DEPARTMENT OF VETERANS AFFAIRS

**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

# Comprehensive Healthcare Inspection Program Review of the G.V. (Sonny) Montgomery VA Medical Center

## Jackson, Mississippi

CHIP REPORT | REPORT #18-01142-25 | DECEMBER 6, 2018

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***Figure 1.*** *G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi (Source: https://vaww.va.gov/directory/guide/, accessed on August 23, 2018)*

# Abbreviations

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

# Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the G.V. (Sonny) Montgomery 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;
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 21, 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), Acting Associate Director, and Assistant Director. Organizational communication and accountability are carried out through a committee reporting structure, with the Quality, Safety, and Value Board having oversight for groups such as the Resource Executive, Administrative Executive, and Clinical Executive Boards. The leaders are members of the Quality, Safety, and Value Board through which they track, trend, and monitor quality of care and patient outcomes.

The Director, Chief of Staff, ADPCS, and Assistant Director have worked together since June 2017. The Acting Associate Director position has been in place since April 2018.

The OIG noted opportunities appear to exist to improve employee satisfaction with the ADPCS, Associate Director, and Assistant Director and for these leaders to provide a safe workplace environment where employees feel comfortable bringing forth issues or ethical concerns. Further, opportunities appear to exist to improve patient satisfaction with leadership and care provided, and Facility leaders described ongoing efforts to improve patient satisfaction.

The presence of organizational risk factors, as evidenced by sentinel events,[1] disclosures, and Patient Safety Indicator may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored.

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

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

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

The OIG noted findings in four of the eight areas of clinical operations reviewed and issued 11 recommendations that are attributable to the Chief of Staff and Associate Director. These are briefly described below.

## Quality, Safety, and Value

The OIG found general compliance with requirements for utilization management and patient safety.[3] However, the OIG identified a deficiency with the protected peer review process.

## Credentialing and Privileging

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

## Environment of Care

The OIG found general compliance with privacy measures at the Facility and the McComb CBOC and did not note any issues with the availability of medical equipment and supplies. However, the OIG found cleanliness issues in three of six patient care areas, including dirty ventilation grills, furnishings, and floors. The OIG also noted deficiencies with MH EOC seclusion room safety requirements and medical equipment and supply storage at the Facility, and with medical equipment and supply storage, environment of care rounds, medication management, environmental cleanliness, and storage and shelving requirements at the McComb CBOC that warranted recommendations for improvement.

## Mental Health

The OIG identified deficiencies with suicide risk assessment completion and timeliness and the offer and referral for diagnostic evaluations.

## Summary

In the review of key care processes, the OIG issued 11 recommendations that are attributable to the Chief of Staff and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this Facility. The intent is for Facility leaders to use these recommendations as a road map to help improve operations and clinical care. The

[3] 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.

recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

## Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 59–60, and the responses within the body of the report for the full text of the Directors' comments.) The OIG considers recommendation five closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

# Contents

# 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 G.V. (Sonny) Montgomery 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.[4,5] 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.[6] 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).[7]

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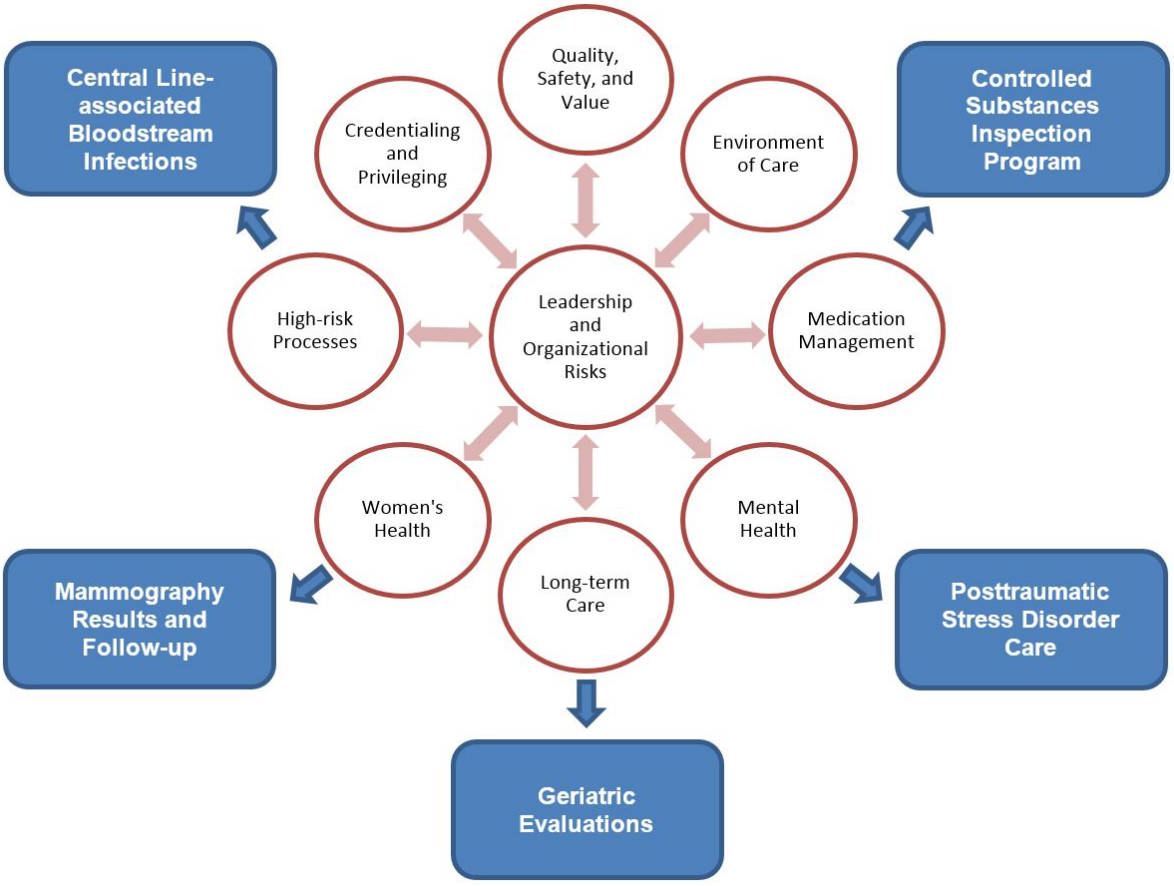
[4] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

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

[6] 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.)

[7] 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;[8] 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 June 15, 2015,[9] through May 21, 2018, the date when an unannounced week-long site visit commenced.

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

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

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

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

# Results and Recommendations

## Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the Facility's ability to provide care in all the selected clinical areas of focus.[10] 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.

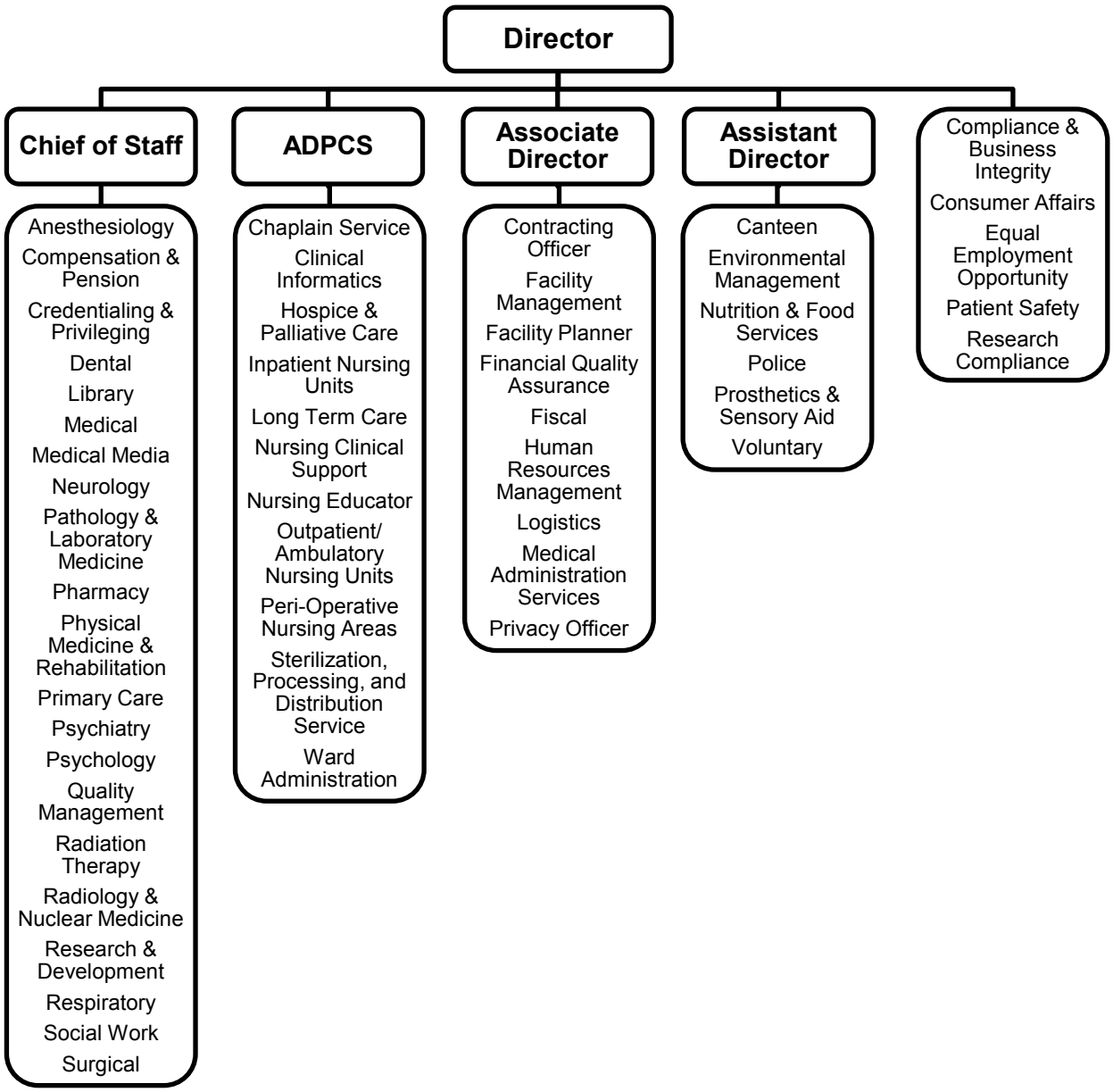
### Executive Leadership Stability and Engagement

