety

TJC requires hospitals to keep furnishings and equipment safe and in good repair.<sup>61</sup> The OIG found damaged furniture in patient rooms on two inpatient units.<sup>62</sup> The OIG determined that Facility managers were aware of the deficiency and were awaiting delivery of replacement furniture.

## Recommendation 5

5. The Associate Director ensures that damaged furniture is repaired or removed from service and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility response: The Chief, Facilities Management Services completed a purchase order to replace all damaged bedside tables throughout the facility. This purchase was completed and

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<sup>60</sup> Community Living Center.

<sup>61</sup> TJC. Infection Prevention and Control standard EC.02.06.01, EP 26.

<sup>62</sup> Medical/surgical unit and intensive care unit.

installed on June 11, 2018. Continuous surveillance and compliance will be completed through Environment of Care rounds which are completed twice a year and reported to Environment of Care Committee.

### **Parent Facility: Emergency Power Testing and Availability**

VHA and TJC require facilities to perform weekly inspections of the emergency power supply system and document results.<sup>63,64</sup> In the event of a power disruption, the emergency power supply system enables the Facility to continue providing patient care. Testing at regular frequencies increases the likelihood of detecting reliability problems and reduces the risk of losing this critical resource when it is most needed. The OIG did not find evidence of weekly inspections of the emergency power supply system. Engineering staff reported conducting and documenting inspections but could not produce evidence. Facility managers stated they were aware of requirements but did not provide adequate oversight to ensure compliance.

### **Recommendation 6**

6. The Associate Director ensures weekly inspections of the emergency power supply system are performed and documented and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: The Chief, Facilities Management Services developed a documentation system to aid in monitoring weekly emergency power supply systems in May 2018. Monitoring will continue until three consecutive months at 100% compliance. Monitoring began in May 2018 and continued through September 2018; compliance was at 100%. Report on this process will be presented in the Environment of Care Committee quarterly.

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<sup>63</sup> VHA Directive 1028 *Electrical Power Distribution Systems*, July 25, 2014.

<sup>64</sup> TJC. EOC standard EC.02.05.07, EP4.

## Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.<sup>65</sup> Diversion by healthcare workers—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—remains a serious problem that can increase serious patient safety issues, causes harm to the diverter, and elevates the liability risk to healthcare organizations.<sup>66</sup>

VHA requires that facility managers implement and maintain a CS inspection program to minimize the risk for loss and diversion and to enhance patient safety.<sup>67</sup> Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSI), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.

The OIG review of these issues was conducted to determine whether the Facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.<sup>68</sup> The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;<sup>69</sup> monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;<sup>70</sup> CS inspection quarterly trend reports for the prior four quarters;<sup>71</sup> and other relevant documents. The OIG evaluated the following performance indicators:

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

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<sup>65</sup> Drug Enforcement Agency Controlled Substance Schedules. <https://www.deadiversion.usdoj.gov/schedules/>. (Website accessed on August 21, 2017.)

<sup>66</sup> American Society of Health-System Pharmacists, “ASHP Guidelines on Preventing Diversion of Controlled Substances,” *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

<sup>67</sup> VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

<sup>68</sup> VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

<sup>69</sup> The review period was October 1, 2017, through March 31, 2018.

<sup>70</sup> The review period was April 1, 2017, through March 31, 2018.

<sup>71</sup> The four quarters were from April 1, 2017, through March 31, 2018.

- CS ordering processes
- Inventory completion during Chief of Pharmacy transition
- Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from conflicts of interest
  - Appointed in writing by the Director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSIs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated
  - Security and documentation of drugs held for destruction<sup>72</sup>
  - Accountability for all prescription pads in pharmacy

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<sup>72</sup> The “Destructions File Holding Report” lists all drugs awaiting local destruction or turnover to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

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

## Conclusion

The OIG found general compliance with requirements for CSC reports, pharmacy operations, and CSCs and CSIs having no conflicts of interest and completing required training. However, the OIG identified deficiencies in reconciliation of one day's dispensing and verification of CS orders that warranted recommendations for improvement.

## Reconciliation of Dispensing

VHA requires CSIs 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 area inspections.<sup>73</sup> The reconciliation provides the opportunity to identify potential drug diversion activities and any discrepancies with refilling or returning CS.

The inspection checklist used by CSIs during area inspections did not include this requirement, and the OIG did not find evidence of this reconciliation during monthly inspections of the 10 clinical areas reviewed. The CSC stated the oversight of the requirement was due to a lack of attention to detail when the checklist was updated.

## Recommendation 7

7. The Facility Director ensures that controlled substance inspectors perform reconciliation of controlled substance dispensing from the pharmacy to automated dispensing cabinets and returns to pharmacy stock during monthly area inspections and monitors compliance.

