DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the Robley Rex VA Medical Center

Louisville, Kentucky

CHIP REPORT | REPORT #18-01163-36 | DECEMBER 19, 2018

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Figure 1. *Robley Rex VA Medical Center, Louisville, Kentucky*
(Source: https://vaww.va.gov/directory/guide/, accessed on October 2, 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 Robley Rex 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 August 27, 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 Interim Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. Organizational

communication and accountability are carried out through a committee reporting structure, with the Executive Leadership Council having oversight for committees such as the Administrative Executive; Healthcare Quality, Safety & Value; and Patient Care Executive Boards. The Interim Director serves as the chairperson of the Executive Leadership Council with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Healthcare Quality, Safety & Value Board, co-chaired by the Interim Director, is responsible for tracking, trending, and monitoring quality of care and patient outcomes.

The current interim Director was assigned in August 2018 after two other interim Directors were in this position which was vacated in February 2018. The Associate Director was permanently assigned in January 2018. Prior to this, the position had been vacant since July 2017 and was filled by five interim appointees. The Chief of Staff and ADPCS have been in their roles since June 2004 and January 2016, respectively.

In the review of selected employee satisfaction survey results regarding Facility leaders, the OIG noted employees appear generally satisfied with Facility leaders. However, opportunities may exist for the Chief of Staff to provide a safe workplace environment where employees feel comfortable bringing forth issues or ethical concerns, and the leaders discussed ongoing efforts to improve the culture of the organization.

In the review of selected patient experience survey results regarding Facility leaders, the OIG noted that patients appear generally satisfied with the leadership and care provided, and Facility leaders appeared to be actively engaged with patients.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[1] The OIG noted opportunities for all interviewed executive leaders to increase their knowledge about actions taken during the previous 12 months in order to maintain or improve performance of the Quality of Care and Efficiency metrics likely contributing to the current "3-Star" rating.

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

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

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

Quality, Safety, and Value

The OIG found general compliance with requirements for protected peer reviews and with the completion of UM and PUMA reviews, the patient safety annual report, and the minimum eight root cause analyses (RCAs). The OIG noted inconsistencies with the RCA processes prior to closure and documentation in WebSPOT. The OIG also identified deficiencies with interdisciplinary reviews of UM data and providing feedback about RCA actions.[3]

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing and privileging; however, the OIG identified deficiencies in professional practice evaluations.

Environment of Care

The OIG noted general safety and privacy measures were in place at the parent Facility and the representative CBOC and did not identify any issues with the availability of medical equipment and supplies. However, the OIG noted deficiencies in environmental cleanliness, inpatient mental health patient safety, and emergency management.

Medication Management

The OIG found general compliance with requirements for most of the performance indicators evaluated, including controlled substance (CS) ordering procedures, the CS Coordinator and CS Inspectors having no conflicts of interest and completing required training, and CS area inspections. The OIG noted deficiencies in the CSC reports and annual physical security survey.

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

[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.

Women's Health

The OIG noted compliance with requirements for scanning hard copy reports for outsourced mammograms, inclusion of required components in reports, communication of results and any recommended course of action to the ordering provider, communication of results to patients, and performance of follow-up mammograms and studies if indicated. However, the OIG identified a deficiency with electronic linking of mammogram results to the radiology order.

Summary

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

Comments

The Veterans Integrated Service Network Director and Interim Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 61–62, and the responses within the body of the report for the full text of the Directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
for Healthcare Inspections

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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Robley Rex 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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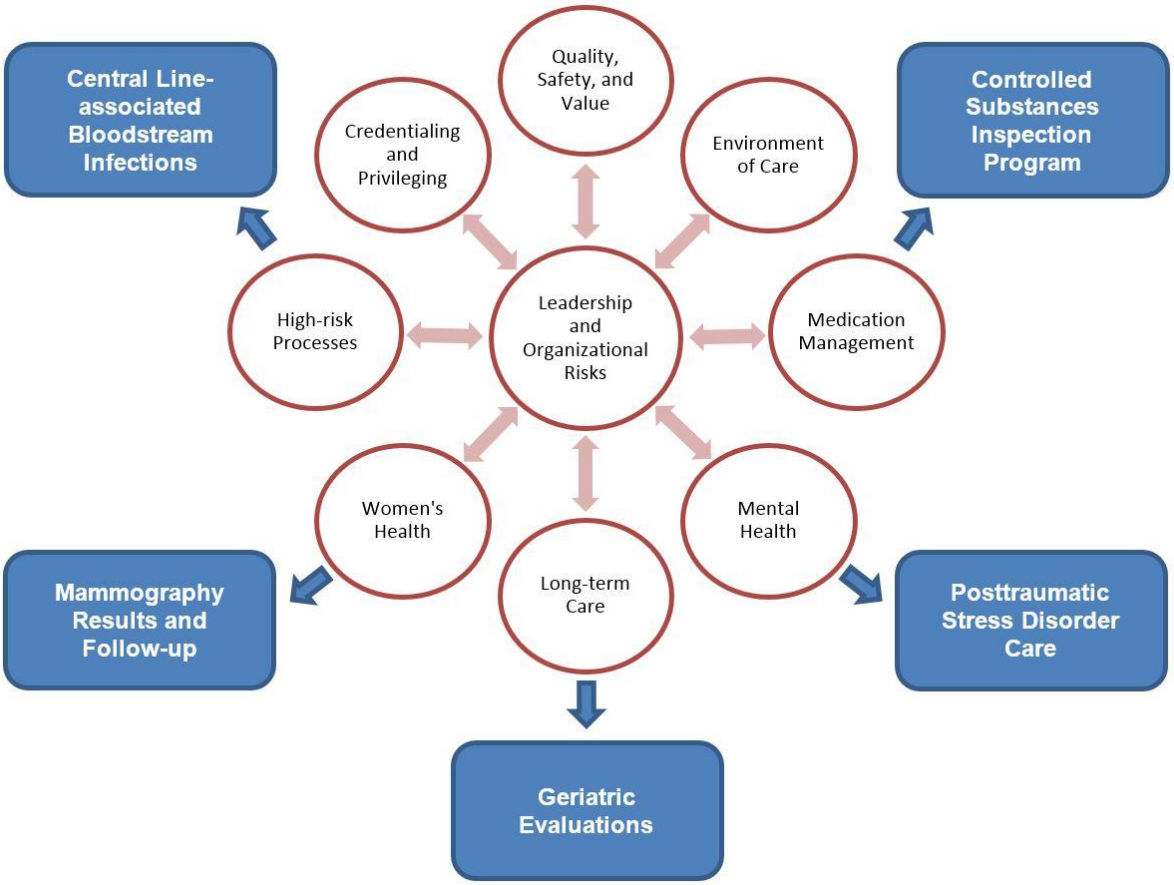
[4] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

[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 August 4, 2015,[9] through August 27, 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 Interim 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.

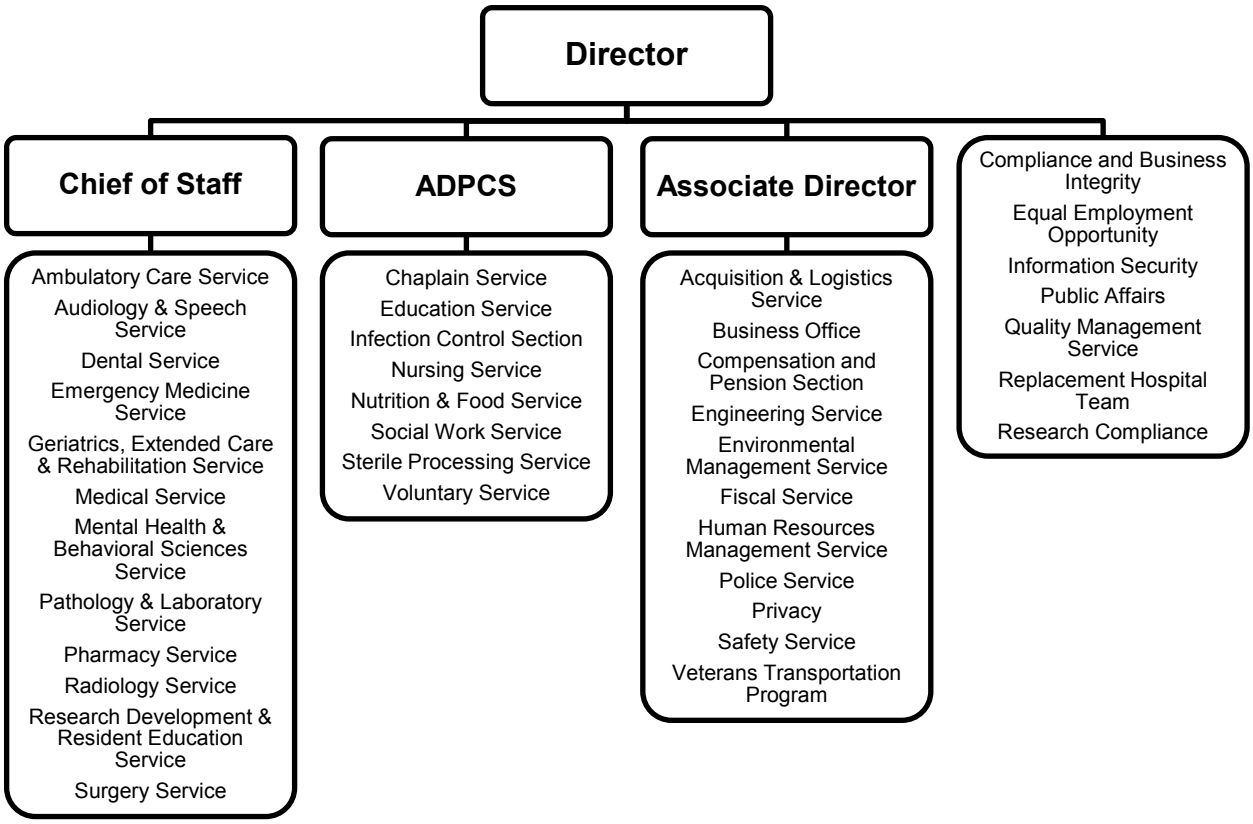
Executive Leadership Stability and Engagement

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 Interim Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. The Chief of Staff, ADPCS, and Associate Director are responsible for overseeing patient care and service directors, as well as program and practice chiefs.

