DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System

West Haven, Connecticut

CHIP REPORT | REPORT #18-04675-23 | NOVEMBER 20, 2019

The mission of the Office of Inspector General is to serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs through independent audits, inspections, reviews, and investigations.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Figure 1. *VA Connecticut Healthcare System, West Haven, CT (Source: https://va medicine.yale.edu/psychiatry/newsandevents/archive/article.aspx?id=6069/, accessed on July 16, 2019)*

Abbreviations

ADNPCS	associate director for Nursing and Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
FPPE	focused professional practice evaluation
FY	fiscal year
LIP	licensed independent practitioner
MST	military sexual trauma
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UCC	urgent care center
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Connecticut Healthcare System (the facility). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

CHIP inspections are one element of the OIG's overall efforts to ensure that the 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 each year.

The OIG team looks at leadership and organizational risks as well as areas affecting quality patient care. At the time of the review, the clinical areas of focus were

1. Quality, safety, and value;
2. Medical staff privileging;
3. Environment of care;
4. Medication management (specifically the controlled substances inspection program);
5. Mental health (focusing on military sexual trauma follow-up and staff training);
6. Geriatric care (spotlighting antidepressant use for elderly veterans);
7. Women's health (particularly abnormal cervical pathology result notification and follow-up); and
8. High-risk processes (specifically the emergency department and urgent care center operations and management).

This unannounced visit was conducted during the week of March 18, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's 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 this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, acting chief of staff, associate director for Nursing and Patient Care Services (ADNPCS), associate director, and assistant director. Organizational communications and accountability were managed through a committee reporting structure, with the Governing Body having oversight for several working groups. The director served as the chairperson of the Governing Body, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The facility leaders are engaged in monitoring patient safety and care through the Continuous Quality Improvement Council, which is responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes; however, the OIG noted that the director did not chair this council as required.

At the time of the OIG site visit, four members of the executive team had been working together for over two years, and several team members had been in their position for years.

The OIG noted the facility average for several selected survey leadership questions was generally similar to the VHA average; however, opportunities appear to exist for the ADNPCS and associate director to improve employee satisfaction. All four patient survey results reflected better care ratings than the VHA average. Patients were generally satisfied with the leadership and care provided.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[1] and patient safety indicator data. The OIG noted opportunities to improve the institutional disclosure process.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[2] Although the leadership team members were knowledgeable within their areas of responsibility about selected SAIL metrics and SAIL community living center (CLC) measures, the leaders should continue to take

[1] The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

[2] VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star rating" system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 6, 2019, but is not accessible by the public.)

actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "5-star" and CLC "1-star" quality ratings.[3]

The OIG noted deficiencies in five of the eight clinical areas reviewed and issued 13 recommendations that are attributable to the director and chief of staff. These are briefly described below.

Medical Staff Privileging

The OIG found there was general compliance with requirements for privileging. However, the OIG identified deficiencies in focused and ongoing professional practice evaluations,[4] review of solo and few practitioners, and reporting of professional practice evaluation results.

Medication Management

Overall, the OIG found compliance with some of the performance requirements, including the controlled substances coordinator reports and pharmacy operations. However, the OIG identified noncompliance with requirements for controlled substances inspectors, controlled substances area inspections, and facility review of override reports.

Mental Health

The OIG also found compliance with many of the mental health performance indicators, including the designation of a military sexual trauma (MST) coordinator, tracking of MST-related data, and provision of clinical care. The OIG noted a concern with requirements that primary care and mental health providers complete MST mandatory training within the required time frame.

Geriatric Care

This inspection revealed providers followed requirements for justifying the reason for medication initiation. However, the OIG identified inadequate patient and/or caregiver education related to newly prescribed medications, evaluation of patient and/or caregiver understanding

[3] Based on fiscal year 2018, quarter 3 ratings at the time of the site visit.

[4] The definitions of ongoing professional practice evaluation and focused professional practice evaluations can be found within Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2). An ongoing professional practice evaluation is "the ongoing monitoring of privileged providers to confirm the quality of care delivered and ensures patient safety." A focused professional practice evaluation is "a time-limited process whereby the clinical leadership evaluates the privilege-specific competence of a provider who does not yet have documented evidence of competently performing the requested privilege(s) at the facility." A focused professional practice evaluation for cause is "a time-limited period during which the medical staff leadership assesses the provider's professional performance to determine if any action should be taken on the provider's privileges."

when education was provided, and medication reconciliation to minimize duplicative medications and adverse interactions.

Women's Health

The OIG also noted the facility achieved many of the performance indicators related to women's health, including requirements for a designated women veterans program manager, clinical oversight of the women's health program, Women Veterans Health Committee, tracking data related to cervical cancer screenings, and provision of follow-up care when indicated. However, the OIG identified a deficiency related to communicating abnormal results to patients within the required time frame.

Summary

In reviewing key healthcare processes, the OIG issued 13 recommendations for improvement directed to the facility director and chief of staff. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 75–76, 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.

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

Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to provide oversight of healthcare services to veterans. This focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Connecticut Healthcare System (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.[5] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[6] Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility:

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (specifically the controlled substances inspection program)
6. Mental health (focusing on military sexual trauma follow-up and staff training)
7. Geriatric care (spotlighting antidepressant use for elderly veterans)
8. Women's health (particularly abnormal cervical pathology results notification and follow-up)

[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/. (The website was accessed on January 24, 2019.)

[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. (The website was accessed on January 24, 2019.)

9. High-risk processes (specifically the emergency department and urgent care center operations and management).[7]

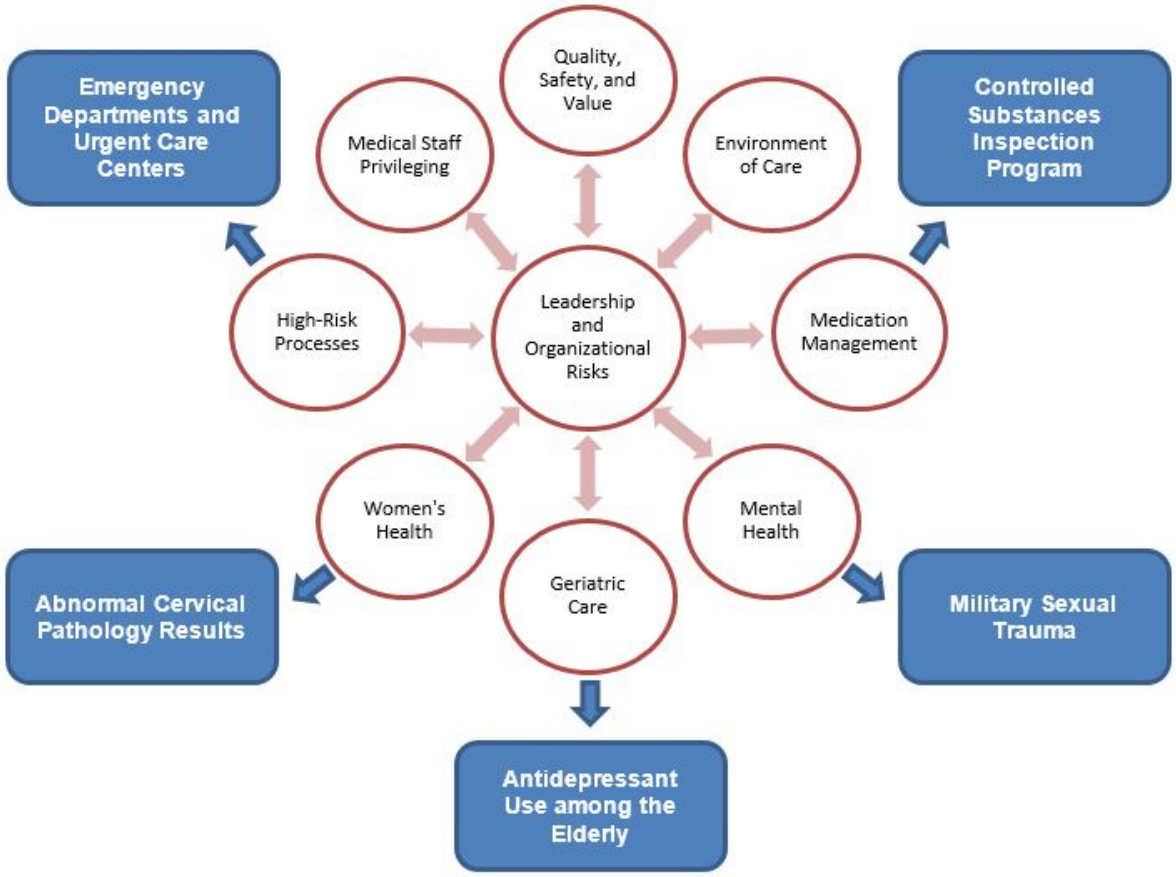


Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

[7] See Figure 2. CHIP inspections address these processes during FY 2019 (October 1, 2018, through September 30, 2019); they may differ from prior years' focus areas.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;[8] physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from March 26, 2016, through March 21, 2019, the last day of the unannounced week-long site visit.[9] While on site, the OIG did not receive any complaints beyond the scope of the CHIP review.

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

The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reports 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, instead focusing on OIG inspections and external surveys that affect facility accreditation status.

[9] The range represents the time period from the last Clinical Assessment Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. 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 indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation and/or for-cause surveys and oversight inspections
5. Factors related to possible lapses in care
6. VHA performance data

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this facility's reported organizational structure. The facility had a leadership team consisting of the director, acting chief of staff, associate director for Nursing and Patient Care Services (ADNPCS), and associate director (primarily nonclinical). The chief of staff and ADNPCS oversee patient care, which requires managing service directors and chiefs of programs and practices.

[10] L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper, 2006. www.IHI.org. (The website was accessed on February 2, 2017.)