Facility concurred.

Target date for completion: February 28, 2019

Facility response: The Controlled Substance Coordinator created two new templates which includes dispensing and return to stock actions during monthly area inspections and a PowerPoint for education. This action was created in December 2017 and put into place June 2018. Monthly monitoring will verify controlled substance orders during monthly area inspections for 100% of all locations for three consecutive months. Ongoing monthly reports are presented to the Executive Leadership Team.

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<sup>73</sup> VHA Directive 1108.02(1).

## Verification of Orders

VHA requires that CSIs verify during CS area inspections that there is evidence of a written or electronic CS order for a prescribed number of randomly selected patients.<sup>74</sup> This ensures accountability for all CS. The OIG did not find evidence of order verification during monthly inspections of the 10 clinical areas reviewed. The CSC was aware of the requirement and the oversight of the requirement was due to a lack of attention to detail when the checklist was updated.

## Recommendation 8

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

Facility concurred.

Target date for completion: February 28, 2019

Facility response: In June 2018, the facility Controlled Substance Coordinator developed a new template to include all required elements to verify controlled substance orders monthly. Monthly monitoring will verify controlled substance orders during monthly area inspections for 100% of all locations for three consecutive months. Ongoing reports are presented to the Executive Leadership Team monthly.

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<sup>74</sup> VHA Directive 1108.02(1).

## Mental Health Care: Posttraumatic Stress Disorder Care

Posttraumatic Stress Disorder (PTSD) may occur “following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one’s physical integrity; witnessing an event that involves death, injury, or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate.”<sup>75</sup> For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. Non-war zone military experiences, such as the crash of a military aircraft, may also contribute to the development of PTSD.<sup>76</sup>

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed.<sup>77</sup> VHA requires that

1. PTSD screening is performed for every new patient and then is repeated every year for the first five years post-separation and every five years thereafter, unless there is a clinical need to re-screen earlier;
2. If the patient’s PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.<sup>78</sup>

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG team reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 46 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

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

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<sup>75</sup> VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (rescinded November 16, 2017.)

<sup>76</sup> VHA Handbook 1160.03.

<sup>77</sup> A PTSD screen is not required if the patient received a PTSD diagnosis in outpatient setting in the past year; has a life expectancy of 6 months or less; has severe cognitive impairment, including dementia; is enrolled in a VHA or community-based hospice program; or has a diagnosis of cancer of the liver, pancreas, or esophagus.

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

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

## **Conclusion**

The OIG found general compliance with the above performance indicators. The OIG made no recommendations.

## Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.<sup>79</sup> As a group, veterans experience more chronic disease and disability than their non-veteran peers. VA must plan for the growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.<sup>80</sup> Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.<sup>81</sup>

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.<sup>82</sup> This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. The healthcare team would then manage the patient with treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.<sup>83</sup> Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.<sup>84</sup>

In determining whether the Facility provided an effective geriatric evaluation, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of 49 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

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

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

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

<sup>81</sup> Chad Boulton, Lisa B. Boulton, Lynne Morishita, Bryan Dowd, Robert L. Kane, and Cristina F. Urdangarin, "A randomized clinical trial of outpatient geriatric evaluation and management," *Journal of the American Geriatrics Society* 49, no. 4 (April 2001): 351–359.

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

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

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

- 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**

The OIG found general compliance with the above performance indicators. The OIG made no recommendations.

## Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.<sup>85</sup> Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

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

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

The OIG team examined whether the Facility complied with selected VHA requirements for the reporting of mammography results by reviewing relevant documents and interviewing selected employees and managers. The team also reviewed the EHRs of 50 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

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

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

<sup>86</sup> 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).

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

<sup>88</sup> VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017, and further amended July 24, 2018).

- Performance of follow-up mammogram if indicated
- Performance of follow-up study<sup>89</sup>

## **Conclusion**

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

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<sup>89</sup> This performance indicator did not apply to this Facility.

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

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.<sup>90</sup> Central lines “refer to a broad category of intravascular (within blood vessels) devices used to administer fluids, medications, blood and blood products, and parenteral nutrition. Unlike the short, temporary catheters inserted into the peripheral vasculature,”<sup>91</sup> central lines are threaded through a vein in the arm, chest, neck, or groin and advanced so that the furthest tip terminates at or close to the heart or in one of the great vessels.<sup>92</sup>

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a central line-associated bloodstream infection (CLABSI) as a “primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site.”<sup>93</sup>

Infections occurring on or after the third calendar day following admission to an inpatient location are considered “healthcare-associated.”<sup>94</sup> The patient’s age, underlying conditions, and gender are basic risk factors, but external risk factors such as prolonged hospitalization, multi-lumen central lines, and central line duration far outnumber the basic ones. External factors are associated with a 2.27-fold increased risk for mortality and increased healthcare costs.<sup>95</sup>

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

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<sup>90</sup> TJC. Infection Prevention and Control IC.01.03.01.