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), Acting Associate Director, and Assistant Director. The Chief of Staff and ADPCS are responsible for overseeing patient care and service directors, as well as program and practice chiefs.

It is important to note that the Director, Chief of Staff, ADPCS, and Assistant Director have worked together since June 2017. The Acting Associate Director has been in place since April 2018.

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

**Figure 3. Facility Organizational Chart**




*Source: G.V. (Sonny) Montgomery VA Medical Center (received May 21, 2018)*

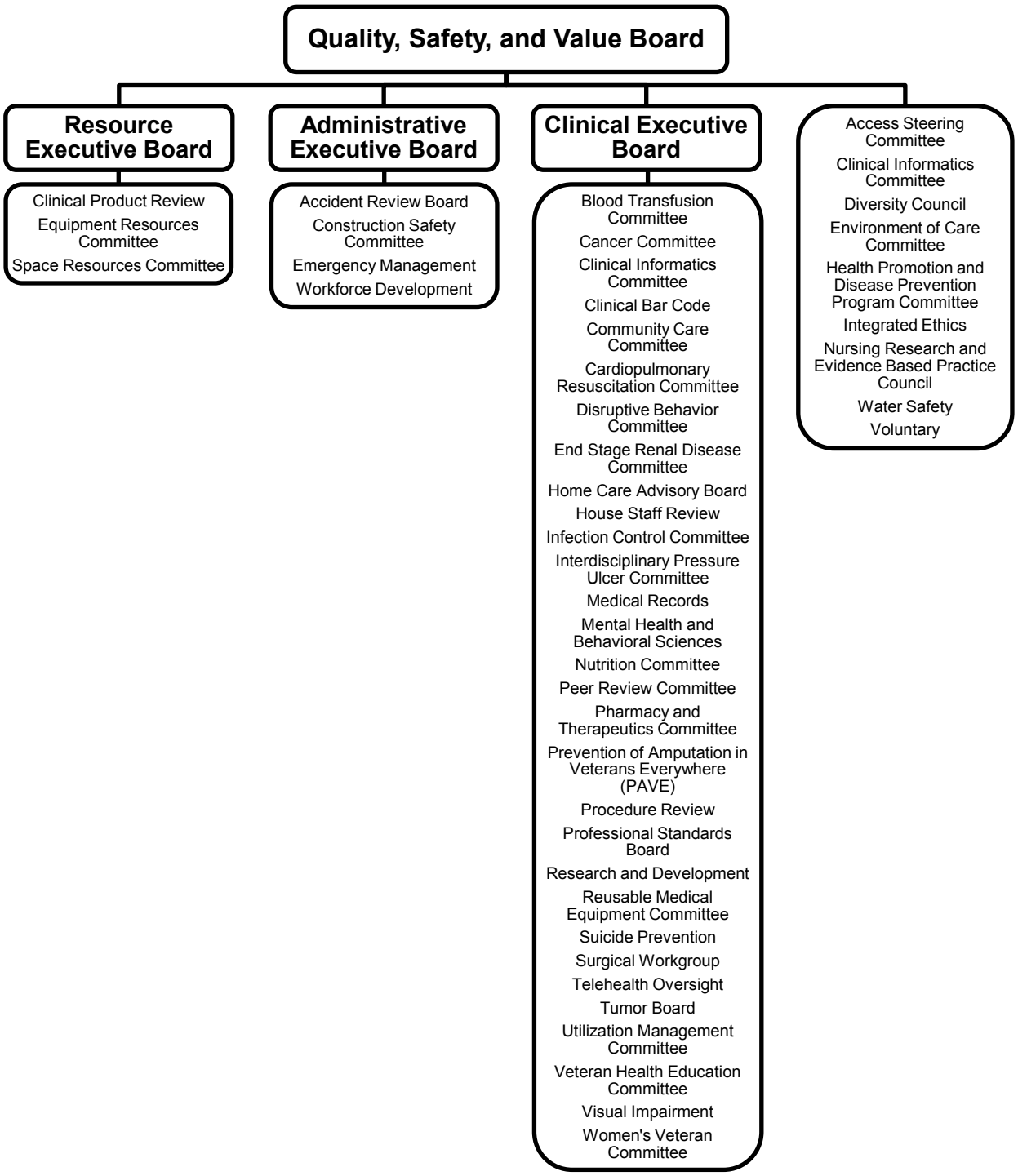
To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Chief of Staff, ADPCS, Acting Associate Director, and Assistant Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably, within their scope of responsibilities and tenure, about actions taken during the previous 12 months to maintain or improve performance, employee and patient survey results,

and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Facility's Quality, Safety, and Value Board which tracks, trends, and monitors quality of care and patient outcomes. The Director serves as the chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Quality, Safety, and Value Board also oversees various working groups, such as the Resource Executive, Administrative Executive, and Clinical Executive Boards. See Figure 4.

**Figure 4. Facility Committee Reporting Structure**




*Source: G.V. (Sonny) Montgomery VA Medical Center (received May 21, 2018)*

## Employee Satisfaction and Patient Experience

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

To assess employee and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017. Tables 1–3 provide relevant survey results for VHA, the Facility, and selected Facility executive leaders.[11]

Table 1 summarizes employee attitudes toward selected Facility leaders as expressed in VHA's All Employee Survey.[12] The Facility average for both of the selected survey questions was less than the VHA average; the Director and Chief of Staff averages were markedly greater than both the VHA and Facility averages.[13] Opportunities appear to exist to improve employee satisfaction with the ADPCS, Associate Director, and Assistant Director.

**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 | Asst. Director Average |
|---|---|---|---|---|---|---|---|---|
| All Employee Survey: *Servant Leader Index Composite* | 0–100 where HIGHER scores are more favorable | 67.7 | 63.2 | 78.1 | 88.3 | 53.9 | 59.0 | 57.4 |
| All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?* | 1 (Very Dissatisfied)–5 (Very Satisfied) | 3.3 | 3.2 | 3.8 | 4.1 | 3.1 | 3.3 | 3.1 |

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

[12] 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.

[13] 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.

*Source: VA All Employee Survey (accessed April 20, 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 less than the VHA averages; the Director and Chief of Staff averages were markedly greater than both the VHA and Facility averages. Opportunities appear to exist for the ADPCS, Associate Director, and Assistant Director to provide a safe workplace environment where employees feel comfortable with bringing forth issues or ethical concerns.

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

| Questions/ Survey Items | Scoring | VHA Average | Facility Average | Director Average | Chief of Staff Average | ADPCS Average | Assoc. Director Average | Asst. Director Average |
|---|---|---|---|---|---|---|---|---|
| All Employee Survey Q43. *My supervisor encourages people to speak up when they disagree with a decision.* | 1 (Strongly Disagree)–5 (Strongly Agree) | 3.8 | 3.6 | 4.1 | 4.6 | 3.4 | 3.0 | 3.1 |
| All Employee Survey Q44. *I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.* | 1 (Strongly Disagree)–5 (Strongly Agree) | 3.9 | 3.8 | 4.1 | 4.6 | 3.6 | 3.6 | 3.5 |
| All Employee Survey Q75. *I can talk with my direct supervisor about ethical concerns without fear of having my comments held against me.* | 1 (Strongly Disagree)–5 (Strongly Agree) | 3.9 | 3.7 | 4.5 | 4.6 | 3.1 | 3.4 | 3.6 |

*Source: VA All Employee Survey (accessed April 20, 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 Survey results that relate to the period of October 1, 2016, through September 30, 2017. From these, the OIG selected four survey items that reflect patient attitudes towards facility leaders (see Table 3). For this Facility, all selected survey results reflected lower care ratings than the VHA averages. Opportunities appear to exist to improve patient satisfaction with

leadership and care provided, and Facility leaders described ongoing efforts to improve patient satisfaction.