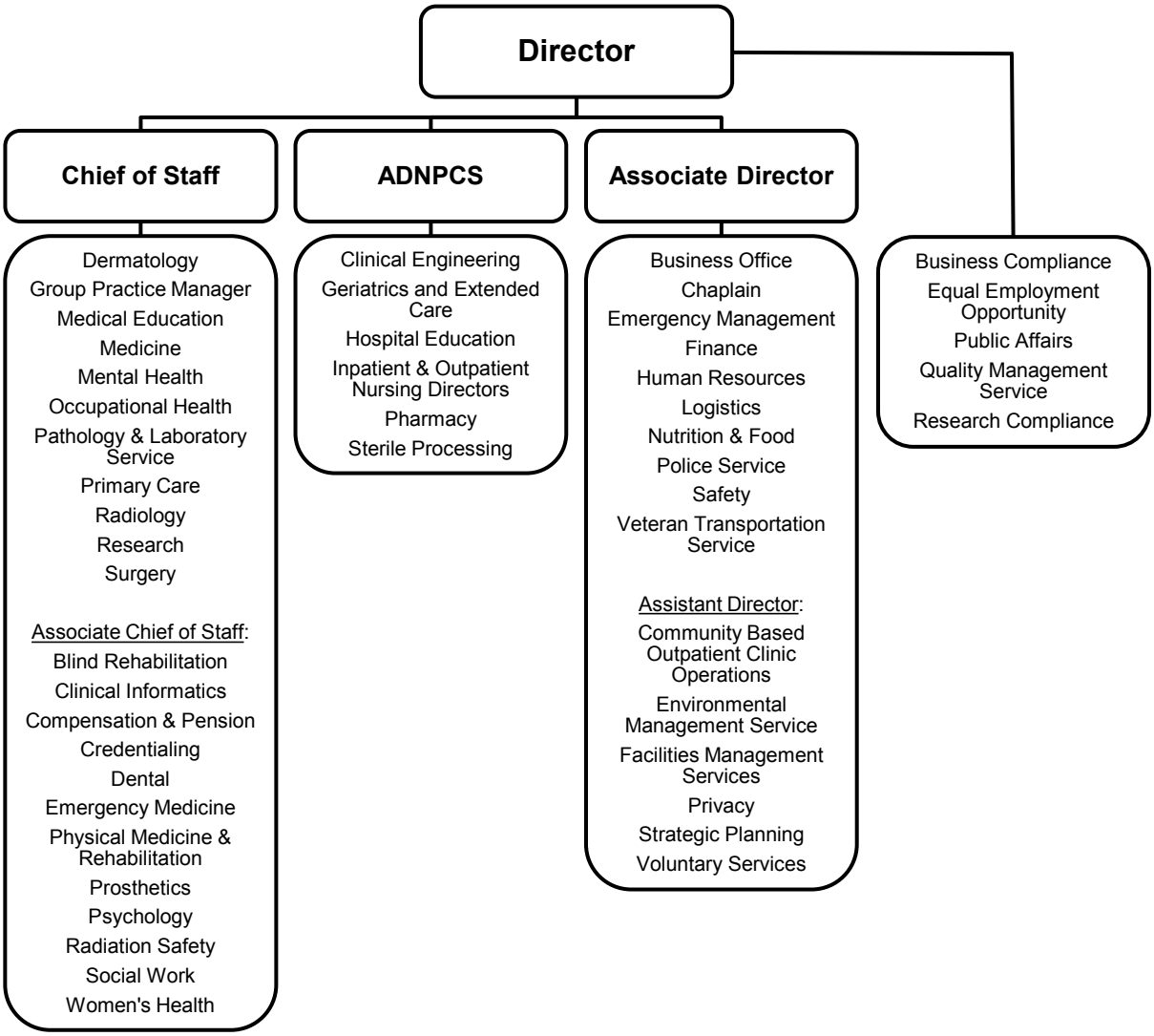


Figure 3. *Facility Organizational Chart*[11]
Source: VA Connecticut Healthcare System (received March 18, 2019)

At the time of the OIG site visit, four members of the executive team had been working together for over two years. The associate chief of staff was assigned to the acting chief of staff position on January 7, 2019, when the chief of staff was detailed to the VISN 1 office to perform special projects. Several team members had been in their position for years (see Table 1).

[11] At this facility, the director is responsible for Business Compliance, Equal Employment Opportunity, Public Affairs, Quality Management Service, and Research Compliance.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	August 11, 2013
Chief of staff	January 7, 2019 (acting)
Associate director for Nursing and Patient Care Services	October 2, 2016
Associate director	January 29, 2012
Assistant director	January 22, 2017

Source: VA Connecticut Healthcare System human resources officer (received March 19, 2019)

To help assess facility executive leaders' engagement, the OIG interviewed the director, acting chief of staff, ADNPCS, and associate director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL community living center (CLC) measures. These are discussed in greater detail below.

The director serves as the chairperson of the Governing Body, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Governing Body oversees various working groups, such as the Strategic Planning, Medical Staff Executive, and Continuous Quality Improvement Councils.

The facility leaders are engaged in monitoring patient safety and care through the Continuous Quality Improvement Council, the facility-identified committee with responsibility for key quality, safety, and value functions. The Continuous Quality Improvement Council is responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes; however, the OIG noted that the director did not chair this council as required. See Figure 4.

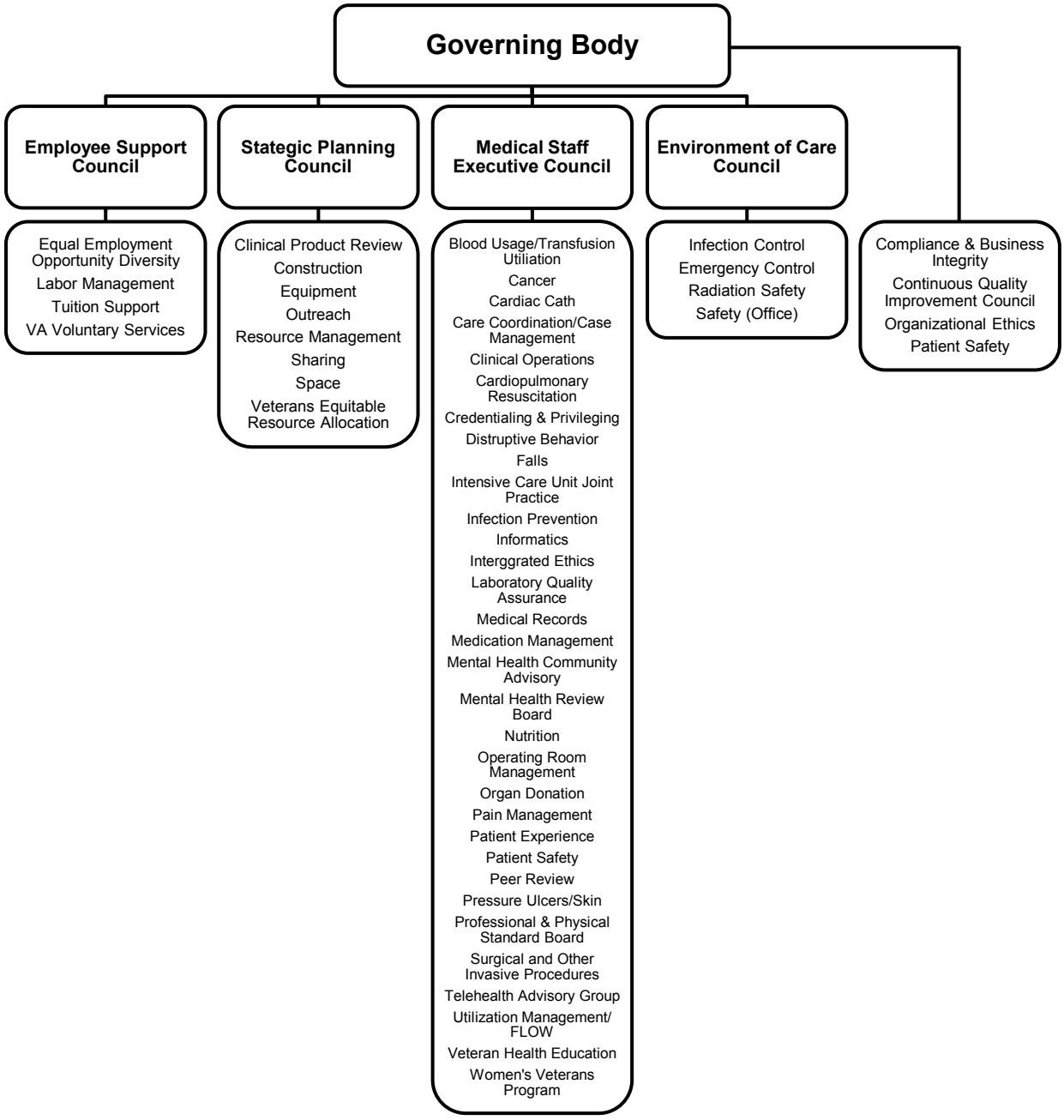


Figure 4. *Facility Committee Reporting Structure*[12]
Source: VA Connecticut Healthcare System (March 19, 2019)

[12] The Governing Body oversees Compliance and Business Integrity, Continuous Quality Improvement Council, Organizational Ethics, and Patient Safety.

Employee Satisfaction

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 several times in response to VA leaders' 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 attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2017, through September 30, 2018.[13] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for selected survey leadership questions was generally similar to the VHA average.[14] The director and chief of staff scored better than the VHA average while the ADNPCS and associate director scored generally lower than the VHA average. Opportunities appear to exist to improve employee satisfaction.

Table 2. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADNPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[15]	0–100 where HIGHER scores are more favorable	71.7	69.8	77.1	72.1	70.5	72.9

[13] Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADNPCS, and associate director.

[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.

[15] According to the 2018 VA All Employee Survey Questions by Organizational Health Framework, Servant Leader Index "is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others' contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others' needs before their own."

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADNPCS Average	Assoc. Director Average
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.2	4.0	3.7	3.2	2.9
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.4	3.9	3.8	3.2	3.5
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.5	3.8	3.8	3.2	3.4

Source: VA All Employee Survey (accessed February 14, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility and executive leadership team averages for the selected survey questions were generally similar to the VHA average. Facility leaders appear to maintain an environment where employees feel safe bringing forth issues and concerns.

Table 3. Survey Results on Employee Attitudes toward the Workplace (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADNPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.7	4.5	4.3	3.2	3.8
All Employee Survey:	1 (Strongly Disagree) –	3.7	3.6	4.3	3.8	3.7	3.9

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADNPCS Average	Assoc. Director Average
Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).	5 (Strongly Agree)						
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.5	1.5	1.6	1.1	1.5	1.2

Source: VA All Employee Survey (accessed February 14, 2019)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through June 30, 2018. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.[16]

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward facility leaders (see Table 4). For this facility, all four patient survey

[16] Ratings are based on responses by patients who received care at this facility.

results reflected better care ratings than the VHA average. Patients were generally satisfied with the leadership and care provided.

Table 4. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

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.	66.9	77.9
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.2	91.3
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.	76.5	84.6
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.5	84.3

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28, 2018)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[17] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint

[17] 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 other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.