TJC. Infection Control and National Patient Safety Goals standards IC.01.03.01, EP 4 and 5, July 2017.

<sup>91</sup> Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

<sup>92</sup> These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.

<sup>93</sup> The Centers for Disease Control and Prevention, *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011.

<sup>94</sup> The Centers for Disease Control and Prevention National Healthcare Safety Network, *Bloodstream Infection Event: Central Line-Associated Bloodstream Infection and non-central line-associated Bloodstream Infection*, January 2017.

<sup>95</sup> Association for Professionals in Infection Control and Epidemiology, 2015.

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

## Conclusion

The OIG noted that the Facility has current policies on the use and care of central lines. An annual risk assessment was completed, and CLABSI data and prevention outcome measures were reported and discussed in appropriate committees. The Facility also used a checklist for central line insertion and maintenance and had educational materials for patients and families. However, the OIG identified a deficiency in staff training.

## CLABSI Training Requirements

TJC requires that all clinical staff involved in managing the insertion and maintenance of central lines receive CLABSI and infection prevention education upon hire or granting of initial privileges and periodically thereafter.<sup>96</sup> This ensures that involved staff are aware of what is necessary to prevent central line infections. Failure to educate staff may result in increased incidence of CLABSI. For 15 of 25 employees, the OIG did not find evidence of the required CLABSI training. The Quality Accreditation Specialist conducted an internal review of staff CLABSI training in March 2018 and noted that some managers were unaware of the training requirement and that the lack of awareness contributed to the Facility's noncompliance.

## Recommendation 9

9. The Associate Director for Patient Care Services ensures that all staff involved in inserting and managing central lines receive the required central line-associated bloodstream infection and infection prevention education and monitors compliance.

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<sup>96</sup> TJC. National Patient Safety Goals (NPSG) standard NPSG.07.04.01, EP 1, January 2018.

Facility concurred

Target date for completion: December 31, 2018

Facility Response: The facility Infection Control Nurse assigned the Talent Management System education course on the Prevention of Central Line Associated Bloodstream Infections (100600) to all required nursing staff for completion. The overall compliance rate for this required education will be at least 90% compliance by June 30, 2018. On June 27, 2018 the facility was at 98%. Overall compliance for this action will be reported monthly to the Quality Executive Council by the Infection Control Nurse.

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

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	<ul style="list-style-type: none"> <li>• Executive leadership stability and engagement</li> <li>• Employee satisfaction and patient experience</li> <li>• Accreditation/for-cause surveys and oversight inspections</li> <li>• Indicators for possible lapses in care</li> <li>• VHA performance data</li> </ul>	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, ADPCS, and Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> <li>• UM reviews</li> <li>• Patient safety incident reporting and RCAs</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database.</li> <li>• The interdisciplinary group or committee that reviews utilization management data includes required representatives and meets regularly.</li> </ul>