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

| Questions | Scoring | VHA Average | Facility Average |
|---|---|---|---|
| Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?* | The response average is the percent of "Definitely Yes" responses. | 66.7 | 59.9 |
| Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.* | The response average is the percent of "Agree" and "Strongly Agree" responses. | 83.4 | 79.5 |
| Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.* | The response average is the percent of "Agree" and "Strongly Agree" responses. | 74.9 | 70.6 |
| Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.* | The response average is the percent of "Agree" and "Strongly Agree" responses. | 75.2 | 72.1 |

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

## Accreditation/For-Cause Surveys[14] and Oversight Inspections

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

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

recently performed by the OIG and The Joint Commission (TJC).[15] One recommendation remains open, as listed in Table 4.[16]

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[17] and College of American Pathologists.[18] Additionally, the Long Term Care Institute conducted inspections of the Facility's Community Living Center.[19]

**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 G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi, August 18, 2015*) | June 2015 | 10 | 0 |
| OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi, August 19, 2015*) | June 2015 | 7 | 0 |
| TJC | February 2017 | | |
| • Hospital Accreditation | | 38 | 1 |
| • Behavioral Health Care Accreditation | | 9 | 0 |
| • Home Care Accreditation | | 2 | 0 |

*Sources: OIG and TJC (Inspection/survey results verified with the Director on May 22, 2018.)*

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

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

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

[18] 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.

[19] 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.

## Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 5 summarizes key indicators of risk since the OIG's previous June 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of May 21, 2018.[20]

**Table 5. Summary of Selected Organizational Risk Factors (June 2015 to May 21, 2018)**

| Factor | Number of Occurrences |
|---|---|
| Sentinel Events[21] | 6 |
| Institutional Disclosures[22] | 8 |
| Large-Scale Disclosures[23] | 0 |

*Source: G.V. (Sonny) Montgomery VA Medical Center's Patient Safety Manager (received May 22, 2018)*

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

[20] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the Facility. (Note that the G.V. (Sonny) Montgomery VA Medical Center is a high-complexity (1b) affiliated Facility as described in Appendix B.)

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

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

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

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

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

| Measure | Reported Rate per 1,000 Hospital Discharges | | |
|---|---|---|---|
| | VHA | VISN 16 | Facility |
| Pressure ulcers | 0.60 | 0.73 | 0.63 |
| Death among surgical inpatients with serious treatable conditions | 100.97 | 85.8 | 157.89 |
| Iatrogenic pneumothorax | 0.19 | 0.21 | 0.00 |
| Central venous catheter-related bloodstream infection | 0.15 | 0.14 | 0.00 |
| In-hospital fall with hip fracture | 0.08 | 0.02 | 0.00 |
| Perioperative hemorrhage or hematoma | 1.94 | 1.86 | 0.00 |
| Postoperative acute kidney injury requiring dialysis | 0.88 | 1.00 | 0.00 |
| Postoperative respiratory failure | 5.55 | 2.65 | 0.00 |
| Perioperative pulmonary embolism or deep vein thrombosis | 3.29 | 3.61 | 2.13 |
| Postoperative sepsis | 4.00 | 4.84 | 1.88 |
| Postoperative wound dehiscence | 0.52 | 0.00 | 0.00 |
| Unrecognized abdominopelvic accidental puncture/laceration | 0.53 | 0.65 | 0.00 |

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

Two Patient Safety Indicator measures (pressure ulcers and death among surgical inpatients with serious treatable conditions) show a higher observed rate than VHA and/or Veterans Integrated Service Network (VISN) 16.

Two patient cases for pressure ulcers were reviewed, and documentation indicated that the patient's pressure ulcers were pre-existing on admission and had been miscoded as hospital-acquired. No patient care concerns were identified; however, coding processes warranted additional monitoring.

Three patients died following post-surgical complications and were identified during an internal review. All cases had a comprehensive review done by a surgical service representative. As a result, training and mentoring processes for Facility staff were implemented.

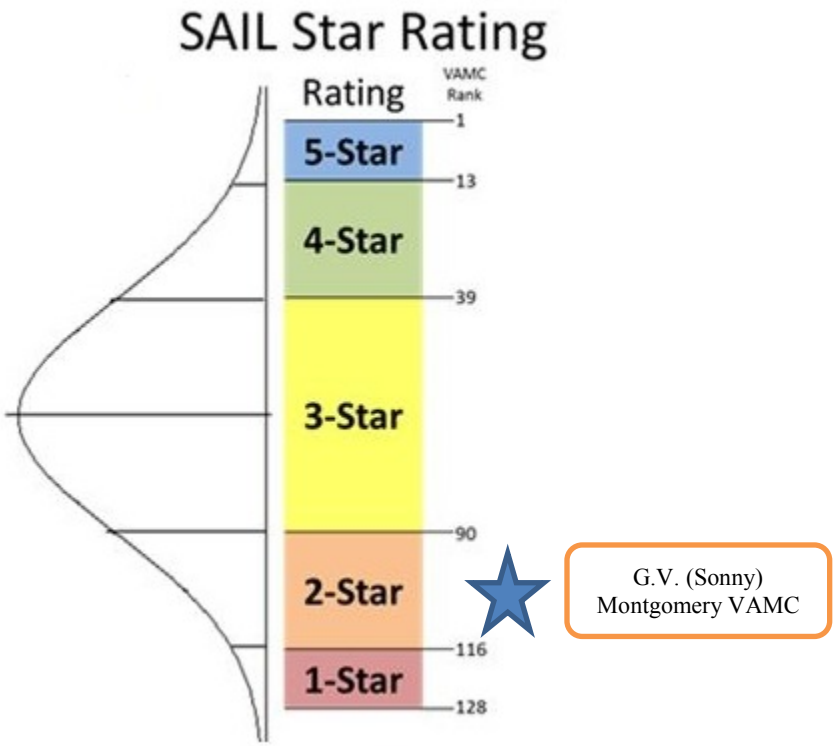
## Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for

identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[25]

VA also uses a star-rating system where facilities with a "5-Star" rating are performing within the top 10 percent of facilities and "1-Star" facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.[26] As of June 30, 2017, the Facility was rated "2-Star" for overall quality. Updated data as of June 30, 2018, indicates that the Facility's rating remained at "2-Star" for overall quality.

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




*Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed April 20, 2018)*

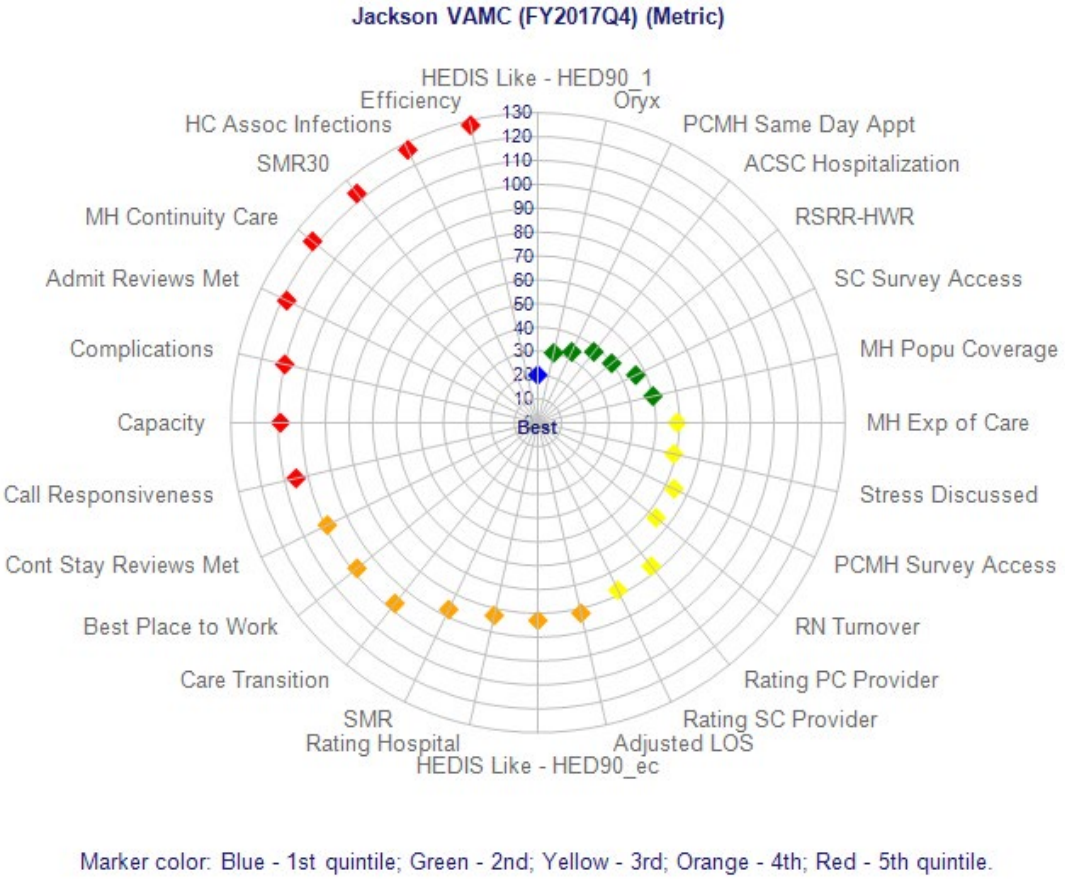
Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of September 30, 2017. Of note, Figure 6 uses

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

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

blue and green data points to indicate high performance (for example, in the areas of Outpatient Performance Measures (HEDIS Like – HED90_1), Patient Centered Medical Home (PCMH) Same Day Appointment (Appt), and Mental Health (MH) Population (Popu) Coverage).[27] Metrics that need improvement are denoted in orange and red (for example, in the areas of Outpatient Performance Measures (HEDIS Like – HED90_ec), Mental Health (MH) Continuity (of) Care, and Healthcare (HC) Associated (Assoc) Infections).