Commission (TJC).[18] Indicative of effective leadership, the facility has closed all recommendations for improvement. The OIG found that TJC issued a preliminary denial of accreditation on May 4, 2018, for issues related to Sterile Processing Services. The facility provided evidence of compliance with TJC standards and received hospital accreditation on September 5, 2018. TJC's subsequent follow-up review on January 3, 2019, made no recommendations for improvement.[19]

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[20] Additional results included the Long Term Care Institute's inspection of the facility's CLC.[21]

[18] According to VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017, TJC provides 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."

[19] 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.

[20] According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017, 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. According to the College of American Pathologists, for 70 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." College of American Pathologists. https://www.cap.org/about-the-cap. (The website was accessed on February 20, 2019.); In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

[21] The Long Term Care Institute states that it has been to over 4,000 healthcare facilities conducting quality reviews and over 1,145 external regulatory surveys since 1999. The Long Term Care Institute is "focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings." Long Term Care Institute. http://www.ltciorg.org/about-us/. (The website was accessed on March 6, 2019.)

Table 5. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the VA Connecticut Healthcare System, West Haven, Connecticut, Report No.16-00116-323, June 23, 2016*)	March 2016	9	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of the VA Connecticut Healthcare System, West Haven, Connecticut, Report No.16-00027-318, June 10, 2016*)	March 2016	5	0
OIG (*Healthcare Inspection – Alleged Failure in Patient Notification of Test Results, VA Connecticut Healthcare System, West Haven, Connecticut, Report No. 17-02678-107, February 27, 2018*)	May 2017	1	0
TJC Hospital Accreditation	February 2018	40	0
TJC Behavioral Health Care Accreditation		10	0
TJC Home Care Accreditation		2	0
TJC Opioid Survey Accreditation	July 2018	9	0
TJC For cause	May 2018	2	0
TJC Follow up	January 2019	0	0

Sources: OIG and TJC (Inspection/survey results verified with the chief of Quality Management on March 20, 2019)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from March 26, 2016 (the prior comprehensive OIG inspection), through March 21, 2019.[22]

[22] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm 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 *VA Connecticut Healthcare System* is a high complexity (1a) affiliated facility as described in Appendix B.)

The OIG identified organizational risk factors related to the reporting of disclosures. When requested, the chief of Quality Management provided four completed institutional disclosures from March 21, 2016, through March 21, 2019. However, the OIG found an additional five patients that received a clinical disclosure who should have also received an institutional disclosure. Further, six patients received clinical disclosures that were noted as institutional disclosures. The chief of Quality Management reported that institutional disclosures were not provided to the patients and/or family due to staff oversight. During the OIG site visit, the chief of Quality Management implemented procedures to improve the institutional disclosure process.

Table 6. Summary of Selected Organizational Risk Factors (March 26, 2016, to March 21, 2019)

Factor	Number of Occurrences
Sentinel Events[23]	0
Institutional Disclosures[24]	4
Large-Scale Disclosures[25]	0

Source: VA Connecticut Healthcare System chief of Quality Management (received March 19, 2019)

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.[26] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 7 summarizes patient safety indicator data from October 1, 2016, through September 30, 2018.

[23] The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

[24] According to VHA Directive 1004.08, *Disclosure of Adverse Events To Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical 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 the patient's 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."

[25] According to VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "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."

[26] Agency for Healthcare Research and Quality. https://www.qualityindicators.ahrq.gov/. (The website was accessed on December 11, 2017.)

Table 7. Patient Safety Indicator Data
(October 1, 2016, through September 30, 2018)

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 1	Facility
Pressure ulcer	0.74	0.48	0.92
Death among surgical inpatients with serious treatable conditions	113.42	119.32	116.28
Iatrogenic pneumothorax[27]	0.17	0.19	0.15
Central venous catheter-related bloodstream infection	0.16	0.00	0.00
In-hospital fall with hip fracture	0.09	0.04	0.00
Perioperative hemorrhage or hematoma	2.61	2.01	1.30
Postoperative acute kidney injury requiring dialysis	0.89	0.41	0.95
Postoperative respiratory failure	4.54	8.82	32.52
Perioperative pulmonary embolism or deep vein thrombosis	2.97	1.80	3.08
Postoperative sepsis	3.55	1.88	2.96
Postoperative wound dehiscence (rupture along incision)	0.82	0.00	0.00
Unrecognized abdominopelvic accidental puncture or laceration	1.00	0.71	0.00

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

The patient safety indicator measures for pressure ulcer, postoperative acute kidney injury requiring dialysis, postoperative respiratory failure, and perioperative pulmonary embolism or deep vein thrombosis show a higher reported rate than VHA and VISN 1. The death among surgical inpatients with serious treatable conditions measure shows a higher reported rate than VHA, and the postoperative sepsis measure shows a higher reported rate than VISN 1. The six remaining patient safety indicator measures show a lower reported rate than VHA and VISN 1.

Four patients experienced pressure ulcers, and the facility Pressure Ulcers/Skin Committee reviewed the patients' care. The committee determined two CLC patients developed ulcers consistent with end-of-life organ failure, and two inpatients developed pressure ulcers related to respiratory device use. As a result of an aggregate pressure ulcer root cause analysis, facility

[27] According to Northwestern Memorial Hospital, "A Pneumothorax is a type of lung injury that allows air to leak into the area between the lungs and the chest wall, which causes mild to severe chest pain and shortness of breath. An Iatrogenic Pneumothorax is caused by medical treatment, often as an incidental event during a procedure such as a pacemaker insertion." Northwestern Medicine. http://www.nmh.org/nm/quality-lung-injury-due-to-medical-care. (The website was accessed on March 6, 2019.)

wound care nurses provided pressure ulcer education to appointed "Skin Care Champions" on each inpatient unit.

Five surgical patients with serious treatable conditions died. The chief of staff and the peer review committee reviewed the patients' care and determined appropriate care was provided.

One patient suffered postoperative acute kidney injury requiring dialysis. The chief of staff reviewed the patient's care, and education was provided to the provider.

Twenty-four patients were reported to have experienced postoperative respiratory failure. In January 2019, the acting chief of staff, after assuming the role, reviewed the care of all 24 patients and determined that the surgical intensive care unit's medical coding was incorrect for 22 patients. The acting chief of staff determined the two patients who experienced postoperative respiratory failure received appropriate care.

Five patients experienced perioperative pulmonary embolism or deep vein thrombosis. The chief of staff reviewed the patients' care and determined the care was appropriate.

Three patients developed postoperative sepsis. The chief of staff reviewed the patients' care. In one case, the provider received education on postoperative sepsis care. The chief of staff determined that the remaining two patients' care was appropriate.

The OIG also reviewed patient safety indicator data for FY 2018, quarter 4 (the most recent data) and the previous four quarters to identify any potential trends that may impact patient safety or increase the risk for patient harm. It is important to note that although the data are collected and reported by quarter, each set of quarterly data represents potential complications or patient safety events over an eight-quarter or two-year period. Further, it is possible for a facility measure to exceed the VHA rate due to a single incident and for that measure to vary above or below the VHA rate over time due to differences in the number of patients treated. Figure 5 illustrates the time frames covered by the data reviewed.

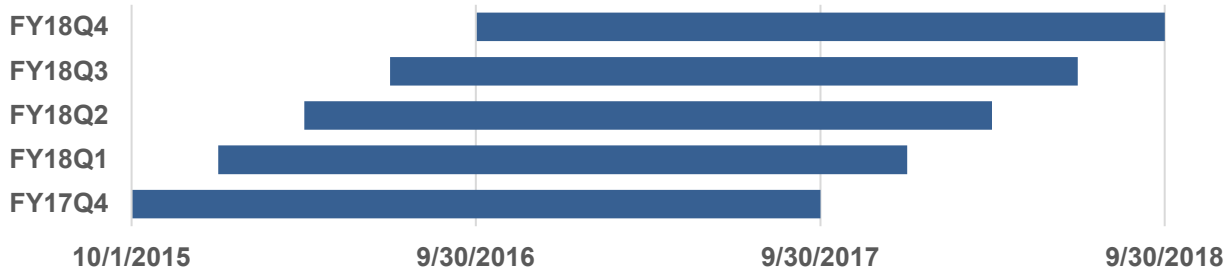


Figure 5. *Associated Time Frames for Quarterly Patient Safety Indicator Data*
Source: VA OIG
FY18Q4 = fiscal year 2018, quarter 4
FY18Q3 = fiscal year 2018, quarter 3
FY18Q2 = fiscal year 2018, quarter 2
FY18Q1 = fiscal year 2018, quarter 1
FY17Q4 = fiscal year 2017, quarter 4

Table 8 summarizes patient safety indicator data for FY 2017, quarter 4 (FY17Q4) through FY 2018, quarter 4 (FY18Q4), which includes potential complications from October 1, 2015, through September 30, 2018.

Table 8. Patient Safety Indicator Data Trending (October 1, 2015, through September 30, 2018)

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
Pressure ulcer	VHA	0.60	0.88	n/a[28]	0.76	0.74
	Facility	0.42	1.24	n/a	1.07	0.92
Death among surgical inpatients with serious treatable conditions	VHA	100.97	118.96	113.92	114.89	113.42
	Facility	145.83	157.89	102.04	125.00	116.28
Iatrogenic pneumothorax	VHA	0.19	0.19	0.17	0.15	0.17
	Facility	0.26	0.23	0.14	0.14	0.15
Central venous catheter-related bloodstream infection	VHA	0.15	0.14	0.15	0.16	0.16
	Facility	0.22	0.20	0.23	0.24	0.00
In-hospital fall with hip fracture	VHA	0.08	0.09	0.08	0.09	0.09
	Facility	0.00	0.00	0.00	0.00	0.00
Perioperative hemorrhage or hematoma	VHA	1.94	2.58	2.62	2.59	2.61
	Facility	1.01	1.37	1.10	1.17	1.30

[28] According to VHA's Inpatient Evaluation Center, pressure ulcer data are not available for the time frame of April 1, 2016, through March 31, 2018.