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
<p>Credentialing and Privileging</p>	<ul style="list-style-type: none"> <li>• Medical licenses</li> <li>• Privileges</li> <li>• FPPEs</li> <li>• OPPEs</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical managers consistently collect and review Ongoing Professional Practice Evaluation data and monitors compliance.</li> <li>• Medical Executive Council uses and documents the use of the results of Ongoing Professional Practice Evaluations in the determination of whether to recommend continuation of licensed independent practitioners' privileges.</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	<ul style="list-style-type: none"> <li>• Parent Facility               <ul style="list-style-type: none"> <li>○ EOC rounds and deficiency tracking</li> <li>○ Infection prevention</li> <li>○ General safety</li> <li>○ Environmental cleanliness</li> <li>○ General and exam room privacy</li> <li>○ Availability of medical equipment and supplies</li> </ul> </li> <li>• CBOC               <ul style="list-style-type: none"> <li>○ General safety</li> <li>○ Medication safety and security</li> <li>○ Infection prevention</li> <li>○ Environmental cleanliness</li> <li>○ General and exam room privacy</li> <li>○ Availability of medical equipment and supplies</li> </ul> </li> <li>• Locked MH Unit               <ul style="list-style-type: none"> <li>○ Bi-annual MH EOC rounds</li> <li>○ Nursing station security</li> <li>○ Public area and general unit safety</li> <li>○ Patient room safety</li> <li>○ Infection prevention</li> <li>○ Availability of medical equipment and supplies</li> </ul> </li> <li>• Emergency Management               <ul style="list-style-type: none"> <li>○ Hazard Vulnerability Analysis (HVA)</li> <li>○ Emergency Operations Plan (EOP)</li> <li>○ Emergency power testing and availability</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Damaged furniture is repaired or removed from service.</li> <li>• Weekly inspections of the emergency power supply system are performed and documented.</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	<ul style="list-style-type: none"> <li>• CSC reports</li> <li>• Pharmacy operations</li> <li>• Annual physical security survey</li> <li>• CS ordering processes</li> <li>• Inventory completion during Chief of Pharmacy transition</li> <li>• Review of balance adjustments</li> <li>• CSC requirements</li> <li>• CSI requirements</li> <li>• CS area inspections</li> <li>• Pharmacy inspections</li> </ul>	<ul style="list-style-type: none"> <li>• CSIs reconcile CS dispensing from pharmacy and returns to pharmacy stock during monthly area inspections.</li> <li>• CSIs verify CS orders during monthly area inspections.</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Mental Health Care: Posttraumatic Stress Disorder Care	<ul style="list-style-type: none"> <li>• Suicide risk assessment</li> <li>• Offer of further diagnostic evaluation</li> <li>• Referral for diagnostic evaluation</li> <li>• Completion of diagnostic evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Long-term Care: Geriatric Evaluations	<ul style="list-style-type: none"> <li>• Provision of or access to geriatric evaluation</li> <li>• Program oversight and evaluation requirements</li> <li>• Geriatric evaluation requirements</li> <li>• Geriatric management requirements</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Women's Health: Mammography Results and Follow-Up	<ul style="list-style-type: none"> <li>• Result linking</li> <li>• Report scanning and content</li> <li>• Communication of results and recommended actions</li> <li>• Follow-up mammograms and studies</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
High-Risk Processes: Central Line-Associated Bloodstream Infections	<ul style="list-style-type: none"> <li>• Policy and infection prevention risk assessment</li> <li>• Committee discussion</li> <li>• Infection incidence data</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• All staff involved in inserting and maintaining central lines receive the required CLABSI and</li> </ul>

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

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

### Facility Profile

The table below provides general background information for this mid-high complexity (1c)<sup>97</sup> affiliated<sup>98</sup> Facility reporting to VISN 5.

**Table 7. Facility Profile for Louis A. Johnson VA Medical Center (540)  
(October 1, 2014, through September 30, 2017)**

Profile Element	Facility Data FY 2015 <sup>99</sup>	Facility Data FY 2016 <sup>100</sup>	Facility Data FY 2017 <sup>101</sup>
Total Medical Care Budget in Millions	\$175.4	\$188.5	\$187.8
Number of:			
• Unique Patients	21,955	22,107	22,215
• Outpatient Visits	293,974	306,924	311,456
• Unique Employees <sup>102</sup>	783	758	795
Type and Number of Operating Beds:			
• Community Living Center	30	30	30
• Domiciliary	15	15	15
• Medicine	41	41	41
• Mental Health	10	10	10
• Surgery	7	7	7
Average Daily Census:			
• Community Living Center	21	22	25
• Domiciliary	14	14	15
• Medicine	28	24	24
• Mental Health	5	5	6

<sup>97</sup> The VHA medical centers are classified according to a facility complexity model; 1c designation indicates a Facility with medium-high volume, medium-risk patients, some complex clinical programs, and medium-sized research and teaching programs.

<sup>98</sup> Associated with a medical residency program.

<sup>99</sup> October 1, 2014, through September 30, 2015.

<sup>100</sup> October 1, 2015, through September 30, 2016.

<sup>101</sup> October 1, 2016, through September 30, 2017.

<sup>102</sup> Unique employees involved in direct medical care (cost center 8200).

<b>Profile Element</b>	<b>Facility Data FY 2015<sup>99</sup></b>	<b>Facility Data FY 2016<sup>100</sup></b>	<b>Facility Data FY 2017<sup>101</sup></b>
• Surgery	1	2	2

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

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

## VA Outpatient Clinic Profiles<sup>103</sup>

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

**Table 8. VA Outpatient Clinic Workload/Encounters<sup>104</sup> and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)**

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services <sup>105</sup> Provided	Diagnostic Services <sup>106</sup> Provided	Ancillary Services <sup>107</sup> Provided
Parsons, WV	540GA	2,777	172	n/a	n/a	Pharmacy Social Work Nutrition
Parkersburg, WV	540GB	10,274	4,134	Dermatology Endocrinology	EKG	Pharmacy Social Work Nutrition
Gassaway, WV	540GC	5,285	1,089	Dermatology	EKG	Pharmacy Nutrition

<sup>103</sup> Includes all outpatient clinics in the community that were in operation as of February 15, 2018.