**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.*

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

## Conclusion

Four of five Facility leadership positions were filled by permanent staff for at least a year prior to the OIG's on-site visit. The Acting Associate Director has been in place since April 2018. The OIG noted opportunities to improve employee and patient satisfaction, and the presence of organizational risk factors, as evidenced by sentinel events, disclosures, and Patient Safety Indicator data may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored. Although the leadership team was generally knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve care and performance of selected Quality of Care and Efficiency metrics that are likely contributing to the current "2-Star" rating.

## Quality, Safety, and Value

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

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

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

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

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

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

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

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

[33] VHA Handbook 1050.01.

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

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Entry of all reported patient incidents into VHA's patient safety reporting system[35]
  - Annual completion of a minimum of eight RCAs[36]
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

## Conclusion

The OIG found general compliance with requirements for UM and Patient Safety. However, the OIG identified a deficiency with the completion of protected peer review improvement actions that warranted a recommendation for improvement.

## Peer Review Committee

VHA requires that if the Peer Review Committee recommends individual improvement actions as a result of peer review, clinical managers initiate appropriate action and follow-up.[37] Peer

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

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

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

review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in the practice of one or multiple providers. For three of eight peer reviews where improvement actions were recommended, there was no evidence that actions were implemented. The Chief of Staff stated the service chiefs were either unaware of the recommendations or did not know how to document completed peer review actions.

## Recommendation 1

1. The Chief of Staff ensures that service chiefs communicate to the Peer Review Committee the completion of individual improvement actions and monitors compliance.

Facility concurred.

Target date for completion: January 31, 2019

Facility response: Service Chiefs were re-educated by the Chief of Staff on August 10, 2018, regarding the requirement to implement recommended actions and return of the signed implementation memo. Recommended improvement actions and implementation of improvement actions are tracked in the Peer Review Committee Minutes. To monitor ongoing compliance, a spreadsheet was created to track required improvement actions and return of signed memo. Compliance will be demonstrated when a rate of 90% or greater is achieved for three consecutive months.

[37] VHA Directive 2010-025.

## Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIP).[38]

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.[39]

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.[40]

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,[41] and 20 LIPs who were re-privileged within 12 months prior to the visit.[42] The OIG evaluated the following performance indicators:

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

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

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] The 18-month period was from November 21, 2016, through May 21, 2018.

[42] The 12-month review period was from May 1, 2017, through May 1, 2018.

    - 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
    - Time frame 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 selected requirements for credentialing and privileging. However, the OIG identified deficiencies for FPPE and OPPE processes that warranted recommendations for improvements.

## Focused Professional Practice Evaluations

VHA requires that all LIPs new to the Facility have FPPEs completed and documented in the practitioners' provider profiles and reported to an Executive Committee of the Medical Staff.[43] The process involves the timely evaluation of privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges at the Facility. This process may include periodic charts reviews, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in patient care. VHA also requires that FPPEs be time limited.[44] Time limitations help to ensure an efficient process by preventing undefined or indefinite evaluation of providers.

[43] VHA Handbook 1100.19.
[44] VHA Handbook 1100.19.

For two of nine applicable FPPEs reviewed, clinical managers did not clearly delineate the time frame for the initiated FPPEs. This may have resulted in an inefficient process for evaluating these LIPs. The Chief of Staff reported that a lack of credentialing staff impacted the oversight of FPPE processes.

## Recommendation 2

2. The Chief of Staff ensures that all Focused Professional Practice Evaluations include clearly delineated timeframes and monitor compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: Service Chiefs were re-educated on the expectation and requirement to include delineated time frames on all Focused Professional Practice Evaluations (FPPE) on June 21, 2018. An audit tool was developed to assess specific required measures including delineated timeframes. The Chief of Staff or designee will complete random audits of FPPEs to assess the completeness of documentation and work with under-performing services to ensure they are documenting clearly as defined within VHA Handbook 1100.19. Compliance will be monitored until 90% greater is achieved for three consecutive months. Audit results will be reported to the Professional Standards Board (PSB) and the audited service.

## Ongoing Professional Practice Evaluations

VHA requires that at the time of re-privileging, service chiefs consider relevant service and practitioner-specific data when recommending the renewal of LIP privileges to the Executive Committee of the Medical Staff. Such data is maintained as part of the practitioner's provider profile and may include direct observation, clinical discussions, and clinical reviews. The 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.[45]

For 3 of 20 provider profiles reviewed, there was no evidence in the provider profiles that the decision to continue current privileges was based on OPPE data. This resulted in providers continuing to deliver care without a thorough evaluation of their practice. The Chief of Staff reported that the lack of data to support continuing provider privileges was due to a lack of attention to detail by clinical leadership.

[45] VHA Handbook 1100.19.

## Recommendation 3

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

Facility concurred.

Target date for completion: December 31, 2018

Facility response: Service Chiefs were re-educated on the expectation and requirement to include relevant service and practitioner specific data in the provider profile for Ongoing Professional Practice Evaluations (OPPE) on June 21, 2018. An audit tool was developed to assess specific required measures including service and practitioner specific data. The Chief of Staff or designee will complete random audits of OPPEs to assess the completeness of documentation and work with under-performing services to ensure they are documenting clearly as defined within VHA Handbook 1100.19. Compliance will be monitored until 90% or greater is achieved for three consecutive months. Audit results will be reported to the Professional Standards Board (PSB) and the audited service.

## 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.[46]

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.[47]

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.[48]

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).[49] 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,[50] Occupational Safety and Health Administration,[51] and

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

[47] 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).

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

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

[50] TJC. EOC standard EC.02.05.07.

[51] 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.[52] The provision of sustained electrical power during disasters or emergencies is critical to continued operations of a healthcare facility.

The OIG team inspected five inpatient units (4C medical, medical intensive care, post-anesthesia care, first floor Community Living Center, and 3L locked MH), the Emergency Department, the Primary Care Green Clinic, and the McComb CBOC. The OIG also reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent Facility
  - EOC rounds
  - EOC deficiency tracking
  - Infection prevention
  - General safety
  - Environmental cleanliness
  - General privacy
  - Women veterans' exam room privacy
  - Availability of medical equipment and supplies
- Locked MH Unit
  - Bi-annual MH EOC Rounds
  - Nursing station security
  - Public area and general unit safety
  - Patient room safety
  - Infection prevention
  - Availability of medical equipment and supplies
- Emergency Management
  - Hazard Vulnerability Analysis (HVA)
  - Emergency Operations Plan (EOP)
  - Emergency power testing and availability
- 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

[52] 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.

## Conclusion

The OIG found general compliance with privacy measures at the Facility and the McComb CBOC and did not note any issues with the availability of medical equipment and supplies. However, the OIG found cleanliness issues in three of six patient care areas, including dirty ventilation grills, furnishings,[53] and floors.[54] The OIG also noted deficiencies with medical equipment and supply storage and MH EOC seclusion room safety requirements at the Facility, and with medical equipment and supply storage, environment of care rounds, medication management, environmental cleanliness, and storage and shelving requirements at the McComb CBOC that warranted recommendations for improvement.

## Parent Facility and CBOC: Medical Equipment and Supply Storage

TJC requires hospitals to minimize the possibility of transmitting infections by ensuring that dirty and used equipment are stored separately from sterile supplies.[55] This ensures a healthcare environment that minimizes the spread of infection. The OIG found dirty and clean equipment stored together in two of six supply areas at the parent facility and in a supply closet at the McComb CBOC.[56] The Chief of Engineering reported a knowledge deficit regarding proper storage requirements as the reason for noncompliance, and the CBOC Administrator reported being unaware of the storage requirements.

## Recommendation 4

4. The Associate Director ensures that staff store clean and dirty equipment separately and monitors compliance.

Facility concurred.

Target date for completion: January 31, 2019

Facility response: Clinical staff have separated storage of dirty equipment from clean equipment in the supply areas identified during the survey. All deficiencies have been corrected. To ensure ongoing compliance, all clean supply areas will be inspected during Environment of Care Rounds to ensure that they are being maintained appropriately. Deficiencies are reported and monitored through the Environment of Care Committee. Compliance will be demonstrated by correction of identified deficiency within 14 days, and this will be monitored until 90% is achieved for three consecutive months.

[53] Primary Care Green Clinic.
[54] Primary Care Green Clinic and first floor Community Living Center unit.
[55] TJC. Environment of Care standard EC.02.02.01.
[56] 4C medical and first floor Community Living Center units.