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
Postoperative acute kidney injury requiring dialysis	VHA	0.88	0.80	0.65	0.96	0.89
	Facility	0.00	0.00	0.00	0.84	0.95
Postoperative respiratory failure	VHA	5.55	5.34	5.11	4.88	4.54
	Facility	54.82	51.31	48.89	42.45	32.52
Perioperative pulmonary embolism or deep vein thrombosis	VHA	3.29	3.26	3.09	3.05	2.97
	Facility	3.39	3.51	3.16	2.78	3.08
Postoperative sepsis	VHA	4.00	3.96	3.72	3.70	3.55
	Facility	1.49	1.34	1.64	2.60	2.96
Postoperative wound dehiscence (rupture along incision)	VHA	0.52	1.04	1.00	0.93	0.82
	Facility	0.00	0.00	0.00	0.00	0.00
Unrecognized abdominopelvic accidental puncture or laceration	VHA	0.53	1.21	1.02	1.07	1.00
	Facility	0.92	0.67	0.00	0.00	0.00

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

The OIG reviewed facility-provided data for the measures that were higher, or generally higher than the VHA rates (pressure ulcer, death among surgical inpatients with serious treatable conditions, postoperative acute kidney injury requiring dialysis postoperative respiratory failure, perioperative pulmonary embolism or deep vein thrombosis, and postoperative sepsis) and agreed with the trends identified by the facility for the pressure ulcer and postoperative respiratory failures measures. The ADNPCS reviewed each pressure ulcer, and "Skin Champions" were implemented in summer 2018. The acting chief of staff reviewed each postoperative respiratory failure and determined all but two to be due to coding errors. The two patients who did experience postoperative respiratory failure were determined by the acting chief of staff to have received appropriate care.

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." It does, however, have 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.[29]

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 6 describes the distribution of facilities by star rating.[30] As of June 30, 2018, the facility was rated as "5-star" for overall quality.

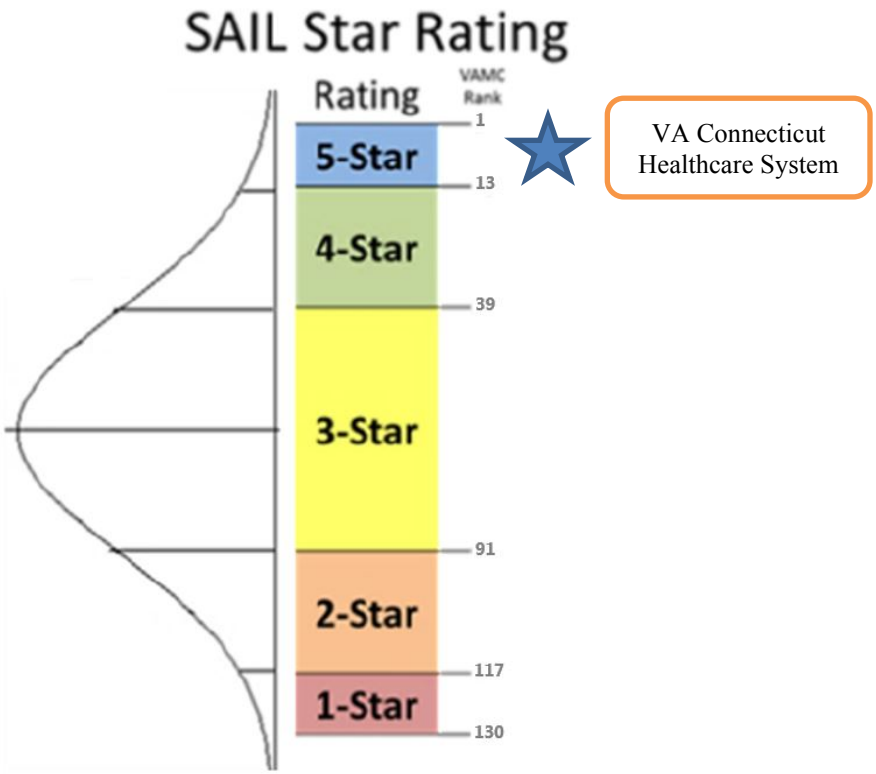


Figure 6. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed February 14, 2019)

Figure 7 illustrates the facility's quality of care and efficiency metric rankings and performance compared with other VA facilities as of September 30, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of registered nurse

[29] 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=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

[30] According to the methods established by the SAIL Model, this is based on normal distribution ranking of the quality domain for 130 VA Medical Centers.

(RN) turnover, rating (of) hospital, specialty care (SC) care coordination, and healthcare (HC) associated (assoc) infections). Metrics that need improvement are denoted in orange and red (for example, best place to work, physician capacity, and continued (cont) stay reviews met).[31]

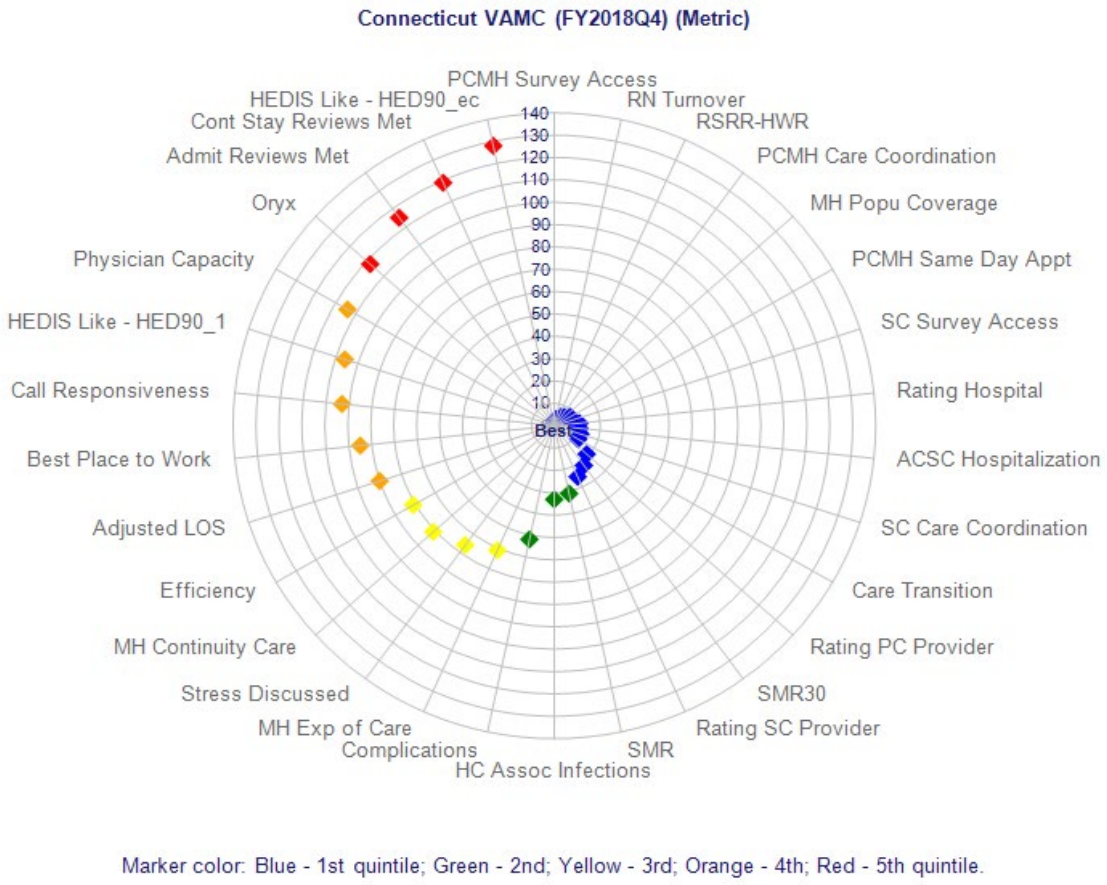


Figure 7. *Facility Quality of Care and Efficiency Metric Rankings (as of September 30, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

The SAIL Value Model also includes "SAIL CLC," which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in

[31] For information on the acronyms in the SAIL metrics, please see Appendix D.

The Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare*.[32] The SAIL CLC provides a single resource to review quality measures and health inspection results. It includes star ratings for an unannounced survey, staffing, quality, and overall results.[33] Table 8 summarizes the rating results for the facility's CLC as of September 30, 2018. Although the facility has an overall "4-star" rating, its rating for quality is only a "1-star."

Table 8. Facility CLC Star Ratings (as of September 30, 2018)

Domain	Star Rating
Unannounced Survey	4
Staffing	5
Quality	1
Overall	4

Source: VHA Support Service Center

In exploring the reasons for the "1-star" quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 8 illustrates the facility's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of falls with major injury–long stay (LS), help with activities of daily living (ADL) (LS), and improvement in function–short stay (SS)). Metrics that need improvement and were likely the reasons why the facility had a "1-star" for quality are denoted in red (for example, catheter in bladder (LS), newly received antipsychotic medications (SS), and ability to move independently worsened (LS)).[34]

[32] According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, August 22, 2019, "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

[33] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on September 3, 2019, but is not accessible by the public.)

[34] For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.

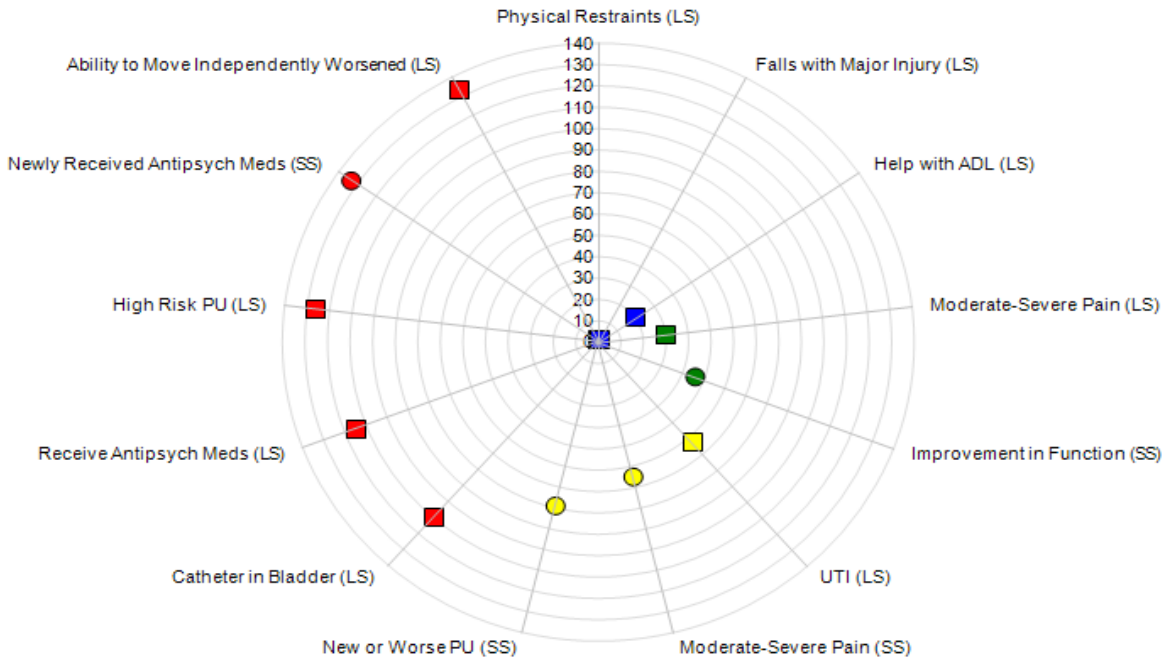


Figure 8. *Facility CLC Quality Measure Rankings (as of September 30, 2018)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

At the time of the OIG site visit, the executive team, except for the acting chief of staff, had been working together for over two years. Several team members had been in their position for years. Selected survey scores related to employees' satisfaction with the facility executive leaders were generally similar to or lower than the VHA average, except for the director and chief of staff who scored better than the VHA average. For this facility, all four patient survey results reflected higher care ratings than the VHA average. Patients were generally satisfied with the leadership and care provided. The facility leaders appeared actively engaged with employees and patients and were working to sustain and further improve employee and patient engagement and satisfaction. The OIG's review of the facility's sentinel events and patient safety indicator data did not identify any substantial organizational risk factors. However, the OIG noted opportunities to improve the institutional disclosure process. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and CLC metrics but should continue to take actions to sustain and improve performance of measures contributing to the facility's SAIL "5-star" and CLC "1-star" quality ratings.