<sup>104</sup> An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.

<sup>105</sup> Specialty care services refer to non-PC and non-MH services provided by a physician.

<sup>106</sup> Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

<sup>107</sup> Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

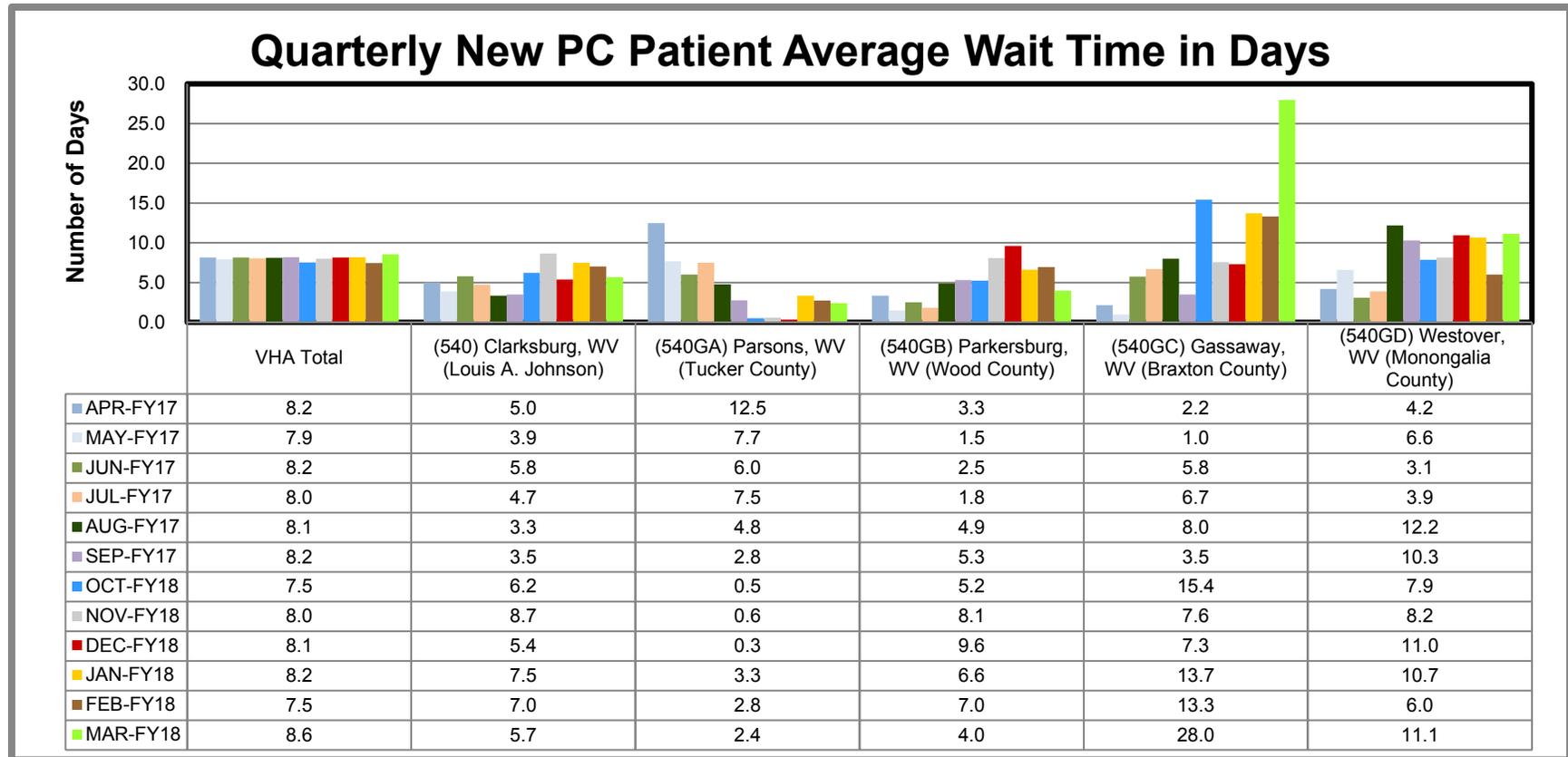
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services <sup>105</sup> Provided	Diagnostic Services <sup>106</sup> Provided	Ancillary Services <sup>107</sup> Provided
Westover, WV	540GD	5,273	6,830	Dermatology	EKG	Pharmacy Social Work Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