The current interim Director was assigned in August 2018 after two other interim Directors were in this position which was vacated in February 2018. The Associate Director was permanently assigned in January 2018. Prior to this, the position had been vacant since July 2017 and was filled by five interim appointees. The Chief of Staff and ADPCS have been in their roles since June 2004 and January 2016, respectively.

[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: Robley Rex VA Medical Center (August 29, 2018)

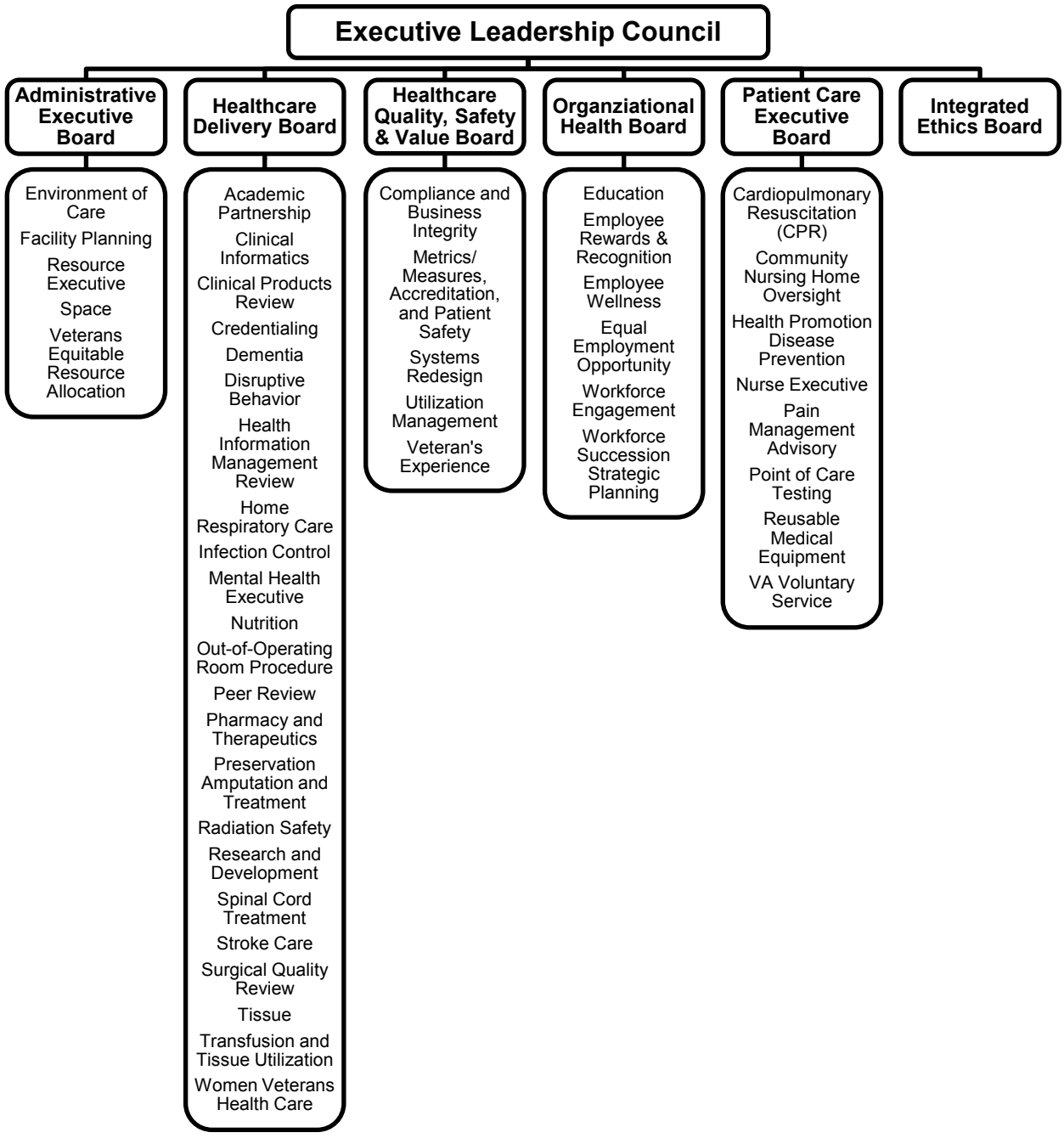
To help assess engagement of Facility executive leadership, the OIG interviewed the Interim Director, Acting Chief of Staff,[11] ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance. In individual interviews, the OIG noted opportunities for all interviewed executive leaders to increase their knowledge about actions taken during the previous 12 months to maintain or improve performance, employee and patient survey results, and/or selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders were also engaged in monitoring patient safety and care through formal mechanisms. Organizational communication and accountability is carried out through a committee reporting structure with the Executive Leadership Council having oversight for committees such as the Administrative Executive; Healthcare Quality, Safety & Value; and Patient Care Executive Boards. The Interim Director serves as the chairperson of the Executive Leadership Council with the authority and responsibility to establish policy, maintain quality care standards, and perform

[11] The Chief of Staff was out of the office the week of the OIG visit. The Chief of Surgery was serving as Acting Chief of Staff.

organizational management and strategic planning. The Healthcare Quality, Safety & Value Board, co-chaired by the Interim Director, is responsible for tracking, trending, and monitoring quality of care and patient outcomes. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: Robley Rex VA Medical Center (August 27, 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 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.[12]

Table 1 summarizes employee attitudes toward selected Facility leaders as expressed in VHA's All Employee Survey.[13] The Facility average for both selected survey questions was similar to or above the VHA average,[14] while the results for the members of the executive leadership team were above the VHA and Facility averages. In all, employees appear generally satisfied with Facility leaders.

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

[13] 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.

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

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	66.5	74.0	71.0	84.0	71.6
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	3.4	4.4	3.8	3.9	3.7

Source: VA All Employee Survey (accessed July 28, 2108)

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 the VHA averages, while the results for the Interim Director, Associate Director, and ADPCS were above the VHA and Facility averages. The results for the Chief of Staff were similar to or lower than the VHA and Facility averages. Opportunities may exist for the Chief of Staff to provide a safe workplace environment where employees feel comfortable bringing forth issues or ethical concerns. The OIG noted the leaders' ongoing efforts to improve the culture of the organization.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey Q43. *My supervisor encourages people to speak up when they disagree with a decision.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.7	4.3	3.5	3.9	4.0
All Employee Survey Q44. *I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.9	4.1	3.8	4.4	4.0
All Employee Survey Q75. *I can talk with my direct supervisor about ethical concerns without fear of having my comments held against me.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.8	4.1	3.8	4.1	4.0

Source: VA All Employee Survey (accessed July 27, 2018)

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

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes towards Facility leaders (see Table 3) that relate to the period of October 1, 2016, through September 30, 2017. For this Facility, three of four patient survey results reflected higher care ratings than the VHA average. Patients appear generally satisfied with the leadership and care provided, and Facility leaders appeared to be actively engaged with patients.

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	64.6
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	83.4	85.0
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	75.2
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	75.2	77.4

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

Accreditation/For-Cause Surveys[15] 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

[15] 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).[16] Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 4.[17]

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[18] and College of American Pathologists[19] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Paralyzed Veterans of America conducted an inspection of the Facility's spinal cord injury/disease unit and related services.[20]

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 Robley Rex VA Medical Center, Louisville, Kentucky, September 17, 2015*)	August 2015	11	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Robley Rex VA Medical Center, Louisville, Kentucky, September 14, 2015*)	August 2015	6	0
TJC	January 2016		
• Hospital Accreditation		37	0
• Behavioral Health Care Accreditation		1	0
• Home Care Accreditation		0	n/a

Sources: OIG and TJC (Inspection/survey results verified with the Quality Manager on August 29, 2018)
n/a = Not applicable

[16] 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.