### Parent Facility: Mental Health EOC Requirements

VHA requires the safety features included on the MH EOC Checklist be implemented to promote safety.[57] The MH EOC Checklist requires that seclusion rooms have shatterproof toilets.[58] This mitigates the risk of patient self-harm. The OIG found a porcelain toilet in the inpatient MH seclusion room. Facility managers were aware of requirements but did not take action to replace the toilet because they felt it was compliant with standards.

## Recommendation 5

5. The Associate Director ensures the mental health unit seclusion room toilet is shatterproof.

Facility concurred.

Target date for completion: Closed

Facility response: The porcelain toilet in the Mental Health seclusion room has been removed. A shatterproof stainless-steel toilet was installed October 25, 2018.

### CBOC: Environment of Care Rounds

VHA requires EOC rounds to be conducted at a minimum of once per fiscal year in non-patient areas and twice per FY in patient care areas using an interdisciplinary team.[59] The OIG did not find evidence that an interdisciplinary team conducted the required EOC rounds at the McComb CBOC during FY17. This resulted in a lack of assurance of a clean and safe environment. Facility leaders acknowledged there was a lack of oversight regarding completion of required EOC rounds at the McComb CBOC.

## Recommendation 6

6. The Associate Director ensures that environment of care rounds are conducted as required at the McComb Community Based Outpatient Clinic and monitors compliance.

Facility concurred.

Target date for completion: January 31, 2019

Facility response: An Interdisciplinary EOC team performed unannounced site visits using a standardized checklist for assessment and documentation. To ensure ongoing compliance, an inspection checklist was created by Quality Management. Compliance will be monitored by

[57] VHA Handbook 1160.06.

[58] VHA MH EOC Checklist (MHEOCC), December 2016.

[59] VHA Directive 1608.

unannounced inspections until 90% or greater compliance is achieved for three consecutive visits.

The seven community based outpatient clinics (CBOC) were incorporated into the remainder of the FY 2018 Environment of Care Assessment and Compliance Tool Rounding schedule. McComb CBOC was visited by the EOC Team on August 6, 2018. All CBOCs, including McComb, are now incorporated in the EOC Rounding schedule with visits twice per fiscal year. Deficiencies are recorded in Performance Logic and tracked in the Environment of Care Committee.

### CBOC General Safety: Medication Management

TJC requires that hospitals remove all expired, damaged, and/or contaminated medications and store them separately from medications available for administration.[60] This ensures safe medication administration for patients. The OIG found open, undated multi-dose lidocaine vials in an unlocked drawer used for storage of random items. CBOC staff stated they were aware of proper medication storage requirements but did not follow appropriate processes for disposal of used medications.

## Recommendation 7

7. The Associate Director ensures that staff at the McComb Community Based Outpatient Clinic remove all expired, damaged, and/or contaminated medications and monitors compliance.

[60] TJC. Medication Management standard MM.03.01.01, EP8.

Facility concurred.

Target date for completion: January 31, 2019

Facility response: On May 24, 2018, members of the Executive Leadership Team and Quality Management inspected the McComb CBOC. All expired medications were removed. McComb CBOC staff were re-educated on proper medication storage requirements on May 24 and May 29, 2018. Additionally, the pharmacy now stocks the Pyxis with single dose Lidocaine vials. To ensure ongoing compliance, an inspection checklist was created by Quality Management. Compliance will be monitored by unannounced inspections until 90% or greater compliance is achieved for three consecutive visits.

## CBOC: Environmental Cleanliness

TJC requires that areas used by patients are clean and free of offensive odors and that furnishings and equipment are safe and in good repair.[61] The OIG found patient care areas in the CBOC with dirty floors, furniture, and ventilation grills. Much of the furniture was also in a state of disrepair, with holes and exposed foam padding. This resulted in potential infection and environmental safety issues. The CBOC Administrator was aware of the conditions but did not take corrective actions.

## Recommendation 8

8. The Associate Director ensures the McComb Community Based Outpatient Clinic managers maintain a safe and clean environment and monitors compliance.

Facility concurred.

Target date for completion: January 31, 2019

Facility response: On May 24, 2018, members of the Executive Leadership Team and Quality Management inspected the McComb CBOC and met with the contracted CBOC Administrator and Quality Manager to reinforce the expectation that the facility is safe and clean, and furniture is free of stains and tears. All furniture in a state of disrepair was removed from the CBOC on May 24, 2018. The CBOC contractor had the facility deep cleaned on May 26-27, 2018. Additionally, the facility is now deep cleaned by the contractor once a month. To ensure ongoing compliance, an inspection checklist was created by Quality Management to ensure facility is clean and safe and furniture is free of stains and tears. Compliance will be monitored by unannounced inspections until 90% or greater compliance is achieved for three consecutive visits.

[61] TJC. Environment of Care standard EC.02.06.01, EP 20 and EP 26.

## CBOC: Storage and Shelving Requirements

VHA requires that storage environments be clean and easily accessible by authorized personnel and that bottom storage shelves are solid.[62] This ensures that clean and sterile supplies do not fall to the floor where the cleanliness of supplies may be compromised. In the supply room, shelves were found to be dirty and dusty, and the bottom shelves were not solid. The CBOC Administrator reported being unaware of these requirements.

## Recommendation 9

9. The Associate Director ensures that shelving is clean and bottom storage shelves are solid at the McComb Community Based Outpatient Clinic and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: On May 24, 2018, members of the Executive Leadership Team and Quality Management inspected the McComb CBOC and met with the contracted CBOC Administrator and Quality Manager to reinforce the expectation that the facility is safe and clean and bottom storage shelves are solid. The CBOC contractor had the facility deep cleaned on May 26-27, 2018 and solid bottom storage liners were ordered. Additionally, the facility is now deep cleaned by the contractor once a month. To ensure ongoing compliance, an inspection checklist was created by Quality Management which includes above areas. Compliance will be monitored by unannounced inspections until 90% or greater compliance is achieved for three consecutive visits.

[62] VHA Directive 1116(2).

## 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.[63] 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.[64]

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.[65] 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.[66] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[67] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[68] CS inspection quarterly trend reports for the prior four quarters;[69] 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
  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transition

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

[64] 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.

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

[66] 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.

[67] The review period was October 1, 2017, through March 31, 2018.

[68] The review period was April 1, 2017, through March 31, 2018.

[69] The four quarters were from April 1, 2017, through March 31, 2018.

  - 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[70]
  - Accountability for all prescription pads in pharmacy
  - Verification of hard copy outpatient pharmacy CS prescriptions
  - Verification of 72-hour inventories of the main vault
  - Quarterly inspections of emergency drugs
  - Monthly CSI checks of locks and verification of lock numbers

## Conclusion

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

[70] The "Destructions File Holding Report" lists all drugs awaiting local destruction or turn-over to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

## Mental Health: 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."[71] 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.[72]

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.[73] 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.[74]

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 38 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
- Referral for diagnostic evaluation

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

[72] VHA Handbook 1160.03.

[73] 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.

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

- Completion of diagnostic evaluation within required timeframe

## Conclusion

The OIG identified deficiencies with suicide risk assessment completion and timeliness and diagnostic evaluations that warranted recommendations for improvement.

## Suicide Risk Assessments

VHA requires an appropriate provider assess patients with a positive PTSD screen by the end of the next business day to ensure immediate safety risks are identified and addressed.[75] The OIG estimated that providers completed suicide risk assessments by the end of the next business day in 66 percent of the EHRs reviewed; and 95 percent of the time, the true compliance rate is between 49.9 and 81.5 percent, which is statistically significantly below the 90 percent benchmark. As a result, patients who were not assessed for suicide timely were potentially placed at risk because staff did not immediately confirm the severity of patients' condition and their clinical needs. Program managers attributed this noncompliance to inadequate communication and/or EHR alerts of patients' positive screens between clinic staff and providers.

## Recommendation 10

10. The Chief of Staff ensures that providers complete suicide risk assessments within the required timeframe for patients with positive posttraumatic stress disorder screens and monitors compliance.

Facility concurred.

Target date for completion: February 28, 2019

Facility response: Chief of Staff Office will re-educate Primary Care providers on the requirements for completion of a suicide risk assessment for all Veterans with positive PTSD screens. Associate Chief of Staff (ACOS) for Primary Care and Deputy ACOS for Primary Care will be responsible for continued education for all new providers. Primary Care Service will report positive PTSD screens and suicide risk assessment compliance during the daily Leadership Morning Report.

Random chart audits will be conducted by Quality Management. Compliance will be demonstrated by completion of the suicide risk assessment for Veterans with positive PTSD

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

screens. Audit results will be reported to the Clinical Executive Board Committee. Compliance will be monitored until 90% or greater is demonstrated for three consecutive months.

## Diagnostic Evaluations

VHA requires that an appropriate provider offer and refer patients with positive PTSD screens for further diagnostic evaluation.[76] The OIG estimated that providers documented offers of further diagnostic evaluations in 53 percent of the EHRs reviewed; and 95 percent of the time, the true compliance rate is between 36.7 and 68.3 percent; and providers referred patients for diagnostic evaluations in 64 percent of the EHRs reviewed; and 95 percent of the time, the true compliance rate is between 35.6 and 85.6 percent, which are statistically significantly below the 90 percent benchmark. This may cause delay in early identification and management of stress-related disorders. The program director attributed noncompliance to knowledge deficits of the requirement to offer and refer patients for diagnostic evaluation unless an acceptable reason was documented by the provider.