n/a = not applicable

## Appendix C: Patient Aligned Care Team Compass Metrics<sup>108</sup>

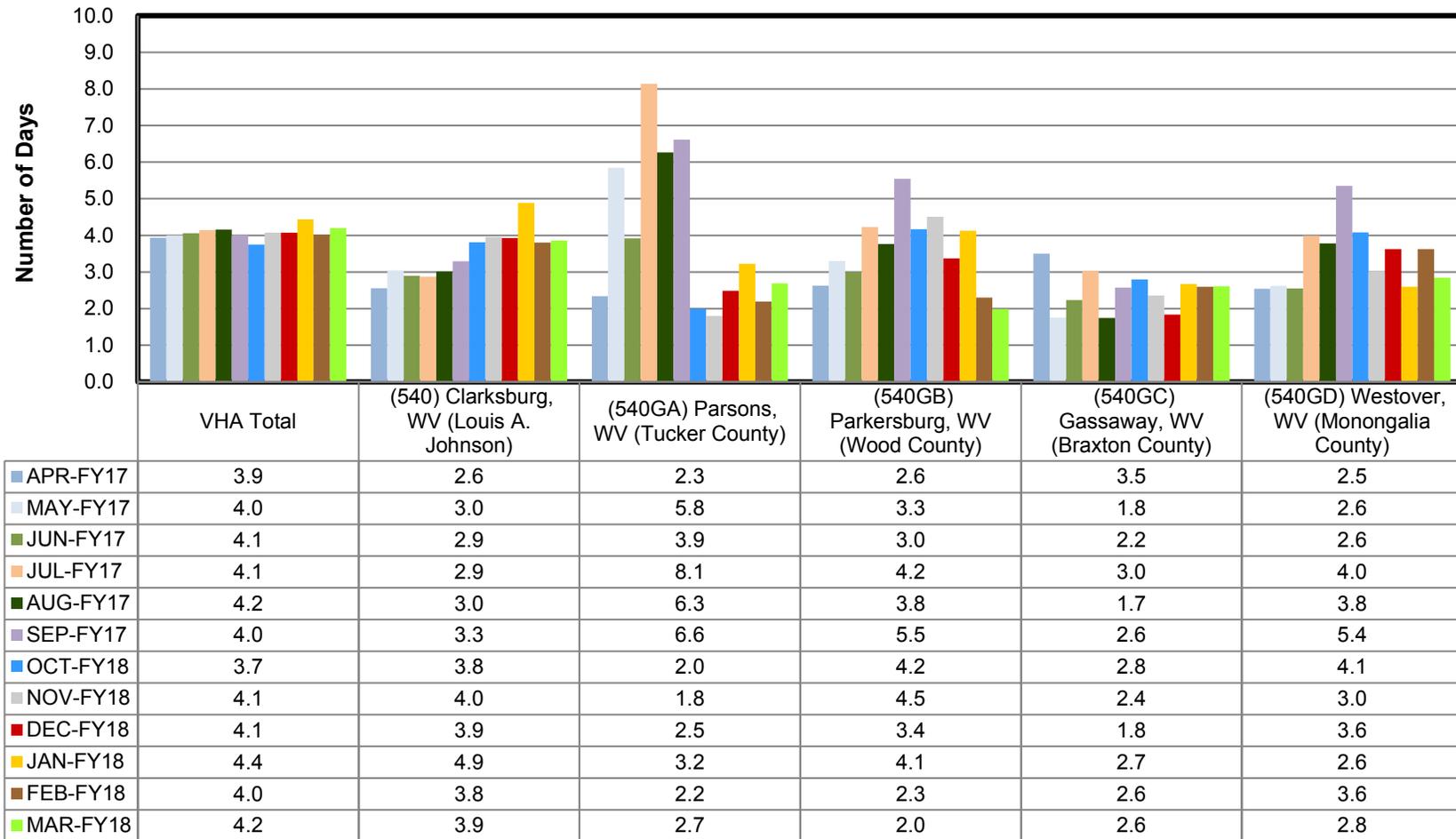


Source: VHA Support Service Center

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

<sup>108</sup> Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.