[17] 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.

[18] 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.

[19] 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.

[20] The Paralyzed Veterans of America inspection took place October 4, 2016. This Veteran Service Organization review does not result in accreditation status.

Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 5 summarizes key indicators of risk since the OIG's previous August 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of August 27, 2018.[21]

Table 5. Summary of Selected Organizational Risk Factors (August 2015 to August 27, 2018)

Factor	Number of Occurrences
Sentinel Events[22]	1
Institutional Disclosures[23]	1
Large-Scale Disclosures[24]	0

Source: Robley Rex VA Medical Center Alternate Patient Safety Manager and Risk Manager (received August 29, 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.[25] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 6 summarizes Patient Safety Indicator data from April 1, 2016, through March 31, 2018.

[21] 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 Robley Rex VA Medical Center is a high complexity (1b) affiliated Facility as described in Appendix B.)

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

[23] 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.

[24] 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.

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

Table 6. Patient Safety Indicator Data (April 1, 2016, through March 31, 2018)

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 9	Facility
Death among surgical inpatients with serious treatable conditions	113.92	112.28	60.00
Iatrogenic pneumothorax	0.17	0.13	0.13
Central venous catheter-related bloodstream infection	0.15	0.15	0.00
In-hospital fall with hip fracture	0.08	0.05	0.00
Perioperative hemorrhage or hematoma	2.62	2.61	2.49
Postoperative acute kidney injury requiring dialysis	0.65	0.51	0.00
Postoperative respiratory failure	5.11	4.24	3.68
Perioperative pulmonary embolism or deep vein thrombosis	3.09	4.52	5.60
Postoperative sepsis	3.72	8.62	5.67
Postoperative wound dehiscence	1.00	1.70	2.32
Unrecognized abdominopelvic accidental puncture/laceration	1.02	0.84	1.00

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

Two Patient Safety Indicator measures (perioperative pulmonary embolism or deep vein thrombosis (DVT) and postoperative wound dehiscence) had a higher observed rate than VHA and Veterans Integrated Service Network VISN 9. The Patient Safety Indicator measures for postoperative sepsis had a higher observed rate than VHA, and unrecognized abdominopelvic accidental puncture or laceration had a higher observed rate than VISN 9.

Seven patients developed perioperative pulmonary embolism or DVT. Six of the seven cases were individually reviewed. Through trend analysis, it was determined that opportunities for improvement existed and actions were taken to mediate future risk of similar incidents.

One patient developed postoperative wound dehiscence and was reviewed by the Chief of Surgery, who determined care was appropriate.

Four patients had postoperative sepsis, and one patient had an unrecognized abdominopelvic accidental puncture/laceration. All the cases were reviewed, and care was found to be appropriate.

Veterans Health Administration Performance Data

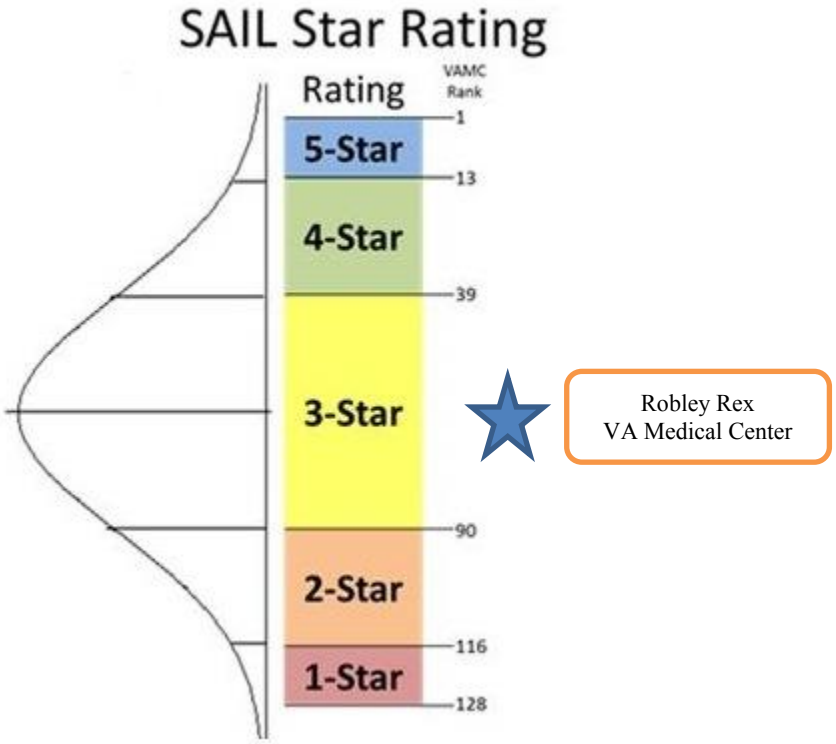
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[26]

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.[27] As of June 30, 2017, the Facility was rated at "3-Star" for overall quality. Updated data as of June 30, 2018, indicates that the Facility has remained at "3-Star" for overall quality.

[26] 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.)

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

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

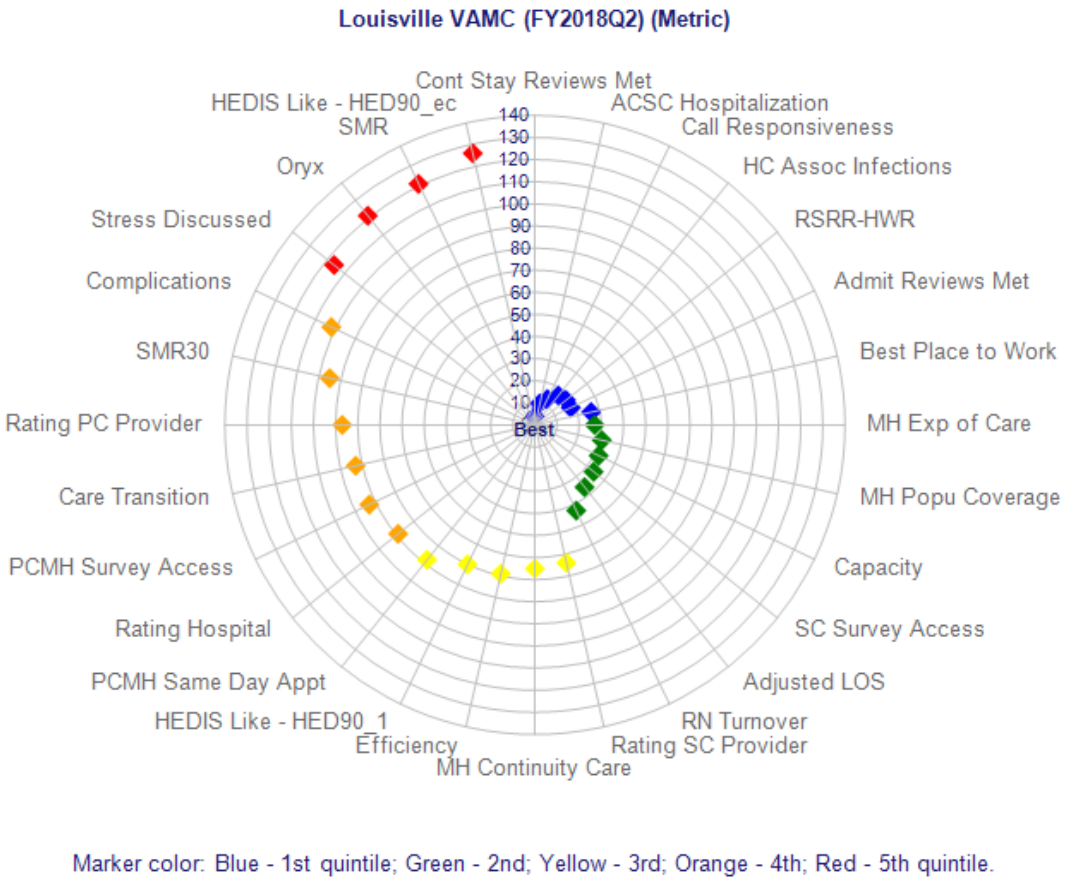


Source: VA Office of Informatics and Analytics-Office of Operational Analytics and Reporting (accessed July 27, 2018)

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of March 31, 2018. Of note, Figure 6 uses blue and green data points to indicate high performance (for example in the areas of Ambulatory Care Sensitive Conditions (ACSC) Hospitalizations, Call Responsiveness, Healthcare (HC) associated infections, Risk Standardized Mortality Rate for Hospital Wide Readmission (RSRR-HWR), and Registered Nurse (RN) Turnover).[28] Metrics that need improvement are denoted in orange and red (for example, Complications, Stress Discussed, Inpatient performance measure (Oryx), and Acute Care In-hospital Standardized Mortality Ratio (SMR)).