## Recommendation 11

11. The Chief of Staff ensures that acceptable providers offer and refer patients with positive posttraumatic stress disorder screens for further diagnostic evaluations and monitors compliance.

Facility concurred.

Target date for completion: February 28, 2019

Facility response: Chief of Staff Office will re-educate Primary Care providers on the requirements for offering and referring Veterans with a positive PTSD screen for further diagnostic evaluations. Associate Chief of Staff (ACOS) for Primary Care and Deputy ACOS for Primary Care will be responsible for continued education of new providers. Primary Care Service will report positive PTSD screens and compliance with offering and referring Veterans for further diagnostic evaluation during the daily Leadership Morning Report.

Random chart audits will be conducted by Quality Management. Compliance will be demonstrated by documented evidence of offering and referring Veterans for further diagnostic evaluation with positive PTSD screens. Audit results will be reported to the Clinical Executive Board Committee. Compliance will be monitored until 90% or greater is demonstrated for three consecutive months.

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

## 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.[77] 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.[78] 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.[79]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[80] 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.[81] 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.[82]

In determining whether the Facility provided an effective geriatric evaluation, the OIG team reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of 41 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Provisions 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
  - Comprehensive psychosocial assessment by GE social worker

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

[78] VHA Directive 1140.04.

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

[80] Public Law 106-117.

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

[82] VHA Directive 1140.04.

  - Patient or family education
  - Plan of care based on GE
- Geriatric management
  - Implementation of interventions noted in plan of care

## Conclusion

Generally, the Facility met requirements with the above performance indicators. Although we found inconsistent GE assessment documentation by the nurse and social worker, we made no recommendation due to the change in the interdisciplinary core team member requirement with the rescission of VHA Handbook 1140.04.

## 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.[83] 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.[84] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services including mammography services to eligible women veterans.[85]

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.[86]

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 45 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
- Performance of follow-up mammogram if indicated
- Performance of follow-up study

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

[84] 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).

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

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

## Conclusion

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

## High-risk Processes: Central Line-associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[87] 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,"[88] 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.[89]

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."[90]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[91] 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.[92]

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 15 clinical employees involved in inserting and/or managing central lines. The OIG evaluated the following performance indicators:

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

[87] TJC. Infection Prevention and Control standard IC.01.03.01.

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

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

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

[91] 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.

[92] Association for Professionals in Infection Control and Epidemiology, 2015.

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

## Conclusion

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

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

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

| Healthcare Processes | Performance Indicators | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|---|---|
| Quality, Safety, and Value | • Protected peer review of clinical care<br>• UM reviews<br>• Patient safety incident reporting and RCAs | • Service chiefs communicate to the Peer Review Committee the completion of individual improvement actions. | • None |
| Credentialing and Privileging | • Medical licenses<br>• Privileges<br>• FPPEs<br>• OPPEs | • Clinical managers consistently collect and maintain OPPE data. | • All FPPEs include clearly delineated timeframes. |

| Healthcare Processes | Performance Indicators | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|---|---|
| Environment of Care | • Parent Facility<br>  ○ EOC rounds and deficiency tracking<br>  ○ Infection prevention<br>  ○ General safety<br>  ○ Environmental cleanliness<br>  ○ General and exam room privacy<br>  ○ Availability of medical equipment and supplies<br>• Locked MH Unit<br>  ○ Bi-annual MH EOC rounds<br>  ○ Nursing station security<br>  ○ Public area and general unit safety<br>  ○ Patient room safety<br>  ○ Infection prevention<br>  ○ Availability of medical equipment and supplies<br>• Emergency Management<br>  ○ Hazard Vulnerability Analysis (HVA)<br>  ○ Emergency Operations Plan (EOP)<br>  ○ Emergency power testing and availability<br>• CBOC<br>  ○ General safety<br>  ○ Medication safety and security<br>  ○ Infection prevention<br>  ○ Environmental cleanliness<br>  ○ General and exam room privacy<br>  ○ Availability of medical equipment and supplies | • Staff store clean and dirty equipment separately.<br>• There is a shatterproof toilet in the Facility's MH seclusion room.<br>• EOC rounds are conducted as required at the McComb. CBOC.<br>• Staff at the McComb CBOC removed all expired, damaged, and/or contaminated medications. | • A safe and clean environment is maintained at the McComb CBOC.<br>• Shelving is clean and bottom storage shelves are solid at the McComb CBOC. |

| Healthcare Processes | Performance Indicators | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|---|---|
| Medication Management | • CSC reports<br>• Pharmacy operations<br>• Annual physical security survey<br>• CS ordering processes<br>• Inventory completion during Chief of Pharmacy transition<br>• Review of balance adjustments<br>• CSC requirements<br>• CSI requirements<br>• CS area inspections<br>• Pharmacy inspections | • None | • None |
| Mental Health: Posttraumatic Stress Disorder Care | • Suicide risk assessment<br>• Offer of further diagnostic evaluation<br>• Referral for diagnostic evaluation<br>• Completion of diagnostic evaluation | • Providers complete suicide risk assessments within the required timeframe for patients with positive posttraumatic stress disorder screens.<br>• Acceptable providers offer and refer patients with positive posttraumatic stress disorder screens for further diagnostic evaluations. | • None |
| Long-term Care: Geriatric Evaluations | • Provision of or access to geriatric evaluation<br>• Program oversight and evaluation requirements<br>• Geriatric evaluation requirements<br>• Geriatric management requirements | • None | • None |
| Women's Health: Mammography Results and Follow-up | • Result linking<br>• Report scanning and content<br>• Communication of results and recommended actions | • None | • None |

| Healthcare Processes | Performance Indicators | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|---|---|
| | • Follow-up mammograms and studies | | |
| High-risk Processes: Central Line-associated Bloodstream Infections | • Policy and infection prevention risk assessment<br>• Committee discussion<br>• Infection incidence data<br>• Education and educational materials<br>• Policy, procedure, and checklist for insertion and maintenance of central venous catheters | • None | • None |

# Appendix B: Facility Profile and VA Outpatient Clinic Profiles

## Facility Profile

The table below provides general background information for this high complexity (1b)[93] affiliated[94] Facility reporting to VISN 16.

**Table 7. Facility Profile for Jackson (586)**
**(October 1, 2014, through September 30, 2017)**

| Profile Element | Facility Data FY 2015[95] | Facility Data FY 2016[96] | Facility Data FY 2017[97] |
|---|---|---|---|
| Total Medical Care Budget in Millions | $381.0 | $389.1 | $365.3 |
| Number of: | | | |
| • Unique Patients | 45,100 | 44,303 | 42,844 |
| • Outpatient Visits | 490,315 | 480,595 | 442,675 |
| • Unique Employees[98] | 1,766 | 1,629 | 1,562 |
| Type and Number of Operating Beds: | | | |
| • Community Living Center | 86 | 86 | 86 |
| • Domiciliary | 27 | 27 | 27 |
| • Medicine | 65 | 59 | 58 |
| • Mental Health | 24 | 12 | 14 |
| • Neurology | 4 | 4 | 3 |
| • Surgery | 30 | 30 | 20 |
| Average Daily Census: | | | |
| • Community Living Center | 77 | 72 | 73 |
| • Domiciliary | 25 | 23 | 23 |

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

[94] Associated with a medical residency program.

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

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

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

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

| Profile Element | Facility Data FY 2015[95] | Facility Data FY 2016[96] | Facility Data FY 2017[97] |
|---|---|---|---|
| • Medicine | 47 | 57 | 37 |
| • Mental Health | 12 | 13 | 13 |
| • Neurology | 2 | 3 | 2 |
| • Surgery | 9 | 11 | 7 |

*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[99]

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[100] 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[101] Provided | Diagnostic Services[102] Provided | Ancillary Services[103] Provided |
|---|---|---|---|---|---|---|
| Kosciusko, MS | 586GA | 4,112 | 712 | n/a | n/a | n/a |
| Meridian, MS | 586GB | 6,361 | 1,271 | Endocrinology<br>Rheumatology<br>Rehab Physician | n/a | Nutrition |
| Greenville. MS | 586GC | 4,506 | 856 | Endocrinology<br>Poly-Trauma<br>Rehab Physician<br>Cardio Thoracic | Laboratory and Pathology | Nutrition |

[99] Includes all outpatient clinics in the community that were in operation as of February 15, 2018. The OIG omitted Jackson, MS (586QB) and Flowood, MS (586QC), as no workload/encounters or services were reported.