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 that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.[35] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[36] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[37]

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,[38] utilization management (UM) reviews,[39] patient safety incident reporting with related root cause analyses,[40] and cardiopulmonary resuscitation (CPR) episode reviews.[41]

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and

[35] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 but was rescinded on October 24, 2019.)

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

[37] VHA Directive 1026.

[38] The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a critical review of care, performed by a peer, to evaluate care provided by a clinician for a specific episode of care, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements.

[39] The definition of utilization management can be found within VHA Directive 1117(1), *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." The January 2018 version of the directive was in effect at the time of the March 2019 review Subsequently, the directive was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), which expired on July 31, 2019. The utilization management definition remained consistent in both versions of the directive.

[40] The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

[41] VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[42]

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[43]

Among VHA's approaches for improving patient safety is the mandated 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 root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.[44]

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.[45]

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[46]

- Protected peer reviews
    - Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
    - Implementation of improvement actions recommended by the Peer Review Committee
    - Completion of final reviews within 120 calendar days

[42] VHA Directive 1190.

[43] VHA Directive 1117(1).

[44] VHA Handbook 1050.01.

[45] VHA Directive 1177, VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, January 11, 2017.

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

  - Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee
  - Peer review of all applicable deaths within 24 hours of admission to the hospital
  - Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[47]
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Annual completion of a minimum of eight root cause analyses[48]
  - Inclusion of required content in root cause analyses (generally)
  - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report to facility leaders
- Resuscitation episode review
  - Evidence of a committee responsible for reviewing resuscitation episodes
  - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
  - Evidence of basic or advanced cardiac life support certification for code team responders
  - Evaluation of each resuscitation episode by the CPR Committee or equivalent

[47] VHA Directive 1190.

[48] According to VHA Handbook 1050.01, "the requirement for a total of eight [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of [root cause analyses] 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 [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses]."

Quality, Safety, Value Conclusion

Generally, the facility achieved the performance indicators listed above. The OIG made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical 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 (LIPs).[49]

Clinical privileges need to be specific, based on the individual's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff 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 their expiration.[50]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges." "The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluations (OPPE), is essential to confirm the quality of care delivered."[51]

According to TJC, the "FPPE for Cause" should be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care. The "FPPE for Cause" is limited to a particular time frame and customized to the specific provider and related clinical concerns.[52] Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.[53]

To determine whether the facility complied with requirements for privileging, the OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members.

---

[49] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA Handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

[50] VHA Handbook 1100.19.

[51] VHA Handbook 1100.19.

[52] Office of Safety and Risk Awareness, Office of Quality and Performance, Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance, July 2016 (Revision 2).

[53] VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. (This VHA Handbook was scheduled for recertification on or before the last working date of December 2014 and has not been recertified.)

- One solo or few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months[54]
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs re-privileged within 12 months before the visit
- No providers underwent a FPPE for cause within 12 months prior to the visit.

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[55]
  - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
  - Criteria defined in advance
  - Use of required criteria in FPPEs for selected specialty LIPs
  - Results and time frames clearly documented
  - Evaluation by another provider with similar training and privileges
  - Executive Committee of the Medical Staff consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
  - Criteria specific to the service or section
  - Use of required criteria in OPPEs for selected specialty LIPs

[54] The 18-month period was from September 18, 2017, through March 18, 2019. The 12-month review period covered March 18, 2018, through March 18, 2019; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being fewer than three providers in the facility that are privileged in a particular specialty.

[55] According to VHA Handbook 1100.19, facility-specific means that privileges are granted only for procedures and types of services performed at the facility; service-specific refers to privileges being granted in a specific clinical service, such as neurology; and provider-specific means that the privileges should be granted to the individual provider based on their clinical competence and capabilities.

  - Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities
  - Evaluation by another provider with similar training and privileges
  - Executive Committee of the Medical Staff 's decision to recommend continuing privileges based on OPPE results
- Focused professional practice evaluations for cause
  - Clearly defined expectations/outcomes
  - Time-limited
  - Provider's ability to practice independently not limited for more than 30 days
  - Shared with the provider in advance
- Reporting of privileging actions to National Practitioner Data Bank

Medical Staff Privileging Conclusion

The OIG found there was general compliance with requirements for privileging. However, the OIG identified deficiencies in focused and ongoing professional practice evaluations, review of solo/few practitioners, and reporting of professional practice evaluation results.

Specifically, VHA requires the "criteria for the FPPE process to be defined in advance, using objective criteria accepted by the practitioner."[56] For the 9 of 10 LIP profiles reviewed, the OIG noted lack of evidence that the FPPE process was defined in advance with the providers. This could potentially result in unclear and ill-defined expectations for the medical staff leaders performing the evaluation as well as for the providers who are being evaluated. The acting chief of staff reported service chiefs had discussions in advance with providers about the FPPE process but did not document the discussions.

Recommendation 1

1. The chief of staff ensures that service chiefs clearly define and share in advance the expectations for the focused professional practice evaluation process with providers and monitors the service chiefs' compliance.

[56] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: June 1, 2020

Facility response: The VA Connecticut Healthcare System met with stakeholders from the Chief of Staff office to review the current FPPE process. The Medical Staff Executive Council also reviewed the current FPPE process and determined a change in the documentation process was necessary. Moving forward, a check box was added to the FPPE document which the provider will check to acknowledge discussion about the expectations for the FPPE. The form will also be dated and shared with the provider. Discussion will occur during the credentialing and privileging committee meeting and the decision will be made in that meeting to continue, defer or covert from FPPE evaluation to OPPE. The credentialing and privileging committee minutes will be signed off by the Chief of Staff. Monitoring will occur through the Chief of Staff's office to reach 90% or greater compliance for 6 consecutive months.

In the OPPE process, VHA requires at the time of reprivileging that each service chief establishes criteria for granting clinical privileges consistent with the needs of the service and facility as well as the available resources to provide these services.[57] For 7 of 21 (6 general and 1 solo) provider profiles used to support the renewal of practitioners' privileges, the OIG found that OPPE criteria were not specific to the service/section. This impacts the ability to thoroughly evaluate the quality of the care delivered by providers. The acting chief of staff reported that clinically relevant reviews in the subspecialty areas were completed by a subspecialist who was unaware of the requirement and therefore, did not use service-specific criteria.

Recommendation 2

2. The chief of staff ensures that service chiefs include service/section-specific criteria in ongoing professional practice evaluations and monitors service chiefs' compliance.

[57] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: June 1, 2020

Facility response: The Chief of Staff or designee will review service chiefs' documentation to ensure relevant service-specific data for OPPEs have been used to determine continuation of current practitioners' privileges. A SharePoint site has been created for each service to upload their OPPE data on a regular basis. Unique OPPEs will be based off privileging documents being reviewed with criteria met. This will be monitored by the Chief of Staff's office until 90% percent or greater compliance is demonstrated for a minimum of 6 consecutive months. Audit results will be reported to credentialing and privileging committee. The credentialing and privileging committee minutes are reviewed at Medical Staff Executive Council, both are signed by the Chief of Staff.

In addition, VHA also requires the service chief's determination to continue current privileges based, in part, on results of OPPE activities, such as results of electronic health record reviews, outcome data, and direct observation.[58,59] In 5 of 21 (4 general and 1 solo) profiles reviewed, the OIG team did not find evidence that the service chiefs' determinations to continue current privileges were based in part on OPPE activities. This resulted in providers continuing to deliver care without a thorough evaluation of their practice. The acting chief of staff reported a lack of awareness of the requirement.

Recommendation 3

3. The chief of staff ensures that service chiefs' determination to continue current privileges is based, in part, on results of ongoing professional practice evaluation activities and monitors service chiefs' compliance.

[58] VHA Handbook 1100.19.

[59] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: June 1, 2020

Facility response: The Chief of Staff or designee will audit OPPE data to ensure current privileges are based upon OPPE activities. Audit results will be reported to the Medical Staff Executive Council. OPPE forms will contain service chief attestation that all appropriate data has been considered in the recommendation to continue privileges. Target: Ninety percent or greater of completed OPPEs will contain service chief recommendation to continue current privileges based on review of OPPE data for 6 consecutive months. OPPEs will be discussed and reviewed at the time of recredentialling and captured in the minutes of credentialing and privileging committee meeting. Minutes are reviewed by the Chief of Staff and signed by the Chief of Staff.

Despite VHA requiring results of professional practice evaluations "be documented in the practitioner's provider profile and reported to the Executive Committee of the Medical Staff for consideration in making the recommendation on privileges,"[60] the OIG found that 30 of 31 of professional practice evaluations (9 general focused, 1 solo ongoing, and 20 general ongoing) were not documented in the Medical Staff Executive Council (Executive Committee of the Medical Staff) minutes. This may have resulted in the facility missing the opportunity to identify professional practice trends that could impact the quality of care and patient safety. The acting chief of staff reported that evaluations were discussed but not documented in the Medical Staff Executive Council minutes.