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

Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of March 31, 2018)



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

Conclusion

The current interim Director was assigned in August 2018 after two other interim Directors were in this position which was vacated in February 2018. The Associate Director was permanently assigned in January 2018. Prior to this, the position had been vacant since July 2017 and was filled by five interim appointees. The Chief of Staff and ADPCS have been in their roles since June 2004 and January 2016, respectively. The OIG noted that Facility leaders were generally engaged with employees and patients to maintain high satisfaction scores. Organizational leadership supported patient safety, quality care, and other positive outcomes. The OIG did not identify any substantial organizational risk factors, but the leaders have the opportunity to

improve care and positively affect Quality of Care and Efficiency metrics that are likely contributing to the Facility's "3-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.[29] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[30]

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,[31] utilization management (UM) reviews,[32] and patient safety incident reporting with related root cause analyses (RCAs).[33]

VHA has implemented approaches to improving patient safety, including the reporting of patient safety incidents to its National Center for 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.[34]

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

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

[31] 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.)

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

[33] 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.

[34] 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:[35]

- 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[36]
  - Annual completion of a minimum of eight RCAs[37]
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

Conclusion

The OIG found general compliance with requirements for protected peer reviews and with the completion of UM and Physician UM Advisor reviews, the patient safety annual report, and the minimum eight RCAs. The OIG noted that two identified actions in one RCA were not performed prior to RCA closure in WebSPOT, and an identified action in one RCA was closed

[35] For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.
[36] 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 also expected that all previous patient safety event reporting systems will have been discontinued by July 1, 2018.
[37] 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.

in WebSPOT prior to completion. The OIG also identified deficiencies with interdisciplinary reviews of UM data and providing feedback about RCA action that warranted recommendations for improvement.

Utilization Management: Data Review

VHA requires that an interdisciplinary facility group review UM data. This group should include representatives from UM, medicine, nursing, social work, case management, MH, and Chief Business Office revenue utilization review (CBO R-UR).[38] From July 2017 through July 2018, the UM Committee met quarterly; however, the CBO R-UR, MH, and Nursing did not consistently attend the meetings. This resulted in a lack of interdisciplinary expertise for review and analysis of UM data. Chief of Mental Health & Behavioral Sciences Service and Chief Nurse for Specialty Care stated that staff were not able to attend the meetings due to conflicting patient care responsibilities. Facility managers also stated that the CBO R-UR representative teleworked and did not consistently call in to attend the meetings.

Recommendation 1

1. The Facility Director ensures all required members consistently participate in the interdisciplinary group that reviews utilization management data and monitors compliance.

Facility concurred.

Target date for completion: January 28, 2019

Facility response: On October 22, 2018, UM Committee members were educated regarding meeting attendance requirements of at least 75% by each of the assigned representative. The members include: UM, Medicine, Nursing, Social Work, Case Management, Discharge Planning, Mental Health and the Business Office Revenue Utilization Review. The October 22, 2018 meeting was attended by the services specified per VHA Directive 1117(1). Compliance will be monitored for two consecutive quarters to maintain at least 75% attendance for each of the required disciplines.

Patient Safety: Root Cause Analyses

VHA requires that the Patient Safety Manager or designee provides feedback about root cause analysis actions to the individuals or departments who reported the incidents.[39] For three of five RCAs conducted during FY 2017 and 2018, there was a lack of evidence that the individual or department reporting the incident received feedback about actions taken. This resulted in missed

[38] VHA Directive 1117.
[39] VHA Handbook 1050.01.

opportunities to establish employee trust in the system and to positively reinforce a culture of safety. The Alternate Patient Safety Manager reported the noncompliance was due to a lack of knowledge and follow-up.

Recommendation 2

2. The Facility Director ensures the Patient Safety Manager or designee provides feedback to employees or departments who submit patient safety incidents that result in root cause analysis and monitors compliance.

Facility concurred.

Target date for completion: March 1, 2019

Facility response: The Patient Safety Manager will consistently address question 17, "Feedback to Reporter" within the National Center for Patient Safety data base SPOT. A practice was implemented in June of 2018 that requires the facilitator/leader of the RCA to communicate the final process flow map, root cause statement, actions, and outcome measures with the event reporter for feedback. This will be audited by the Quality Lead for three consecutive quarters to ensure 100% compliance with providing feedback to staff who submit patient safety incidents that result in a root cause analysis being performed.

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).[40]

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.[41]

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.[42]

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,[43] and 20 LIPs who were re-privileged within 12 months prior to the visit.[44] The OIG evaluated the following performance indicators:

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

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

[41] VHA Handbook 1100.19.

[42] VHA Handbook 1100.19.

[43] The 18-month period was from February 2017 through August 2018.

[44] The 12-month review period was from May 2017 through June 2018.

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

Conclusion

The OIG found general compliance with requirements for credentialing and privileging; however, the OIG identified deficiencies in professional practice evaluations that warranted a recommendation for improvement.

Focused and Ongoing Professional Practice Evaluations

VHA requires that professional practice evaluations be based on an evaluation by another provider with similar training and privileges.[45] For 9 of 28 applicable LIPs, the OIG found that evaluations were not conducted by another provider with similar training and privileges. This resulted in LIPs continuing to deliver care without a thorough evaluation of their practice. The

[45] VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

Chief of Surgery reported completing surgical evaluations because of the belief that FPPE and OPPE results were not to be shared between peers; other clinical leaders were unavailable to provide reasons for noncompliance.

Recommendation 3

3. The Chief of Staff ensures Focused and Ongoing Professional Practice Evaluations are completed by providers with similar training and privileges and monitors compliance.

Facility concurred.

Target date for completion: April 30, 2019

Facility response: The COS will modify hospital memorandum 11-023 Credentialing and Privileging to define the criteria for selecting providers with similar training and privileges for FPPE and OPPE compliance. 100% of all FPPE's and OPPE's will be audited monthly for three consecutive months to demonstrate that 100% of all reviews are conducted by providers with similar training and privileges. The results of the actions will be reported to the Healthcare Delivery Board.

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. Environment of Care 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.

In all, the OIG team inspected five inpatient units— Surgery 4-North, intensive care 6-North, Medicine 6-South, inpatient MH 7-North, and Post Anesthesia Care—in addition to the Emergency Department and the Eye Clinic. The team also inspected the Fort Knox CBOC.[53] The OIG reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

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

[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.

[53] The Fort Knox CBOC is a contracted facility located on the Fort Knox Army Base. Department of Defense staff and contractors maintain the facility and provide maintenance and cleaning.

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

Conclusion

The OIG noted general safety and privacy measures were in place at the parent Facility and the representative CBOC and did not identify any issues with the availability of medical equipment and supplies. However, the OIG noted deficiencies in environmental cleanliness, inpatient mental health patient safety, and emergency management that warranted recommendations for improvement.

Facility and CBOC Cleanliness and Maintenance

TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices and keep furnishings and equipment safe and in good repair.[54] At the parent Facility, of the seven areas inspected, all had dirty ventilation grills, stained or broken ceiling tiles, or unrepaired wall damage; six had dirty/damaged floor tiles;[55] and five had dirty light fixtures and/or dusty fire sprinkler heads.[56] Facility managers reported limited resources to manage the aging infrastructure and staffing challenges as reasons for the Facility's inability to address all deficiencies. Additionally, the Environmental Management Service Specialist noted that housekeeping aides were not using available vacuum backpacks and needed additional training on cleaning techniques. This resulted in a lack of assurance of a clean and safe environment.

At the Fort Knox CBOC, the OIG noted dusty HVAC grills, stained ceiling tiles, and unrepaired wall damage in various patient care areas. The completion of work orders at the CBOC was the responsibility of the Department of Defense (DoD). The Facility tracks these deficiencies using

[54] TJC. EOC standards EC.02.06.01 EP01, EP20, and EP26; and EC.04.01.01, EP14.

[55] Intensive care 6-North, Medical 6-South, inpatient MH 7-North, and Post-Anesthesia Care Units; the Emergency Department; and the Eye Clinic.

[56] Surgical 4-North, Intensive care 6-North, Medical 6-South, and inpatient MH 7-North units; and the Emergency Department.

Performance Logic software but does not consistently track DoD completion times. The Associate Director reported that DoD was not as responsive to work order requests due in part to the active construction of a new VA CBOC.

Recommendation 4

4. The Associate Director ensures that a safe and clean environment is maintained throughout the Facility and Fort Knox Community Based Outpatient Clinic and monitors compliance.

Facility concurred.

Target date for completion: January 2, 2019

Facility response: The identified damages in the main hospital to the wall and floor tiles were repaired during the month of September 2018. The exception to these repairs were the rooms on sixth floor South wing, where a construction project to renovate the rooms began in October 2018. The anticipated completion date of the project is April 2019 during which the damaged environmental deficiencies will be corrected.

The facility has purchased new backpack vacuum cleaners. All applicable staff were trained on their usage and the appropriate technique to utilize when cleaning ventilation grills, light fixtures and sprinkler heads. The systematic cleaning began October 1, 2018. To maintain this standard, high dusting will be done for the clinic areas on a ten-day regular schedule. Additionally, EOC rounds will now include the inspection of vents and other high dusting areas to validate compliance. To immediately evaluate the change of process during the next three months, we will complete random weekly audits of at least 25% of the ventilation grills, light fixtures and sprinkler heads throughout the Fort Knox CBOC and the Medical Center to determine compliance of 90%. If a 90% threshold is not met for three consecutive months the audits will continue and updates of progress will be communicated to the Associate Director until three consecutive months at 90% are met.