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

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

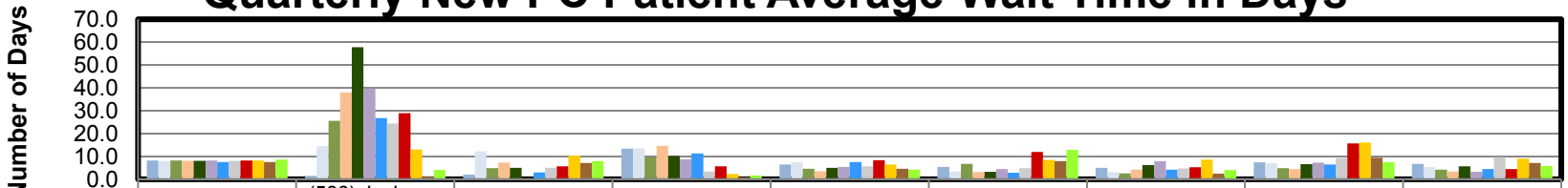
[102] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

[103] 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[101] Provided | Diagnostic Services[102] Provided | Ancillary Services[103] Provided |
|---|---|---|---|---|---|---|
| Hattiesburg, MS | 586GD | 12,597 | 4,098 | Endocrinology<br>Rheumatology<br>Poly-Trauma<br>Rehab Physician | n/a | Nutrition<br>Weight Management |
| Natchez, MS | 586GE | 3,239 | 721 | Endocrinology<br>Poly-Trauma | n/a | Nutrition |
| Columbus, MS | 586GF | 4,313 | 2,030 | Endocrinology<br>Nephrology<br>Poly-Trauma<br>General Surgery | n/a | Nutrition |
| McComb, MS | 586GG | 4,638 | 967 | Endocrinology<br>Rehab Physician<br>General Surgery | n/a | Nutrition<br>Pharmacy<br>Social Work<br>Weight Management |

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

# Appendix C: Patient Aligned Care Team Compass Metrics[104]



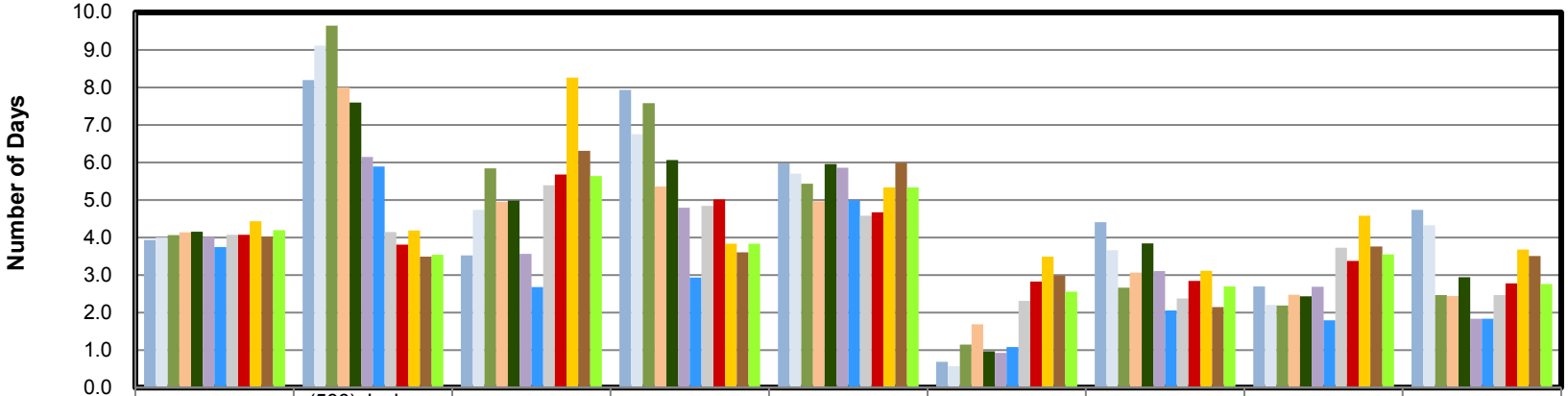

| | VHA Total | (586) Jackson, MS (G.V. (Sonny) Montgomery) | (586GA) Kosciusko, MS | (586GB) Meridian, MS | (586GC) Greenville, MS | (586GD) Hattiesburg, MS | (586GE) Natchez, MS | (586GF) Columbus, MS | (586GG) McComb, MS |
|---|---|---|---|---|---|---|---|---|---|
| APR-FY17 | 8.2 | 1.4 | 2.0 | 13.5 | 6.4 | 5.4 | 5.0 | 7.5 | 6.7 |
| MAY-FY17 | 7.9 | 14.5 | 12.2 | 13.6 | 7.4 | 3.4 | 3.2 | 7.0 | 5.5 |
| JUN-FY17 | 8.2 | 25.6 | 4.9 | 9.5 | 4.6 | 6.7 | 2.6 | 4.9 | 4.2 |
| JUL-FY17 | 8.0 | 38.0 | 7.3 | 14.6 | 3.5 | 3.1 | 4.2 | 4.4 | 3.4 |
| AUG-FY17 | 8.1 | 57.8 | 5.0 | 10.2 | 5.0 | 3.2 | 6.2 | 6.6 | 5.7 |
| SEP-FY17 | 8.2 | 39.7 | 0.4 | 8.7 | 5.4 | 4.4 | 7.9 | 7.3 | 3.2 |
| OCT-FY18 | 7.5 | 26.8 | 3.0 | 11.3 | 7.5 | 2.9 | 4.2 | 6.4 | 4.5 |
| NOV-FY18 | 8.0 | 24.4 | 5.0 | 3.3 | 5.6 | 4.9 | 4.7 | 9.3 | 9.7 |
| DEC-FY18 | 8.1 | 29.0 | 5.6 | 5.7 | 8.3 | 12.0 | 5.2 | 15.7 | 4.4 |
| JAN-FY18 | 8.2 | 13.0 | 10.4 | 2.3 | 6.5 | 8.5 | 8.6 | 16.1 | 9.0 |
| FEB-FY18 | 7.5 | 1.1 | 7.2 | 0.9 | 4.6 | 8.0 | 2.5 | 9.4 | 7.2 |
| MAR-FY18 | 8.6 | 4.0 | 7.9 | 1.6 | 4.3 | 12.9 | 4.0 | 7.5 | 5.8 |

*Source: VHA Support Service Center*

*Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Jackson, MS (586QB) and Flowood (586QC), as no data was reported. The OIG has on file the Facility's explanation for the increased wait times for the G.V. (Sonny) Montgomery VA Medical 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.*

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

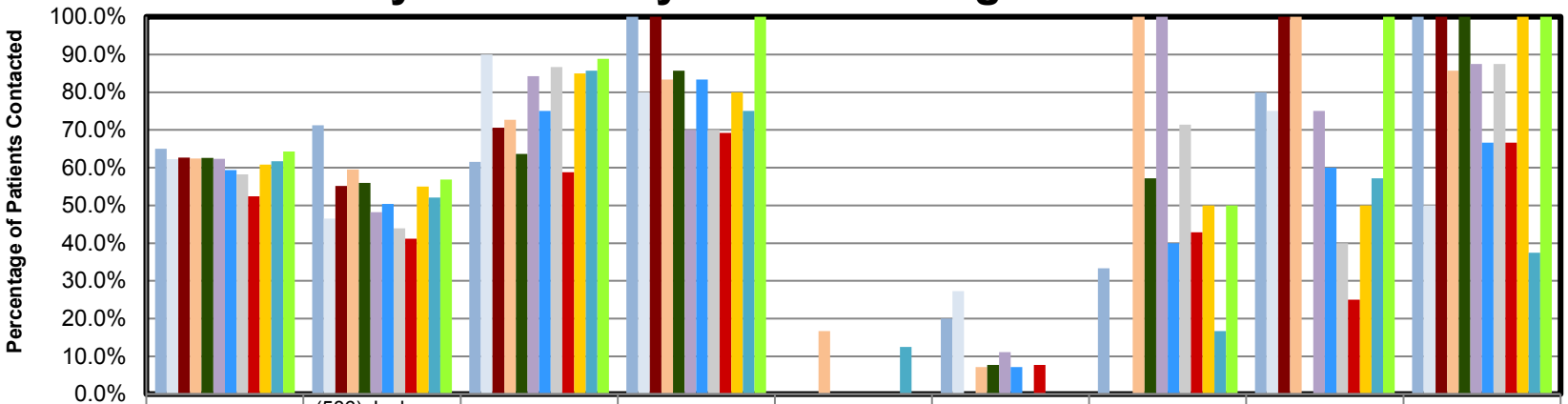



| | VHA Total | (586) Jackson, MS (G.V. (Sonny) Montgomery) | (586GA) Kosciusko, MS | (586GB) Meridian, MS | (586GC) Greenville, MS | (586GD) Hattiesburg, MS | (586GE) Natchez, MS | (586GF) Columbus, MS | (586GG) McComb, MS |
|---|---|---|---|---|---|---|---|---|---|
| APR-FY17 | 3.9 | 8.2 | 3.5 | 7.9 | 6.0 | 0.7 | 4.4 | 2.7 | 4.7 |
| MAY-FY17 | 4.0 | 9.1 | 4.7 | 6.8 | 5.7 | 0.6 | 3.7 | 2.2 | 4.3 |
| JUN-FY17 | 4.1 | 9.6 | 5.8 | 7.6 | 5.4 | 1.1 | 2.7 | 2.2 | 2.5 |
| JUL-FY17 | 4.1 | 8.0 | 4.9 | 5.4 | 5.0 | 1.7 | 3.1 | 2.5 | 2.4 |
| AUG-FY17 | 4.2 | 7.6 | 5.0 | 6.1 | 6.0 | 1.0 | 3.8 | 2.4 | 2.9 |
| SEP-FY17 | 4.0 | 6.1 | 3.6 | 4.8 | 5.9 | 0.9 | 3.1 | 2.7 | 1.8 |
| OCT-FY18 | 3.7 | 5.9 | 2.7 | 2.9 | 5.0 | 1.1 | 2.1 | 1.8 | 1.8 |
| NOV-FY18 | 4.1 | 4.1 | 5.4 | 4.8 | 4.6 | 2.3 | 2.4 | 3.7 | 2.5 |
| DEC-FY18 | 4.1 | 3.8 | 5.7 | 5.0 | 4.7 | 2.8 | 2.8 | 3.4 | 2.8 |
| JAN-FY18 | 4.4 | 4.2 | 8.3 | 3.8 | 5.3 | 3.5 | 3.1 | 4.6 | 3.7 |
| FEB-FY18 | 4.0 | 3.5 | 6.3 | 3.6 | 6.0 | 3.0 | 2.1 | 3.8 | 3.5 |
| MAR-FY18 | 4.2 | 3.5 | 5.6 | 3.8 | 5.3 | 2.6 | 2.7 | 3.5 | 2.8 |