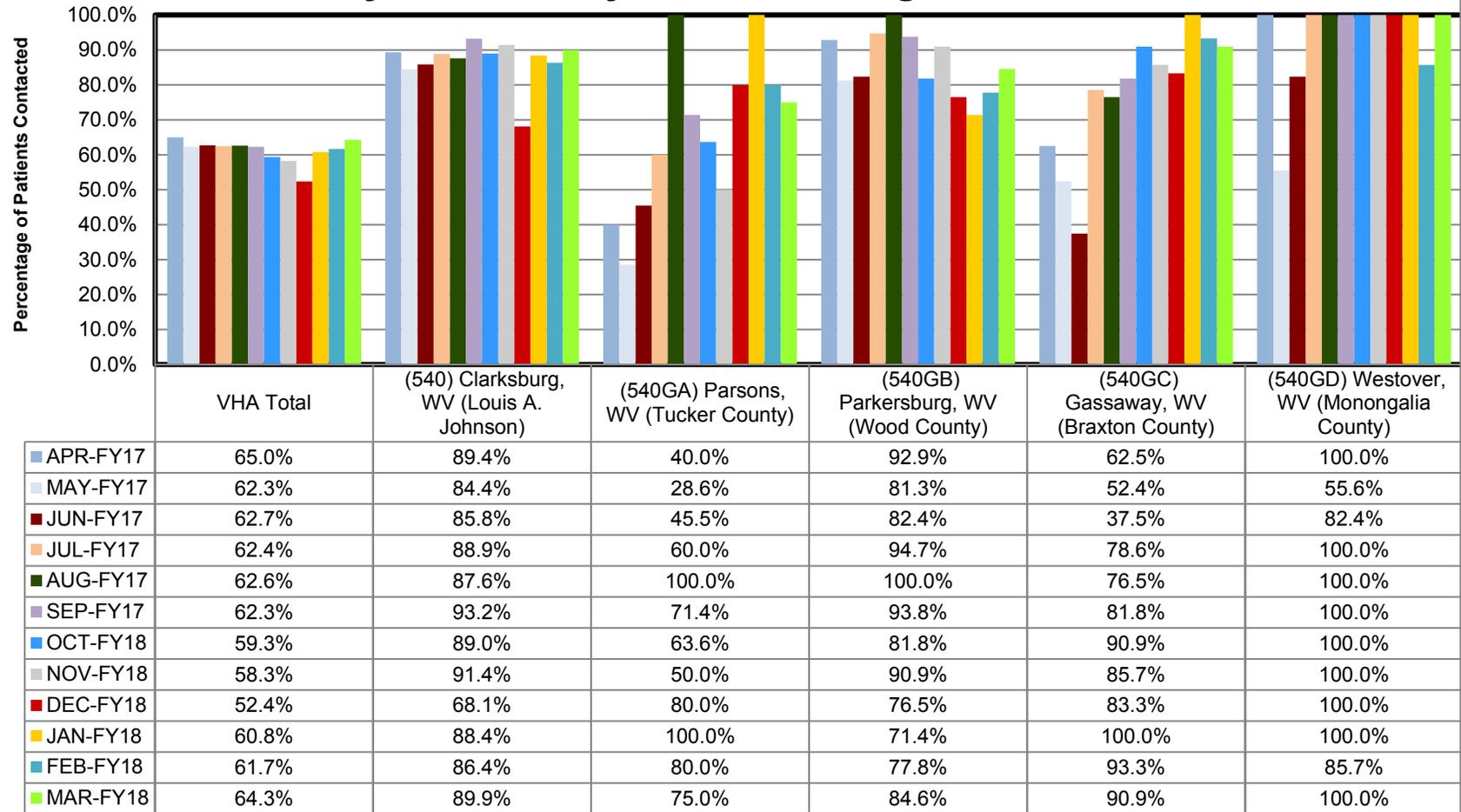
### Quarterly Established PC Patient Average Wait Time in Days