All stained ceiling tiles were replaced in September of 2018.

At the Fort Knox CBOC, located at the Fort Knox Army Base, we have communicated with the base officials on the deficiencies with work orders submitted and they have responded they will correct the deficiencies by the end of December 2018. Our CBOC office manager will monitor the progress to ensure the needed repairs are completed.

Parent Facility: Inpatient MH Safety

VHA requires facilities with inpatient psychiatric units that treat suicidal patients to perform systematic environmental assessments using the MH EOC Checklist (MHEOCC) to eliminate environmental factors that could facilitate suicide attempts or completion or pose a risk of harm

to staff members.[57] The OIG found plastic light switches, receptacles, and old junction box covers in use throughout the patient rooms. A male patient restroom was equipped with a urinal that had anchor points, fire alarm annunciators were not equipped with plastic covers to prevent anchor points, and electrical cover plates were missing tamper-proof screws. Patient room doors had viewing ports insufficiently sized to allow viewing of the room, thus creating blind spots. These deficiencies could result in harm to patients. The Associate Director reported that identification and correction of some of the deficiencies identified by the OIG may have been delayed due to misinterpretation of MHEOCC requirements by Facility staff.

Recommendation 5

5. The Associate Director ensures staff assigned to conduct mental health environment of care inspections use the Mental Health Environment of Care Checklist to identify and correct deficiencies in a timely manner and monitors compliance.

Facility concurred.

Target date for completion: April 30, 2019

Facility response: The plastic light switch plates, receptacle plates and junction boxes have all been replaced with metal. A walk through was completed to evaluate the presence of screws not compliant with the MHEOCC and were subsequently replaced in September of 2018. Fire alarm annunciators were equipped with plastic covers on September 29, 2018. We have ordered a MHEOCC compliant urinal to with the projected delivery date of November 2018, with installation to be completed by end of the December 2018. Our mental health ward is scheduled for renovation in the Strategic Capital Investment Process (SCIP) project number 603-2018-34053 "Renovate 7 North Inpatient Mental Health" which will include enlarging the windows to the rooms for better observation. During the interim, to mitigate risk, we are or will be completing the following: 1) Placing over the door alarms on all the doors on the locked mental health unit that are accessible to patients, with an estimated completion date of April 2019; 2) Conduct 15-minute checks on patients with suicidal ideation that are not clinically ordered to have a 1:1; 3) Purchased (with a tentative delivery date of December 2018) Riley Therapeutic Psychiatric Safety Bed Linen; 4) Overhauled the process of completing MHEOCC which will bring in novice individuals to be paired with individuals who are familiar with the checklist to complete the actual inspection of an assigned area from the checklist. Additionally, we will conduct in briefs and debriefs at the end of each round. In the debrief we will enter any/all work orders that need to be completed or remediate the issue immediately if warranted. All work orders generated from the MHEOCC will all be followed in the Environment of Care Committee monthly.

[57] VHA Mental Health Environment of Care (EOC) Checklist, December 8, 2016.

Parent Facility: Emergency Management

VHA requires facilities to develop and annually review an Emergency Operations Plan (EOP).[58] The OIG noted that the Facility's EOP lacked information about how the Facility communicates with patients and families; manages mental health services; and manages activities required as part of patient scheduling, triage, assessment, treatment, admissions, transfers, and discharges during an emergency. Additionally, the OIG found no evidence that an annual inventory was completed of on-site resources and assets needed during an emergency. This resulted in a lack of assurance that the Facility is prepared for contingency operations during emergencies. The Associate Director acknowledged the Emergency Management staff's lack of attention to detail in following established directives and guides for EOP development and documenting the annual inventory as the reason for the program's noncompliance.

Recommendation 6

6. The Associate Director ensures the Facility's Emergency Operations Plan includes required elements and that the annual review of inventory and assets is conducted and documented and monitors compliance.

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

Facility concurred.

Target date for completion: February 28, 2019

Facility response: Immediately following the OIG review, the Emergency Management Coordinator held a workgroup with pertinent personnel to develop the process for communication with patients and families, managing mental health and the activities required for patient scheduling, triage, assessment, treatment, admissions, transfers and discharges. The new processes were presented and approved during the October 2018 Emergency Management Committee. To evaluate new processes a table top exercise will be conducted by January 31, 2019 with 100% compliance. A review of the table top exercise will be completed by the Associate Director and reported to the Environment of Care Committee by February 28, 2019.

The annual inventory was completed and approved during the October Emergency Management Committee meeting. The annual review of inventory and assets will be presented to Emergency Management Committee on an annual basis and this will be reflected in the minutes. Furthermore, the annual review of inventory and assets will be reported annually to the Environment of Care Committee in Emergency Managements annual report, beginning in January 2019.

The entire Emergency Operations Plan is being reviewed by the Emergency Manager. The review will be completed by December 31, 2018. Concurrence with the review will be completed by the Associate Director and the Environment of Care Committee by February 28, 2019.

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.[59] 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.[60]

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.[61] 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.[62] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[63] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[64] CS inspection quarterly trend reports for the prior four quarters;[65] 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

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

[60] 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.

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

[62] 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.

[63] The review period was January 1, 2018, through June 30, 2018.

[64] The review period was July 1, 2017, through June 30, 2018.

[65] The four quarters were from July 1, 2017, through June 30, 2018.

  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transition
  - Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from conflicts of interest
  - Appointed in writing by the Director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSIs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated
  - Security and documentation of drugs held for destruction[66]
  - Accountability for all prescription pads in pharmacy

[66] 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.

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

Conclusion

The OIG found general compliance with requirements for most of the performance indicators evaluated, including controlled substance (CS) ordering procedures, the CS Coordinator and CS Inspectors having no conflicts of interest and completing required training, and CS area inspections. The OIG noted deficiencies in the CSC reports and the annual physical security survey that warranted recommendations for improvement.

Controlled Substances Coordinator Reports: Monthly Summary of Findings

VHA requires the CSC to provide the Director with a monthly summary of findings, including discrepancies and vulnerabilities, identified during monthly CS inspections.[67] This ensures CS issues are addressed in a timely manner and that appropriate actions are taken and implemented. The OIG noted that the CSC's monthly report to the Director did not include all discrepancies or findings recorded by CSIs in the inspection reports. When the CSIs reported "small" (less than 5) overages and/or shortages found during monthly physical counts of CS in the pharmacy, the CSC did not fully investigate or report those findings, resulting in an increased potential for CS diversion. The CSC and Chief of Pharmacy reported that there was a lack of knowledge and misinterpretation of VHA requirements regarding follow-up for small overages and/or shortages when assessing pharmacy stock.

Recommendation 7

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

[67] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: July 26, 2019

Facility response: Effective August 1, 2018 all discrepancies in pharmacy stock, regardless of the quantity, are investigated and reported to the facility Director. Additionally, beginning January 31, 2019 quarterly written reports regarding discrepancies will also be presented and reviewed by the Healthcare Quality, Safety, & Value Board ensuring compliance with reporting 100% of the discrepancies two full quarters.

Annual Physical Security Survey

VHA requires that the Chief, VA Police, follow up with the pharmacy to ensure that identified deficiencies from the annual physical security survey have been corrected.[68] The OIG found that four deficiencies, initially identified during the 2015 Annual Physical Security Survey, had not been addressed. This resulted in lack of security for medications stored in the pharmacy. The Chief of Pharmacy reported that work orders had been placed for the recommended modifications; however, Engineering had not completed the orders due to competing priorities with patient care area renovations.

Recommendation 8

8. The Facility Director ensures that all deficiencies identified on the annual physical security survey are addressed and monitors compliance.

Facility concurred.

Target date for completion: January 31, 2019

Facility response: Vault door replacement and Ballistic Glass Deficiency- The following barriers are in place to mitigate risk regarding possible diversion of medications from the pharmacy narcotic vault: 1) The narcotics vault is within protected space, there is no physical ability to access it externally, 2) The narcotics room is under surveillance by several cameras that record continuously and are monitored by the VA Police 24/7; 3) The entire area can only be accessed via a Physical Access Control System. The following barriers will be put in place by January 31, 2019 to further mitigate risk regarding possible diversion of medications from the pharmacy: 1) An installation of an audible alarm outside of outpatient pharmacy, 2) Installation of an outside key activation switch for the motion intrusion system for the inpatient pharmacy.

With the construction of a new medical center slated to start in the spring of 2019, a new pharmacy was designed to meet all required standards.

[68] VHA Handbook 0730, *Security and Law Enforcement,* August 11, 2000.

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."[69] 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.[70]

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.[71] 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.[72]

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 37 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

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

[70] VHA Handbook 1160.03.

[71] 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.