*Source: VHA Support Service Center*

*Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Jackson, MS (586QB) and Flowood (586QC), as no data was reported.*

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

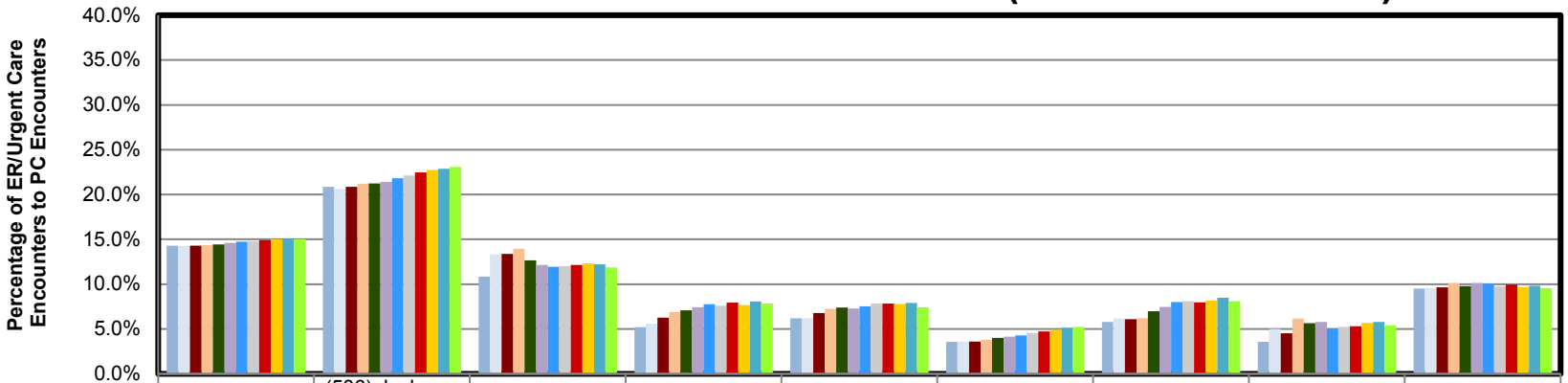



| | VHA Total | (586) Jackson, MS (G.V. (Sonny) Montgomery) | (586GA) Kosciusko, MS | (586GB) Meridian, MS | (586GC) Greenville, MS | (586GD) Hattiesburg, MS | (586GE) Natchez, MS | (586GF) Columbus, MS | (586GG) McComb, MS |
|---|---|---|---|---|---|---|---|---|---|
| APR-FY17 | 65.0% | 71.2% | 61.5% | 100.0% | 0.0% | 20.0% | 33.3% | 80.0% | 100.0% |
| MAY-FY17 | 62.3% | 46.5% | 90.0% | 80.0% | 0.0% | 27.3% | 0.0% | 75.0% | 50.0% |
| JUN-FY17 | 62.7% | 55.2% | 70.6% | 100.0% | 0.0% | 0.0% | 0.0% | 100.0% | 100.0% |
| JUL-FY17 | 62.4% | 59.5% | 72.7% | 83.3% | 16.7% | 7.1% | 100.0% | 100.0% | 85.7% |
| AUG-FY17 | 62.6% | 55.9% | 63.6% | 85.7% | 0.0% | 7.7% | 57.1% | 0.0% | 100.0% |
| SEP-FY17 | 62.3% | 48.2% | 84.2% | 70.0% | 0.0% | 11.1% | 100.0% | 75.0% | 87.5% |
| OCT-FY18 | 59.3% | 50.4% | 75.0% | 83.3% | 0.0% | 7.1% | 40.0% | 60.0% | 66.7% |
| NOV-FY18 | 58.3% | 43.9% | 86.7% | 70.0% | 0.0% | 0.0% | 71.4% | 40.0% | 87.5% |
| DEC-FY18 | 52.4% | 41.2% | 58.8% | 69.2% | 0.0% | 7.7% | 42.9% | 25.0% | 66.7% |
| JAN-FY18 | 60.8% | 55.0% | 85.0% | 80.0% | 0.0% | 0.0% | 50.0% | 50.0% | 100.0% |
| FEB-FY18 | 61.7% | 52.1% | 85.7% | 75.0% | 12.5% | 0.0% | 16.7% | 57.1% | 37.5% |
| MAR-FY18 | 64.3% | 56.9% | 88.9% | 100.0% | 0.0% | 0.0% | 50.0% | 100.0% | 100.0% |

*Source: VHA Support Service Center*

*Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Jackson, MS (586QB) and Flowood (586QC), as no data was reported.*

***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."*




| | VHA Total | (586) Jackson, MS (G.V. (Sonny) Montgomery) | (586GA) Kosciusko, MS | (586GB) Meridian, MS | (586GC) Greenville, MS | (586GD) Hattiesburg, MS | (586GE) Natchez, MS | (586GF) Columbus, MS | (586GG) McComb, MS |
|---|---|---|---|---|---|---|---|---|---|
| APR-FY17 | 14.3% | 20.8% | 10.8% | 5.2% | 6.2% | 3.6% | 5.8% | 3.6% | 9.5% |
| MAY-FY17 | 14.3% | 20.6% | 13.3% | 5.6% | 6.2% | 3.6% | 6.2% | 5.0% | 9.6% |
| JUN-FY17 | 14.3% | 20.9% | 13.4% | 6.3% | 6.8% | 3.6% | 6.1% | 4.5% | 9.7% |
| JUL-FY17 | 14.4% | 21.2% | 13.9% | 6.9% | 7.3% | 3.8% | 6.2% | 6.2% | 10.1% |
| AUG-FY17 | 14.4% | 21.2% | 12.7% | 7.1% | 7.4% | 4.0% | 7.0% | 5.7% | 9.8% |
| SEP-FY17 | 14.6% | 21.4% | 12.2% | 7.4% | 7.3% | 4.2% | 7.5% | 5.8% | 10.1% |
| OCT-FY18 | 14.7% | 21.8% | 12.0% | 7.8% | 7.5% | 4.3% | 8.0% | 5.0% | 10.0% |
| NOV-FY18 | 14.8% | 22.1% | 12.0% | 7.6% | 7.8% | 4.6% | 8.1% | 5.2% | 9.8% |
| DEC-FY18 | 14.9% | 22.5% | 12.2% | 7.9% | 7.9% | 4.7% | 8.0% | 5.3% | 10.0% |
| JAN-FY18 | 15.0% | 22.7% | 12.3% | 7.7% | 7.8% | 4.9% | 8.2% | 5.7% | 9.7% |
| FEB-FY18 | 15.0% | 22.9% | 12.2% | 8.1% | 7.9% | 5.1% | 8.5% | 5.8% | 9.8% |
| MAR-FY18 | 15.0% | 23.1% | 11.9% | 7.8% | 7.4% | 5.3% | 8.1% | 5.4% | 9.6% |

*Source: VHA Support Service Center*

*Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Jackson, MS (586QB) and Flowood (586QC), as no data was reported.*

***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[105]

| 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 |

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

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

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

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

*Source: VHA Support Service Center*

# Appendix E: VISN Director Comments

## Department of Veterans Affairs Memorandum

Date: November 7, 2018

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

Subj: CHIP Review of the G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS

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

Director, GAO/OIG Accountability Liaison (VHA 10E1D MRS Action)

I have reviewed and concur with the action plans regarding the Comprehensive Healthcare Inspection Program (CHIP) review conducted at the G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS.

*(Original signed by:)*

Skye McDougall, PhD

*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: October 31, 2018

From: Director, G.V. (Sonny) Montgomery VA Medical Center (586/00)

Subj: CHIP Review of the G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS

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

I have reviewed and concur with the findings, recommendations, and action plans regarding the Comprehensive Healthcare Inspection Program (CHIP) review conducted at the G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS.

*(Original signed by:)*

David M. Walker, MD, MBA, DFAPA
Medical Center Director

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

# OIG Contact and Staff Acknowledgments

| | |
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