Recommendation 4

4. The facility director ensures that the Medical Staff Executive Council documents consideration of focused and ongoing professional practice evaluation results in its decision to recommend approval of requested privileges and monitors the Medical Staff Executive Council's compliance.

[60] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: June 1, 2020

Facility response: The Chief of Staff or designee reviews credentialing and privileging committee data to ensure relevant service-specific data for OPPEs, as well as FPPEs have been used to determine continuation of current privileges. The medical center has a goal of 100% compliance with reporting details in the Medical Staff Executive Council minutes for six or more consecutive months. Details have been reported to the Medical Staff Executive Council with 100% compliance since June 2019. The facility director reviews and signs minutes from the Medical Staff Executive Council.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care 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.[61]

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health inpatient unit. The inspection team also looked at facility compliance with emergency management processes.[62]

VHA requires its facilities to have the "capacity for [providing] mental health 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;" however, for facilities that do not have inpatient mental health services, that "capacity" could mean facilitating care at a nearby VA or non-VA facility.[63]

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities' efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.[64] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[65]

[61] VHA Directive 1608, Comprehensive Environment of Care (CEOC Program), February 1, 2016.

[62] Applicable requirements for high-risk areas and emergency management include those detailed in or by 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).

[63] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA Handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

[64] VHA Directive 0320.01, Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures, April 6, 2017.

[65] VHA Directive 1028, *Electrical Power Distribution Systems*, July 25, 2014. (This VHA Directive was scheduled for recertification on or before the last working date of July 2019 and has not been recertified.)

Occupational Safety and Health Administration,[66] and National Fire Protection Association standards.[67] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[68]

In all, the OIG team inspected seven inpatient areas—two medical/surgical units (6 east and 4 west), the telemetry unit, the medical intensive care unit, the surgical intensive care unit, CLC, and the inpatient mental health unit. The OIG team also reviewed the post-anesthesia care unit; the specialty, women's health, and dental clinics; and the emergency department. The OIG team inspected a Newington outpatient clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Community based outpatient clinic
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Locked inpatient mental health unit
  - Mental health environment of care rounds
  - Nursing station security

[66] The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA's mission is to assure safe and healthy working conditions "by setting and enforcing standards and by providing training, outreach, education, and assistance." https://www.osha.gov/about.html. (This website was accessed on June 28, 2018.)

[67] The National Fire Protection Association (NFPA) is a global nonprofit organization "devoted to eliminating death, injury, property, and economic loss due to fire, electrical, and related hazards." https://www.nfpa.org/About-NFPA. (This website was accessed on June 28, 2018.)

[68] TJC. Environment of Care standard EC.02.05.07.

- 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

Environment of Care Conclusion

Generally, the facility achieved the performance indicators listed above. The OIG did not note any issues with the availability of medical equipment and supplies. The OIG made no recommendations.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.[69] Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.[70]

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.[71]

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the prior two completed quarters;[72] and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
  - Monthly summary of findings to the director
  - Quarterly trend reports to the director
  - Quality Management Committee's review of monthly and quarterly trend reports
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Staff restrictions for monthly review of balance adjustments[73]
- Requirements for controlled substances inspectors

[69] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (The website was accessed on March 7, 2019.)

[70] 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.

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

[72] The two quarters were from July 01, 2018, through December 31, 2018.

[73] Controlled substances balance adjustment reports list transactions in which the pharmacy vault inventory balance was manually adjusted.

  - No 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 annual competency assessment
- Controlled substances area inspections
  - Completion of monthly inspections
  - Rotations of controlled substances inspectors
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of controlled substances orders
  - Performance of routine controlled substances inspections
- Pharmacy inspections
  - Monthly physical counts of the controlled substances in the pharmacy
  - Completion of inspections on day initiated
  - Security and verification of drugs held for destruction[74]
  - Accountability for all prescription pads in pharmacy
  - Verification of hard copy-controlled substances prescriptions
  - Verification of 72-hour inventories of the main vault
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[75]

Medication Management Conclusion

The OIG found compliance with requirements for some of the performance indicators evaluated, including the controlled substances coordinator reports and pharmacy operations. The OIG

[74] According to VHA Directive 1108.02(1), the Destructions File Holding Report "lists all drugs awaiting local destruction or turn-over to a reverse distributor." Controlled substances inspectors "must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report."

[75] When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists' review of medications ordered by the providers.

identified noncompliance with requirements for controlled substances inspectors, controlled substances area inspections, and facility review of override reports.

Specifically, VHA requires that the director appoint, in writing, an adequate number of controlled substance inspectors "to a term not to exceed three years, who do not have access or involvement in drug procurement, prescribing, dispensing, or administration of controlled substance."[76] The OIG found that 3 of 10 controlled substance inspector's terms had exceeded three years without a one-year hiatus. Over time, this may result in inspectors becoming complacent and possibly not recognizing drug diversion. Although aware of the requirement, the controlled substance coordinator stated the shortage of controlled substance inspectors as the reason for noncompliance.

Recommendation 5

5. The facility director makes certain that an adequate number of controlled substances inspectors are appointed in writing prior to performing inspector duties to a term not to exceed three years and monitors the compliance.

Facility concurred.

Target date for completion: June 1, 2020

Facility response: By November 1, 2019, the medical center director will assure assignment of 8-10 additional controlled substances inspectors and they will be fully trained within 90 days. Additional inspectors will be assigned quarterly as needed due to term limits. The Controlled Substance Coordinator will continue to recruit and assign new controlled substance inspectors so that terms do not exceed three years. The Controlled Substance Coordinator will monitor assignment timeliness for six consecutive months and document the audit as part of the Director's monthly report through the Quality Management Service.

VHA requires controlled substances inspectors to conduct monthly inspections of controlled substances storage areas. Although an inspector may be assigned to assist in monthly inspections, an inspector may not inspect the same controlled substance storage area for two consecutive months.[77] The OIG found that two inspectors conducted the same area inspections for three consecutive months in 2 of 10 areas reviewed. Consecutively inspecting the same storage area could decrease the element of surprise and potentially delay identification of loss and diversion. The controlled substances coordinator reported noncompliance was due to an insufficient number of controlled substances inspectors.

[76] VHA Directive 1108.02(1).
[77] VHA Directive 1108.02(1).

Recommendation 6

6. The facility director ensures that a controlled substances inspector does not inspect the same controlled substances area for two consecutive months and monitors inspectors' compliance.

Facility concurred.

Target date for completion: June 1, 2020

Facility response: The Controlled Substance Coordinator reports that for April - September 2019 no area has been inspected by the same controlled substances inspector for two consecutive months. The Controlled Substance Coordinator refined assignment process to ensure compliance. Monitoring is reported monthly in reports from the Controlled Substance Coordinator to the Director through the Quality Management Service. The Controlled Substance Coordinator will continue to monitor compliance for 6 months at 90% compliance or greater.

Additionally, VHA requires controlled substances inspection program staff to reconcile one random day's stocking/refilling from the pharmacy to every automated dispensing cabinet and one random day's return of stock to pharmacy from every automated dispensing cabinet during monthly controlled substances area inspections.[78] The OIG found that one-day's reconciliation of stocking/refilling from pharmacy to automated dispensing cabinets and one-day's return of stock to the pharmacy from every automated dispensing cabinet was not conducted in controlled substance areas from July 1, 2018, through December 31, 2018. Failure to reconcile dispensing and returns in all controlled substances areas may cause delays in identifying potential drug diversion activities.[79] The controlled substance coordinator reported reconciliations did not occur due to a shortage of staff.

Recommendation 7

7. The facility director ensures that monthly reconciliation of one-day's dispensing from pharmacy to every automated dispensing cabinet and one-day's return of stock to pharmacy from every automated dispensing cabinet is performed during controlled substances inspections and monitors compliance.

[78] VHA Directive 1108.02(1).
[79] VHA Directive 1108.02(1)

Facility concurred.

Target date for completion: June 1, 2020

Facility response: Beginning October 1, 2019, the Controlled Substance Coordinator implemented a process to include the reconciliation in the monthly pharmacy vault review. The Controlled Substance Coordinator will monitor for six consecutive months to ensure 100% compliance. This process will be reported out in the director's monthly report from the Controlled Substance Coordinator through the Quality Management Service.

VHA requires that "controlled substances coordinator should not routinely be scheduled to conduct inspections but may participate in cases of unplanned leave, illness, or other emergency to ensure the completion of all monthly inspections."[80] The OIG found that from July 1, 2018, through December 31, 2018, the controlled substances coordinator conducted routine monthly inspections of two pharmacy areas. When the controlled substances coordinator conducts frequent monthly inspections, program oversight may be compromised. The controlled substances coordinator reported the reason for noncompliance was due to an insufficient number of controlled substances inspectors to perform required monthly inspections.

Recommendation 8

8. The facility director ensures that the controlled substances coordinator refrains from conducting routine inspections of controlled substance storage areas and monitors inspector's compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: Beginning November 1, 2019 the medical center director will assure assignment of 8-10 additional controlled substances inspectors and they will be fully trained within 90 days. Additional inspectors will be assigned quarterly as needed due to term limits. The Controlled Substance Coordinator will continue to recruit and assign new controlled substance inspectors so that terms do not exceed three years. The Controlled Substance Coordinator will monitor for 90% compliance or greater for 6 consecutive months. Monitoring is reported monthly in reports from the Controlled Substance Coordinator to the Director through the Quality Management Service.

[80] VHA Directive 1108.02(1).

Specifically, TJC requires that when automatic dispensing cabinets are used, the hospital has a policy which describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews.[81] Although the facility has a policy that requires nursing staff to review override reports, the OIG did not find evidence that nursing staff reviewed override reports from January 1, 2019, through February 28, 2019. Failure to perform reviews of the automatic dispensing cabinets' overrides can potentially lead to a loss of and diversion of controlled substances medications and risk patient safety. The associate service chief of Pharmacy Operations reported there was a process in place for nursing unit level override report reviews, however, the associate service chief of Pharmacy reported not being aware that acute nursing service were not meeting the requirement.

Recommendation 9

9. The facility director makes certain that the nursing staff complete the review of automatic dispensing cabinets' override reports and monitors the program staff's compliance.

[81] TJC. Mediation Management standard MM.08.01.01, EP16.

Facility concurred.