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

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

Conclusion

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

Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.[73] 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.[74] 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.[75]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[76] 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.[77] 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.[78]

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

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

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

[74] VHA Directive 1140.04.

[75] 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.

[76] Public Law 106-117.

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

[78] VHA Directive 1140.04.

  - Comprehensive psychosocial assessment by GE social worker
  - Patient or family education
  - Plan of care based on GE
- Geriatric management
  - Implementation of interventions noted in plan of care

Conclusion

The OIG noted compliance with provision of or access to geriatric evaluation, program oversight and evaluation, provider and social worker evaluations, patient education, development of plan of care, and implementation of interventions in plan of care when indicated. Although the OIG found inconsistent GE nurse assessments, 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.[79] 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.[80] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services including mammography services to eligible women veterans.[81]

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.[82]

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

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

[80] 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).

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

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

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

Conclusion

Generally, the OIG noted compliance with requirements for scanning hard copy reports for outsourced mammograms, inclusion of required components in reports, communication of results and any recommended course of action to the ordering provider, communication of results to patients, and performance of follow-up mammograms and studies if indicated. However, the OIG identified a deficiency with electronic linking of mammogram results to the radiology order that warranted a recommendation for improvement.

Electronically Linking of Mammogram Results to the Radiology Order

VHA requires that all mammogram results (Breast Imaging Reporting and Data System codes), regardless of where the procedure(s) are performed, be entered into the Veterans Health Information Systems and Technology Architecture (VistA) and associated with the radiology order to ensure the systems for tracking and managing mammography and breast cancer operate accurately.[83] This also ensures accurate reporting of data for use in program improvement, compliance, and oversight activities. The OIG estimated that the mammogram results were electronically linked to the order in 73 percent of the EHRs reviewed; and, 95 percent of the time, the true compliance rate is between 60.0 and 86.6 percent, which is statistically significantly below the 90 percent benchmark. Failure to link the mammography results to the radiology order could result in increased difficulty in tracking patients with breast cancer and managing follow-up care. The Women's Health Coordinator and the Radiology Department staff were unaware of the requirement for providers to enter a radiology order so that the results can be electronically linked to that order for outsourced mammograms.

Recommendation 9

9. The Chief of Staff ensures that mammogram results are electronically linked to the radiology order and monitors compliance.

[83] VHA Directive 1330.01(2).

Facility concurred.

Target date for completion: August 30, 2019

Facility response: Radiology and Women's Health worked with the Clinical Applications Coordinators to have mammogram results electronically link between VISTA to the radiology order in CPRS as of August 30, 2018. Continued education for providers on newly attached radiology order form has been initiated and will be ongoing related to academic affiliation. During Radiology and Women's Health monthly meetings, radiology will report for four months the number of orders entered, the number of results that linked to the orders correctly as well as the date of entry for oldest consult being reported. If no compliance issues are identified within the four-month time frame, reporting will go to quarterly for 6 months, at which time if no issues are identified, Women's Health Committee will discuss future reporting. Mammogram results linking to the radiology order will also be addressed at the Women's Health Care Committee bi-monthly, as an on-going agenda item. Compliance benchmark will be 100% of results linked to mammogram orders for two full quarters. Any outliers will be discussed as to cause and effect.

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.[84] 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,"[85] 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.[86]

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."[87]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[88] 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.[89]

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 17 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

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

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

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

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

[88] 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.

[89] 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 • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Nine OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Interim Director, Chief of Staff, and Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs	• None	• Required members consistently participate in the interdisciplinary group that reviews utilization management data. • The Patient Safety Manager or designee provides feedback to employees or departments who submit patient safety incidents that result of root cause analysis.
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• Professional practice evaluations are completed by providers with similar training and privileges.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent Facility
	  ○ EOC rounds and deficiency tracking
	  ○ Infection prevention
	  ○ General safety
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• CBOC
	  ○ General safety
	  ○ Medication safety and security
	  ○ Infection prevention
	  ○ Environmental cleanliness
	  ○ General and 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
		• A safe and clean environment is maintained throughout the Facility and the Fort Knox CBOC.
		• Staff conducting MH inspections use the MHEOCC checklist to identify and correct EOC deficiencies in a timely manner.
			• The Emergency Operations Plan includes required elements and the annual review of inventory and assets is conducted and documented.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	• CSC reports • Pharmacy operations • Annual physical security survey • CS ordering processes • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections	• The CSC reports all CS physical count discrepancies. • Deficiencies identified on the Annual Physical Security Survey are addressed.	• None
Mental Health: Posttraumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• None	• None
Long-term Care: Geriatric Evaluations	• Provision of or access to geriatric evaluation • Program oversight and evaluation requirements • Geriatric evaluation requirements • Geriatric management requirements	• None	• None
Women's Health: Mammography Results and Follow-up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• None	• Mammogram results are electronically linked to the radiology order.
High-risk Processes: Central Line-associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data	• None	• None

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

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this high complexity (1b)[90] affiliated[91] Facility reporting to VISN 9.

**Table 7. Facility Profile for Louisville (603)
(October 1, 2014, through September 30, 2017)**

Profile Element	Facility Data FY 2015[92]	Facility Data FY 2016[93]	Facility Data FY 2017[94]
Total Medical Care Budget in Millions	$334.0	$359.7	$377.2
Number of:			
• Unique Patients	45,032	45,113	44,884
• Outpatient Visits	603,124	618,436	595,114
• Unique Employees[95]	1,708	1,723	1,739
Type and Number of Operating Beds:			
• Domiciliary	16	16	16
• Medicine	62	64	64
• Mental Health	22	22	22
• Surgery	23	23	23
Average Daily Census:			
• Domiciliary	14	13	13
• Medicine	45	47	44
• Mental Health	10	11	12
• Surgery	13	12	8

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.

[90] 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 research and teaching programs.

[91] Associated with a medical residency program.

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

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

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

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

VA Outpatient Clinic Profiles[96]

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[97] 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[98] Provided	Diagnostic Services[99] Provided	Ancillary Services[100] Provided
Fort Knox, KY	603GA	12,100	6,508	Dermatology Endocrinology Gastroenterology Poly-Trauma	n/a	Nutrition Pharmacy Prosthetics Social Work Weight Management
New Albany, IN	603GB	13,796	3,285	Dermatology Endocrinology Gastroenterology	n/a	Pharmacy Social Work Weight Management Nutrition

[96] Includes all outpatient clinics in the community that were in operation as of February 15, 2018.

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

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

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

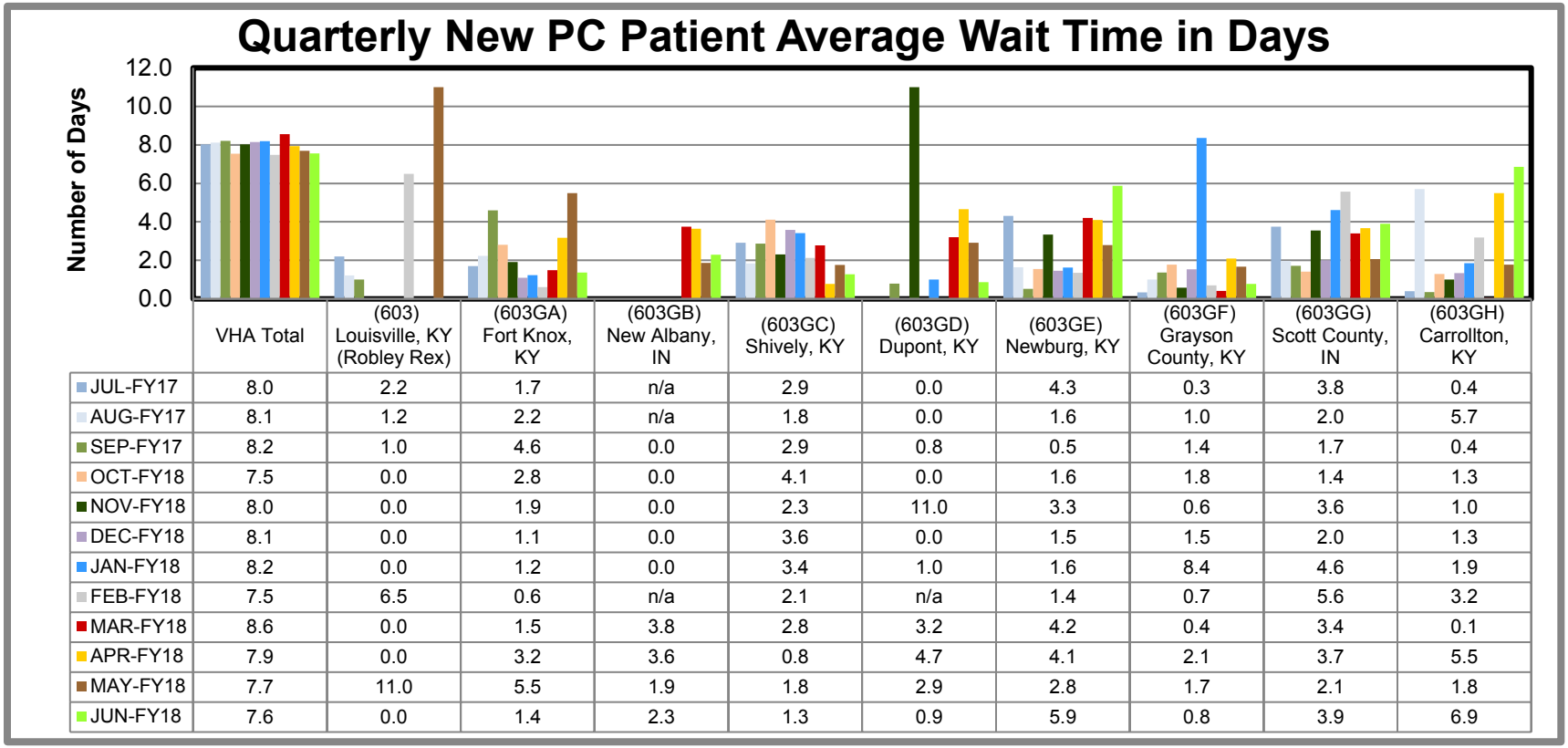
[100] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[98] Provided	Diagnostic Services[99] Provided	Ancillary Services[100] Provided
Louisville, KY	603GC	19,180	8,469	Dermatology Endocrinology Gastroenterology Hematology/ Oncology Anesthesia	n/a	Nutrition Pharmacy Social Work Weight Management
Louisville, KY	603GD	5,828	14,577	Dermatology Endocrinology Gastroenterology	n/a	Pharmacy Social Work
Louisville, KY	603GE	20,693	7,304	Dermatology Endocrinology Gastroenterology	n/a	Nutrition Pharmacy Social Work Weight Management
Clarkson, KY	603GF	9,916	6,009	Dermatology Endocrinology Gastroenterology Hematology/ Oncology Poly-Trauma GYN	n/a	Pharmacy Social Work Weight Management Nutrition
Scottsburg, IN	603GG	6,774	3,007	Dermatology Endocrinology Gastroenterology Hematology/ Oncology Poly-Trauma	n/a	Nutrition Pharmacy Social Work Weight Management