Source: VHA Support Service Center

**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.

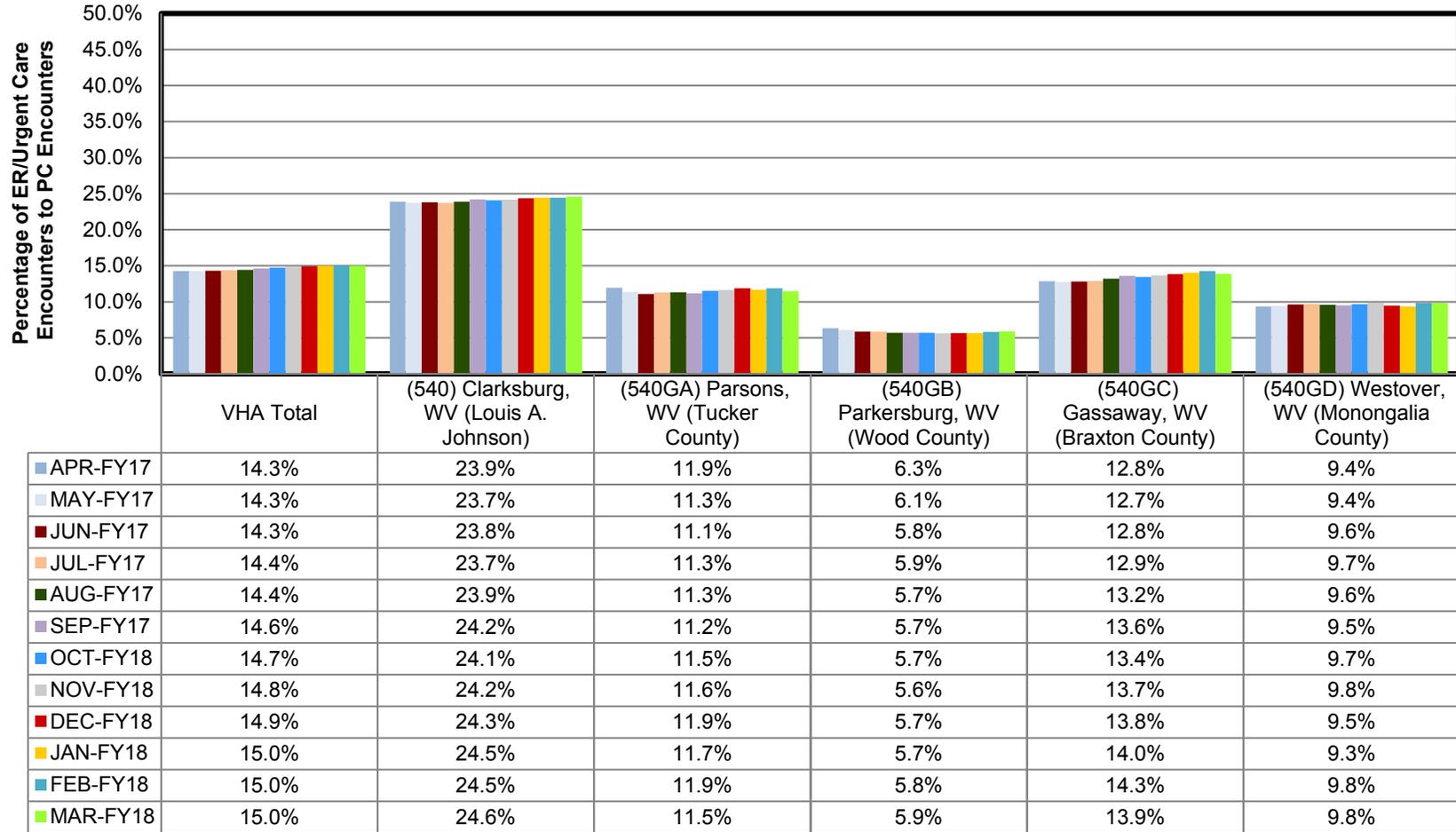
### Quarterly Team 2-Day Post Discharge Contact Ratio



Source: VHA Support Service Center

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

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



Source: VHA Support Service Center

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

## Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions<sup>109</sup>

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory Care Sensitive Conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	All Employee Survey Best Places to Work score	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Capacity	Physician Capacity	A lower value is better than a higher value
Care Transition	Care Transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/Capacity	Efficiency and Physician Capacity	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value

<sup>109</sup> VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: February 14, 2018.

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

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

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

*Source: VHA Support Service Center*

## Appendix E: Acting VISN Director Comments

### Department of Veterans Affairs Memorandum

Date: September 26, 2018

From: Acting Director, VA Capitol Health Care Network (10N05)

Subj: CHIP Review of the Louis A. Johnson VA Medical Center, Clarksburg, West Virginia

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

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

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled Comprehensive Healthcare Inspection Program Review of the Louis A. Johnson VA Medical Center, Clarksburg, West Virginia. Further, I have reviewed and concur with the Medical Center Director's response.
2. Thank you for this opportunity to focus on continuous performance improvement. If you have any questions, please feel free to contact the VISN 5 Office.

*(Original signed by:)*

Raymond C. Chung, M.D.

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

## Appendix F: Facility Director Comments

### Department of Veterans Affairs Memorandum

Date: September 20, 2018

From: Director, Louis A. Johnson VA Medical Center (540/00)

Subj: CHIP Review of the Louis A. Johnson VA Medical Center, Clarksburg, WV

To: Acting Director, VA Capitol Health Care Network (10N05)

1. I have reviewed the report entitled "Comprehensive Healthcare Inspection Program Review of the Louis A. Johnson VA Medical Center, Clarksburg, WV."
2. Actions are underway to resolve each of the nine findings outlined in this report. No barriers to timely resolution are anticipated.
3. The courteous and professional manner that was displayed by the OIG staff during this review is appreciated.

*(Original signed by:)*

Terry C. Massey  
for Glenn R. Snider, Jr., MD, FACP

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

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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