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[98] Provided	Diagnostic Services[99] Provided	Ancillary Services[100] Provided
Carrollton, KY	603GH	3,796	875	Dermatology Endocrinology Gastroenterology Hematology/ Oncology Poly-Trauma	n/a	Pharmacy Social Work Weight Management Nutrition

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

Appendix C: Patient Aligned Care Team Compass Metrics[101]



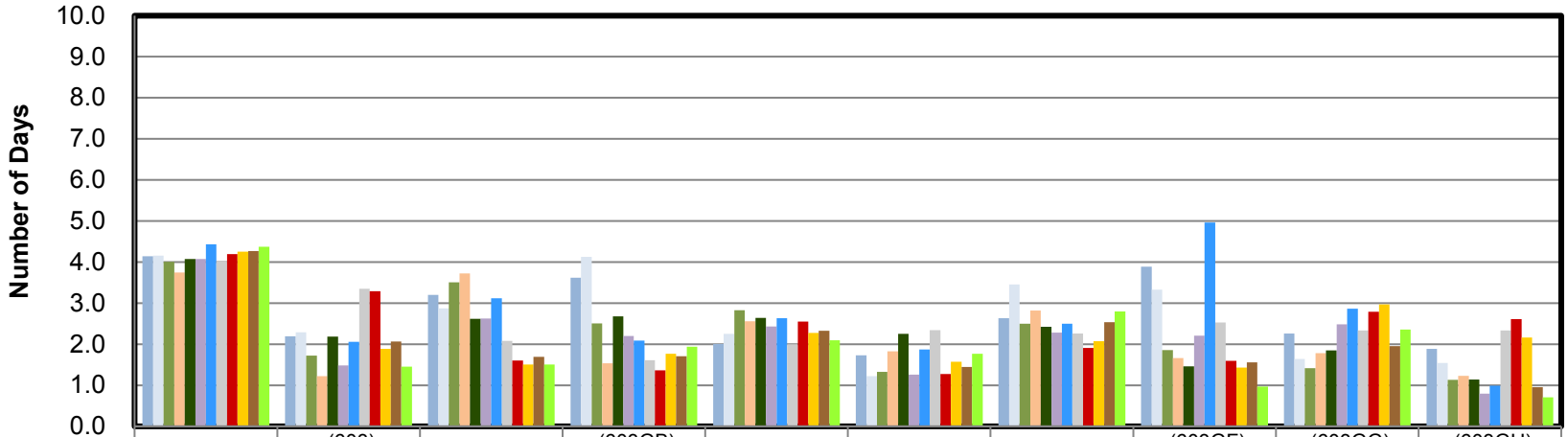
	VHA Total	(603) Louisville, KY (Robley Rex)	(603GA) Fort Knox, KY	(603GB) New Albany, IN	(603GC) Shively, KY	(603GD) Dupont, KY	(603GE) Newburg, KY	(603GF) Grayson County, KY	(603GG) Scott County, IN	(603GH) Carrollton, KY
JUL-FY17	8.0	2.2	1.7	n/a	2.9	0.0	4.3	0.3	3.8	0.4
AUG-FY17	8.1	1.2	2.2	n/a	1.8	0.0	1.6	1.0	2.0	5.7
SEP-FY17	8.2	1.0	4.6	0.0	2.9	0.8	0.5	1.4	1.7	0.4
OCT-FY18	7.5	0.0	2.8	0.0	4.1	0.0	1.6	1.8	1.4	1.3
NOV-FY18	8.0	0.0	1.9	0.0	2.3	11.0	3.3	0.6	3.6	1.0
DEC-FY18	8.1	0.0	1.1	0.0	3.6	0.0	1.5	1.5	2.0	1.3
JAN-FY18	8.2	0.0	1.2	0.0	3.4	1.0	1.6	8.4	4.6	1.9
FEB-FY18	7.5	6.5	0.6	n/a	2.1	n/a	1.4	0.7	5.6	3.2
MAR-FY18	8.6	0.0	1.5	3.8	2.8	3.2	4.2	0.4	3.4	0.1
APR-FY18	7.9	0.0	3.2	3.6	0.8	4.7	4.1	2.1	3.7	5.5
MAY-FY18	7.7	11.0	5.5	1.9	1.8	2.9	2.8	1.7	2.1	1.8
JUN-FY18	7.6	0.0	1.4	2.3	1.3	0.9	5.9	0.8	3.9	6.9

Source: VHA Support Service Center

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

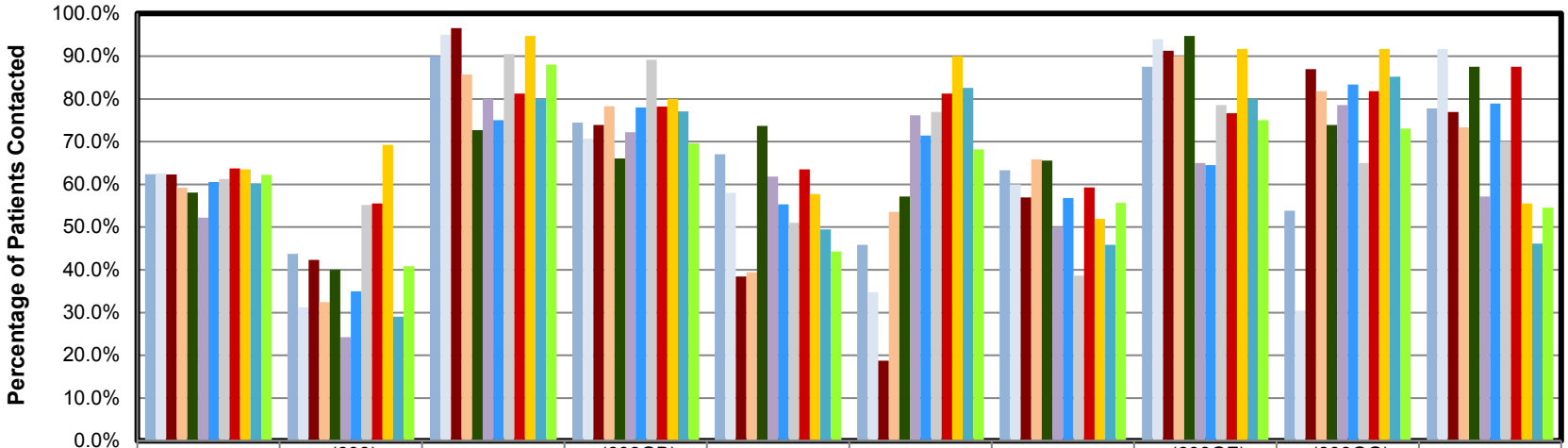
***Data Definition**: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment,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

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



	VHA Total	(603) Louisville, KY (Robley Rex)	(603GA) Fort Knox, KY	(603GB) New Albany, IN	(603GC) Shively, KY	(603GD) Dupont, KY	(603GE) Newburg, KY	(603GF) Grayson County, KY	(603GG) Scott County, IN	(603GH) Carrollton, KY
JUL-FY17	4.1	2.2	3.2	3.6	2.0	1.7	2.6	3.9	2.3	1.9
AUG-FY17	4.2	2.3	2.9	4.1	2.3	1.2	3.5	3.3	1.6	1.5
SEP-FY17	4.0	1.7	3.5	2.5	2.8	1.3	2.5	1.9	1.4	1.1
OCT-FY18	3.7	1.2	3.7	1.5	2.6	1.8	2.8	1.7	1.8	1.2
NOV-FY18	4.1	2.2	2.6	2.7	2.6	2.3	2.4	1.5	1.9	1.1
DEC-FY18	4.1	1.5	2.6	2.2	2.4	1.3	2.3	2.2	2.5	0.8
JAN-FY18	4.4	2.1	3.1	2.1	2.6	1.9	2.5	5.0	2.9	1.0
FEB-FY18	4.0	3.4	2.1	1.6	2.0	2.3	2.3	2.5	2.3	2.3
MAR-FY18	4.2	3.3	1.6	1.4	2.6	1.3	1.9	1.6	2.8	2.6
APR-FY18	4.3	1.9	1.5	1.8	2.3	1.6	2.1	1.4	3.0	2.2
MAY-FY18	4.3	2.1	1.7	1.7	2.3	1.4	2.5	1.6	2.0	1.0
JUN-FY18	4.4	1.5	1.5	1.9	2.1	1.8	2.8	1.0	2.4	0.7

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
Data Definition: *The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.*

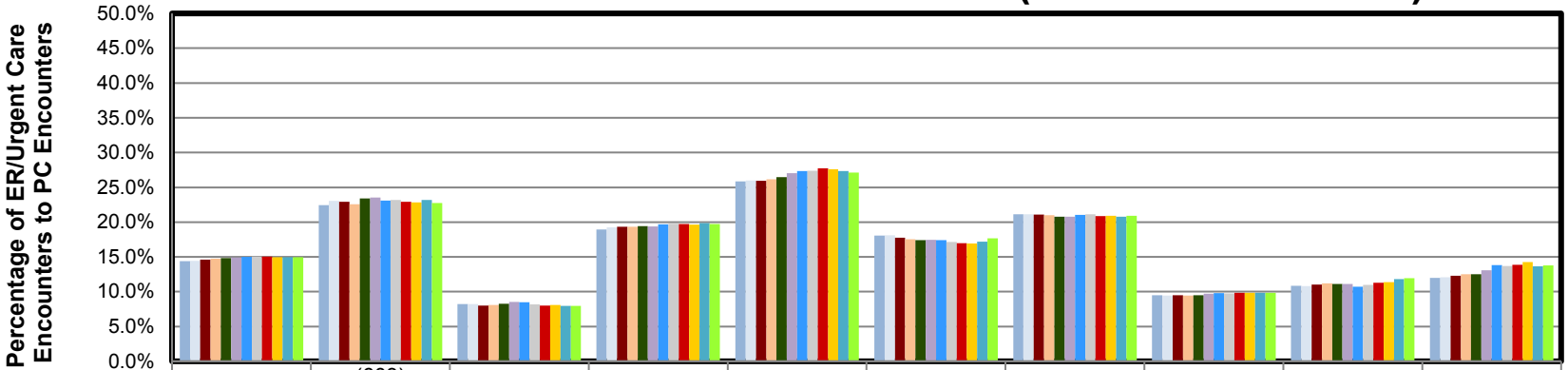


	VHA Total	(603) Louisville, KY (Robley Rex)	(603GA) Fort Knox, KY	(603GB) New Albany, IN	(603GC) Shively, KY	(603GD) Dupont, KY	(603GE) Newburg, KY	(603GF) Grayson County, KY	(603GG) Scott County, IN	(603GH) Carrollton, KY
JUL-FY17	62.4%	43.8%	90.0%	74.5%	67.0%	45.8%	63.3%	87.5%	53.8%	77.8%
AUG-FY17	62.6%	31.3%	95.0%	70.7%	58.0%	34.8%	60.0%	93.9%	30.4%	91.7%
SEP-FY17	62.3%	42.3%	96.6%	73.9%	38.5%	18.8%	57.0%	91.3%	87.0%	76.9%
OCT-FY18	59.2%	32.4%	85.7%	78.3%	39.5%	53.6%	65.9%	90.0%	81.8%	73.3%
NOV-FY18	58.1%	40.0%	72.7%	66.0%	73.7%	57.1%	65.6%	94.7%	73.9%	87.5%
DEC-FY18	52.2%	24.2%	80.0%	72.2%	61.8%	76.2%	50.0%	65.0%	78.6%	57.1%
JAN-FY18	60.5%	35.0%	75.0%	78.0%	55.4%	71.4%	56.8%	64.5%	83.3%	78.9%
FEB-FY18	61.3%	55.2%	90.5%	89.1%	51.0%	76.9%	38.7%	78.6%	65.0%	70.0%
MAR-FY18	63.7%	55.6%	81.3%	78.2%	63.5%	81.3%	59.3%	76.7%	81.8%	87.5%
APR-FY18	63.5%	69.2%	94.7%	80.0%	57.7%	90.0%	51.9%	91.7%	91.7%	55.6%
MAY-FY18	60.2%	29.0%	80.0%	77.1%	49.5%	82.6%	45.8%	80.0%	85.2%	46.2%
JUN-FY18	62.3%	40.8%	88.0%	69.6%	44.3%	68.2%	55.7%	75.0%	73.1%	54.5%

Source: VHA Support Service Center

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

Data Definition: *The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 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	(603) Louisville, KY (Robley Rex)	(603GA) Fort Knox, KY	(603GB) New Albany, IN	(603GC) Shively, KY	(603GD) Dupont, KY	(603GE) Newburg, KY	(603GF) Grayson County, KY	(603GG) Scott County, IN	(603GH) Carrollton, KY
JUL-FY17	14.4%	22.4%	8.2%	18.9%	25.9%	18.1%	21.1%	9.5%	10.9%	12.0%
AUG-FY17	14.4%	23.0%	8.2%	19.3%	26.0%	18.1%	21.1%	9.4%	10.8%	12.1%
SEP-FY17	14.6%	22.9%	8.0%	19.3%	25.9%	17.8%	21.1%	9.5%	11.0%	12.3%
OCT-FY18	14.7%	22.6%	8.1%	19.3%	26.1%	17.6%	21.0%	9.4%	11.2%	12.5%
NOV-FY18	14.8%	23.4%	8.3%	19.4%	26.5%	17.4%	20.8%	9.5%	11.1%	12.5%
DEC-FY18	14.9%	23.5%	8.5%	19.4%	27.0%	17.5%	20.8%	9.7%	11.1%	13.1%
JAN-FY18	15.0%	23.1%	8.5%	19.7%	27.4%	17.4%	21.1%	9.8%	10.7%	13.8%
FEB-FY18	15.0%	23.2%	8.2%	19.8%	27.4%	17.2%	21.1%	9.8%	11.0%	13.7%
MAR-FY18	15.0%	22.9%	8.0%	19.7%	27.8%	17.0%	20.9%	9.8%	11.3%	13.9%
APR-FY18	15.0%	22.9%	8.1%	19.6%	27.6%	16.9%	20.9%	9.8%	11.4%	14.2%
MAY-FY18	14.9%	23.2%	8.0%	19.9%	27.4%	17.2%	20.8%	9.8%	11.8%	13.7%
JUN-FY18	14.9%	22.8%	8.0%	19.7%	27.1%	17.7%	20.9%	9.9%	11.9%	13.8%

Source: VHA Support Service Center

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

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

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[102]

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

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

Measure	Definition	Desired Direction
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
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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
SC Survey Access	Timely Appointment, care and information (Specialty Care)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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 13, 2018

From: Director, VA MidSouth Healthcare Network (10N9)

Subj: CHIP Review of the Robley Rex VA Medical Center, Louisville, KY

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

1. I have reviewed the findings and recommendations in the OIG report entitled, Draft Report: CHIP Review of the Robley Rex VA Medical Center, Louisville, KY. I concur with the action plans submitted by the Louisville VA Medical Center Director.

2. We thank OIG for their review and the opportunity to respond to the draft report.

3. If you have any questions or require additional information, please contact the Quality Management Officer.

(Original signed by:)

Cynthia Breyfogle, FACHE
Network 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.

Appendix F: Interim Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 11, 2018

From: Interim Director, Robley Rex VA Medical Center (603/00)

Subj: CHIP Review of the Robley Rex VA Medical Center, Louisville, KY

To: Director, VA MidSouth Healthcare Network (10N9)

1. I have reviewed the findings and recommendations in the OIG report entitled, CHIP Review of the Robley Rex VA Medical Center. I concur with the attached action plans.

2. We thank OIG for their review and the opportunity to submit feedback to the draft document of this report.

3. If you have any questions or require additional information, please contact the Robley Rex VA Medical Center Front Office.

(Original signed by:)

Duane B. Gill, FACHE
Interim 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.

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