Target date for completion: January 1, 2020

Facility response:

The Chief and Associate Chief of Pharmacy have implemented a procedure to meet the Joint Commission Medication Management Standard to ensure medication override removals from automated dispensing cabinets are reviewed. Pharmacy continues to produce hard-copy printed monthly reports including Omnicell Medication Order Override Report for CII-CV Controlled Substances. These reports are generated monthly, on the first Wednesday of each month, and are provided to nursing leadership. Nursing leadership disseminates these reports to nurse managers of the various care areas utilizing automated dispensing cabinets. In addition to provision of paper copies of these reports, they are loaded onto a secured SharePoint site for pharmacy and nursing reference. Controlled substance override withdrawals are reviewed by nurse managers for appropriateness and reviewed to ensure a removal is paired with documentation of medication administration for the given patient. To show evidence of review of these reports, nurse managers include tick marks and notations of their investigation and observations. After nurse managers review the reports, they sign the reports and return to pharmacy for recordkeeping purposes. Signed and reviewed documents are also scanned and loaded onto a secured SharePoint site. The Associate Chief, Pharmacy Operations or designee conducts monthly compliance checks to ensure that these override reports have been reviewed and are returned for record-keeping. The Associate Chief, Pharmacy Operations or designee follows-up with nurse managers to ensure reports are reviewed and returned in a timely fashion. Any activity suspicious of diversion identified by nurse managers when reviewing the Omnicell Medication Order Override Report for CII-CV Controlled Substances will be handled in accordance with hospital policy 119-056, Controlled Substance Loss Reporting. Pharmacy will continue to monitor this process reaching 90% or greater compliance for 6 consecutive months. Compliance will appear in the Controlled Substance Coordinators monthly report to the facility director received through the Quality Management Service.

Mental Health: Military Sexual Trauma Follow-Up and Staff Training

The Department of Veterans Affairs uses the term "military sexual trauma" (MST) to refer to a "psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training."[82] MST is an experience, not a diagnosis or a mental health condition. Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.[83]

VHA requires that the facility director designate an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.[84] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[85]

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system (CPRS).[86] Those who screen positive must have access to appropriate MST-related care.[87] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.[88]

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.[89] All mental health and primary care providers must complete MST mandatory

---

[82] VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

[83] Military Sexual Trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on November 17, 2017.)

[84] VHA Directive 1115.

[85] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008 (amended November 16, 2015). (This VHA Handbook was scheduled for recertification on or before the last working date of September 2013 and has not been recertified.)

[86] VHA Directive 1115 states that "MST-related care is not subject to the minimum active duty service requirement set forth in 38 U.S.C. 5303A; Veterans may therefore be able to receive MST-related care even if they are not eligible for VA health care under other treatment authorities."

[87] VHA Directive 1115.

[88] VHA Handbook 1160.01.

[89] VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[90]

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 50 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Designated facility MST coordinator
  - Establishes and monitors MST-related staff training
  - Establishes and monitors informational outreach
  - Communicates MST-related issues, services, and initiatives with local leaders
- Evidence of tracking MST-related data
- Provision of clinical care
  - Referral for MST-related care to patients with positive MST screens
  - Initial evaluation within 24 hours of referral for mental health services
  - Comprehensive diagnostic and treatment planning evaluation within 30 days of referral for mental health services
- Completion of MST mandatory training requirement for mental health and primary care providers

Mental Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including the designation of an MST coordinator, tracking of MST-related data, and provision of clinical care. There was a concern noted, however, with the requirement that primary care and mental health providers complete MST mandatory training within the required time frame that warranted a recommendation for improvement.

Specifically, VHA requires that all primary care and mental health providers complete the MST mandatory training; for those hired after July 1, 2012, this training must be completed no later

[90] VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017; Acting Deputy Under Secretary for Health for Operations and Management Memorandum, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

than 90 days after assuming their position.[91] The OIG found that for those hired after July 1, 2012, 3 of 10 did not complete training within 90 days of their hire date. This could potentially prevent clinicians from providing a consistent level of counseling, care, and service to veterans who experienced MST.[92] The MST coordinator reported an access issue in the Talent Management System[93] as the reason for noncompliance.

Recommendation 10

10. The facility director confirms that primary care and mental health providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: June 1, 2020

Facility response: Hospital Education and the MST Coordinator collaborated to ensure a compliance plan was in place prior to OIG departure in March 2019. The Assistant Chief of Hospital Education runs an audit on the New Employee Orientation list and compares it to the MST assignment list to ensure there are no missed assignments for those requiring training based on their job role. This audit will occur quarterly until 90% or greater compliance is achieved for at least two quarters. The MST Coordinator receives a monthly Requirement Compliance Deficiency Detail – MST Monthly Training Report from TMS. The MST Coordinator reviews and follows up on any noted deficiencies in writing. Our overall training compliance is 98.1%. For the mental health training, compliance is 97.8%. For primary care, it is 98.5%. Among employees who came on board since the time of the IG visit, 123 of 129 (95.3%) completed the training within 90 days. The monthly reports from hospital education have allowed the MST Coordinator to contact staff when they are approaching the deadline and maximize the likelihood of completing the training on time. This data will be shared monthly with Quality Management Service and included in the monthly accreditation update to the Medical Center Director to ensure compliance for at least six consecutive months.

[91] VHA Directive 1115.01.

[92] VHA Directive 1115.

[93] "The Talent Management System (TMS) is the system of record for all Veterans Affairs (VA) training." https://www.valu.va.gov/SlickSheet/View/158 (The website was accessed on July 29, 2019.)

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."[94] The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.[95]

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepression drugs, psychotherapy, or a combination of both."[96]

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.[97] The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."[98] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[99] Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.[100] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

---

[94] Hans Peterson, "Late Life Depression," *U.S. Department of Veterans Affairs*, Mental Health Featured Article, March 1, 2011. https://www.mentalhealth.va.gov/featureArticle_Mar11LateLife.asp. (The website was accessed on March 8, 2019.)

[95] *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf. (The website was accessed November 20, 2018.)

[96] Centers for Disease Control and Prevention, "Depression is Not a Normal Part of Growing Older," January 31, 2017. https://www.cdc.gov/aging/mentalhealth/depression.htm. (The website was accessed on March 8, 2019.)

[97] American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." http://www.sigot.org/allegato_docs/1057_Beers-Criteria.pdf. (The website was accessed on March 22, 2018.)

[98] TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

[99] VHA Directive 1164, Essential Medication Information Standards, June 26, 2015.

[100] TJC. National Patient Safety Goal standard NPSG.03.06.01.

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.[101]

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 36 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[102]The OIG evaluated the following performance indicators:

- Justification for medication initiation
- Evidence of patient and/or caregiver education specific to the medication prescribed
- Clinician evaluation of patient and/or caregiver understanding of the education provided
- Medication reconciliation

Geriatric Care Conclusion

The OIG team found compliance with providers justifying the reason for medication initiation. However, the OIG identified inadequate patient and/or caregiver education related to newly prescribed medications, evaluation of patient/caregiver understanding when education was provided, and medication reconciliation processes which warranted recommendations for improvement.

Specifically, TJC requires that clinicians educate patients/caregivers about safe and effective use of medications and assess their understanding of the education provided.[103] The OIG estimated that clinicians provided education to 47 percent of the patients at the facility, based on electronic health records reviewed.[104] In addition, the OIG estimated that clinicians assessed understanding of education provided in six percent of the patients at the facility, based on the records reviewed.[105] Providing medication education is important for patients to be able to manage their health at home.[106] The mental health, primary care, and pharmacy service chiefs reported that

[101] VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

[102] The seven selected antidepressant medications are Amitriptyline, Clomipramine, Desipramine, Doxepin (>6mg/day), Imipramine, Nortriptyline, and Paroxetine.

[103] TJC. Provision of Care standard PC.02.03.01, EP10.

[104] The OIG is 95 percent confident that the true compliance rate is somewhere between 31.2 and 63.7 percent, which is statistically significantly below the 90 percent benchmark.

[105] The OIG is 95 percent confident that the true compliance rate is somewhere between 0.1 and 19.1 percent, which is statistically significantly below the 90 percent benchmark.

[106] TJC. Provision of Care standard PC.02.03.01.

providers were providing education and evaluating the patient's caregivers understanding but were not aware of the requirement to document this in the electronic health record at each visit.

Recommendation 11

11. The chief of staff makes certain that clinicians provide and document patient and/or caregiver education and assess understanding of education provided specific to newly prescribed medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: June 1, 2020

Facility response: The Chief of Staff or designee will ensure clinicians provide education and assess understanding of patients who are 65 years or older and/or caregiver about the risks/benefits, potential interactions, and side effects of newly prescribed antidepressant medications and document that they have given the education. They will also document assessed understanding of the education provided. Requirement will be audited by the Chief of Staff or designee with the goal of six consecutive months of 90% compliance or greater and reported to the Medical Staff Executive Council. The Chief of Staff will sign the minutes of the Medical Staff Executive Council.

According to TJC, "In medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolve any discrepancies."[107] VHA requires that clinicians review and reconcile medications relevant to the episode of care.[108] TJC also requires patients' medical records contain information that reflects the patient's care, treatment, and services.[109] The OIG estimated that clinicians performed medication reconciliation for 53 percent of the patients at the facility, based on electronic health records reviewed.[110] Failure to maintain and communicate accurate patient medication information and reconcile medications increases the risk that there may be duplications, omissions, and interactions in the patient's drug regimen. The mental health, primary care, and pharmacy service chiefs believed medication reconciliation was completed during patient visits but not all providers used the medication reconciliation template for documentation.

[107] TJC. National Patient Safety Goal standard NPSG.03.06.01.

[108] VHA Directive 1164.

[109] TJC. National Patient Safety Goal standard NPSG.03.06.01.

[110] The OIG is 95 percent confident that the true compliance rate is somewhere between 36.4 and 69.1 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 12

12. The chief of staff ensures clinicians review and reconcile patients' medications and maintain and communicate accurate patient medication information in patients' electronic health records and monitors clinicians' compliance.

Facility concurred.

Target date for completion: June 1, 2020

Facility response: The Chief of Staff or designee will ensure clinicians perform a complete and accurate medication reconciliation consisting of reviewing and reconciling patients' medications for patients who are 65 years or older and on antidepressant medications and document communication of review in the electronic medical record. Requirement will be audited for six months for 90% compliance and reported quarterly to the Medical Staff Executive Council. The Chief of Staff will sign the minutes of the Medical Staff Executive Council.

Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.[111] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[112] In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.[113] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[114]

VA is authorized to provide "gender-specific services, such as Papanicolaou tests (Pap smears)," to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.[115]

VHA requires that each facility have a "full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health care." VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women's health program. Each facility must also have a "Women Veterans Health Committee (WVHC) comprised of appropriate facility leadership and program directors, which develops and implements a Women's Health Program strategic plan." The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.[116]

VHA has established time frames for notifying patients of abnormal cervical pathology results. Abnormal cervical pathology results must be communicated to patients within seven calendar days from the date the results are available to the ordering provider. Communication of the

[111] Centers for Disease Control and Prevention, "Cervical Cancer" *Inside Knowledge* fact sheet, December 2016. https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf. (The website was accessed on February 28, 2018.)
[112] Centers for Disease Control and Prevention, *Basic Information About Cervical Cancer*, February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)
[113] Centers for Disease Control and Prevention, *What Are the Risk Factors for Cervical Cancer?* February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm. (The website was accessed on March 8, 2019.)
[114] Centers for Disease Control and Prevention, *Basic Information About Cervical Cancer*, February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)
[115] VHA Directive 1330.01(2), *Health Care Services for Women Veterans,* February 15, 2017 (amended July 24, 2018).
[116] VHA Directive 1330.01(2).

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.[117]

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of 49 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Appointment of a women veteran's program manager
- Appointment of a women's health medical director or clinical champion
- Facility Women Veterans Health Committee
  - Core membership
  - Quarterly meetings
  - Reports to clinical executive leaders
- Collection and tracking of cervical cancer screening data
  - Notification of patients due for screening
  - Completed screenings
  - Results reporting
  - Follow-up care
- Communication of abnormal results to patients within required time frame
- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women's Health Conclusion

Generally, the OIG team found compliance with many of the performance indicators, including requirements for a designated women veterans program manager, clinical oversight of the women's health program, the Women Veterans Health Committee, tracking of data related to cervical cancer screenings, and provision of follow-up care. However, the OIG identified a concern with the communication of abnormal results to patients that warranted a recommendation for improvement.

[117] VHA Directive 1330.01(2).

VHA requires that providers notify patients of abnormal cervical pathology results within seven calendar days of the report becoming available to the ordering provider.[118] The OIG determined that providers communicated abnormal results within the required time frame in 88 percent of the electronic health records reviewed.[119] This resulted in delayed patient notification and initiation of follow-up care. Although aware of the requirement, the women's health program manager reported primary care providers were waiting for guidance from gynecologists to develop appropriate plans of care and follow-up treatment prior to communicating abnormal test results to the patient.

Recommendation 13

13. The chief of staff ensures providers communicate abnormal cervical pathology results to patients within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: June 1, 2020

Facility response: The Women Veteran's Program Manager and Women's Health Physician re-educated Women's Health Primary Care Aligned Care Teams on communicating test results prior to the OIG CHIP team leaving in March 2019 to notify patients within six calendar days of abnormal cervical pathology results and to document next steps per American Society for Colposcopy and Cervical Pathology guidelines. All Women's Health Primary Care Aligned Care Teams were provided the American Society for Colposcopy and Cervical Pathology mobile app and guidelines for follow up of abnormal cervical pathology. The Women Veteran's Program Manager has been discussing the guidelines quarterly at the women's champion committee meeting. Beginning with October 1, 2019, notification results will be monitored with a goal of 90% or greater compliance for at least six months. A random sample of 20 chart reviews will be completed with direct feedback given to any provider not meeting the 7-day time frame. The Women Veteran's Program Manager and Women's Health Physician will continue to communicate guidelines and audit compliance to the women's health teams. Monitoring of results will be tracked and be reported for two consecutive quarters to the Women's Health Committee by the Quality Management Service and any trend below 90% will be investigated. The Chief of Staff or designee is a member of the Women's Health Committee and minutes will be routed to the Chief of Staff for signature.

[118] VHA Directive 1330.01(2).

[119] Confidence intervals are not included because the data represents every patient in the study population.

High-Risk Processes: Operations and Management of Emergency Departments and Urgent Care Centers

VHA defines an emergency department as a "unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations." An urgent care center (UCC) "provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries."[120] A variety of emergency services may exist, dependent on "capability, capacity, and function of the local VA medical facility;" however, emergency care must be uniformly available in all VHA emergency departments and UCCs.[121]

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide "unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week." VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that "evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care."[122]

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can "undermine the timeliness of care and, ultimately, patient safety." Effective management processes that "support patient flow [in the ED or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care."[123]

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement (EMI) initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software (EDIS) tracking program to document and manage the flow of patients.[124]

---

[120] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016 (amended March 7, 2017).

[121] VHA Directive 1101.05(2).

[122] VHA Directive 1101.05(2).

[123] TJC. Leadership standard LD.04.03.11.

[124] VHA Directive 1101.05(2); The Emergency Medicine Management Tool (EMMT) uses data collected from EDIS to generate productivity metrics. The use of EDIS and EMMT are key tools in accomplishing Emergency Medicine Improvement initiative goals.

VA emergency departments and UCCs must also be designed to promote a safe environment of care. Managers must ensure medications are securely stored,[125] a psychiatric intervention room is available,[126] and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also requires emergency departments to have communication systems available to accept requests by local emergency medical services for transporting unstable patients to VA emergency departments.[127]

The OIG examined the clinical risks of the emergency department/UCC areas by evaluating the staffing; the provision of care, including selected aspects of mental health and women's health; and the reduction of patient safety risks to optimize quality care and outcomes in those areas. In addition to conducting manager and staff interviews, the OIG team reviewed emergency department staffing schedules, committee minutes, and other relevant documents. The OIG evaluated the following performance indicators:

- General
  - Presence of an emergency department or UCC
  - Availability of acute care medical and/or surgical inpatient beds in facilities with emergency departments
  - Emergency department/UCC operating hours
  - Workload capture process
- Staffing for emergency department/UCC
  - Dedicated medical director
  - At least one licensed physician privileged to staff the department at all times
  - Minimum of two registered nurses on duty during all hours of operation
  - Backup call schedules for providers
- Support services for emergency department/UCC
  - Access during regular hours, off hours, weekends, and holidays
  - On-call list for staff required to respond
  - Licensed independent mental health provider available as required for the facility's complexity level

[125] TJC. Medication Management standard MM.03.01.01.

[126] A psychiatric intervention room is where individuals experiencing a behavioral health crisis, including serious disturbances, agitation, or intoxication may be taken immediately on arrival.

[127] VHA Directive 1101.05(2).

  - Telephone message system during non-operational hours
  - Inpatient provider available for patients requiring admission
- Patient flow
  - EDIS tracking program
  - Emergency department patient flow evaluation
  - Diversion policy
  - Designated bed flow coordinator
- General safety
  - Directional signage to after-hours emergency care
  - Fast tracks[128]
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
  - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

Generally, the facility achieved the performance indicators listed above. The OIG made no recommendations.

[128] The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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 potentially interfere with the delivery of quality health care.

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation and/or for-cause surveys and oversight inspections • Factors related to possible lapses in care • VHA performance data	Thirteen OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director and chief of staff. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• Service chiefs clearly define and share in advance the expectations for the FPPE process with providers. • Service chiefs include service/ section-specific criteria in OPPEs. • Service chiefs' determination to continue current privileges is based, in part, on results of OPPE activities.	• The Medical Staff Executive Council documents consideration of FPPE and OPPE results in its decision to recommend approval of requested privileges.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent facility
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Community based outpatient clinic
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Locked inpatient mental health unit
	  ○ Mental health environment of care 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
		• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• None	• An adequate number of controlled substances inspectors are appointed in writing to a term not to exceed three years. • A controlled substances inspector does not inspect the same controlled substances areas for two consecutive months. • Monthly reconciliation of one day's dispensing from pharmacy to every automated dispensing cabinet and one day's return of stock to pharmacy from every automated dispensing cabinet is performed during controlled substances inspections. • The controlled substances coordinator refrains from conducting routine inspections of controlled substance storage areas. • Nursing staff complete the review of automatic dispensing cabinets' override reports.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers	• None	• Primary care and mental health providers complete MST mandatory training within the required time frame.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Geriatric Care: Antidepressant Use among the Elderly	• Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation	• Clinicians review and reconcile patients' medications and maintain and communicate accurate patient medication information in patients' electronic health records.	• Clinicians provide and document patient and/or caregiver education and assess understanding of education provided specific to newly prescribed medications.
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a women veteran's program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data • Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated	• Providers communicate abnormal cervical pathology results to patients within the required time frame.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Operations and Management of Emergency Departments and UCCs	• General • Staffing for emergency department/UCC • Support services for emergency department/UCC • Patient flow • General safety • Medication security and labeling • Management of patients with mental health disorders • Emergency department participation in local/regional EMS system • Women veteran services • Life support equipment	• None	• None

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this high-level complexity (1a) affiliated[129] facility reporting to VISN 1.[130]

Table B.1. Facility Profile for VA Connecticut Healthcare System (689) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[131]	Facility Data FY 2017[132]	Facility Data FY 2018[133]
Total medical care budget in dollars	$587,319,353	$618,300,431	$653,614,081
Number of:			
• Unique patients	58,675	58,177	58,687
• Outpatient visits	777,876	764,687	770,394
• Unique employees[134]	2,513	2,512	2,515
Type and number of operating beds:			
• Blind rehabilitation	10	10	10
• Community living center	40	40	40
• Domiciliary	32	32	32
• Intermediate	8	8	8
• Medicine	50	50	50
• Mental health	28	28	28
• Neurology	2	2	2
• Surgery	21	21	21
Average daily census:			
• Blind rehabilitation	9	9	9

[129] Associated with a medical residency program.

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

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

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

[133] October 1, 2017, through September 30, 2018.

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

Profile Element	Facility Data FY 2016[131]	Facility Data FY 2017[132]	Facility Data FY 2018[133]
• Community living center	26	25	22
• Domiciliary	24	25	24
• Medicine	46	44	32
• Mental health	16	16	14
• Neurology	1	1	1
• Residential psychology	3	–	–
• Surgery	20	15	11

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

VA Outpatient Clinic Profiles[135]

The VA outpatient clinics in communities within the catchment area of the facility provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table B.2. provides information relative to each of the clinics.

Table B.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)[136]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[137] Provided	Diagnostic Services[138] Provided	Ancillary Services[139] Provided
Danbury, CT	689GE	3,487	1,385	Dermatology Endocrinology Nephrology Neurology General surgery	n/a	Pharmacy Weight management
Errera, CT	689QA	1,237	267	n/a	n/a	Nutrition

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

[136] The definition of an "encounter" can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015 and has not been updated.) An encounter is a "professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

[137] Specialty care services refer to non-primary care and non-mental health services provided by a physician.

[138] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

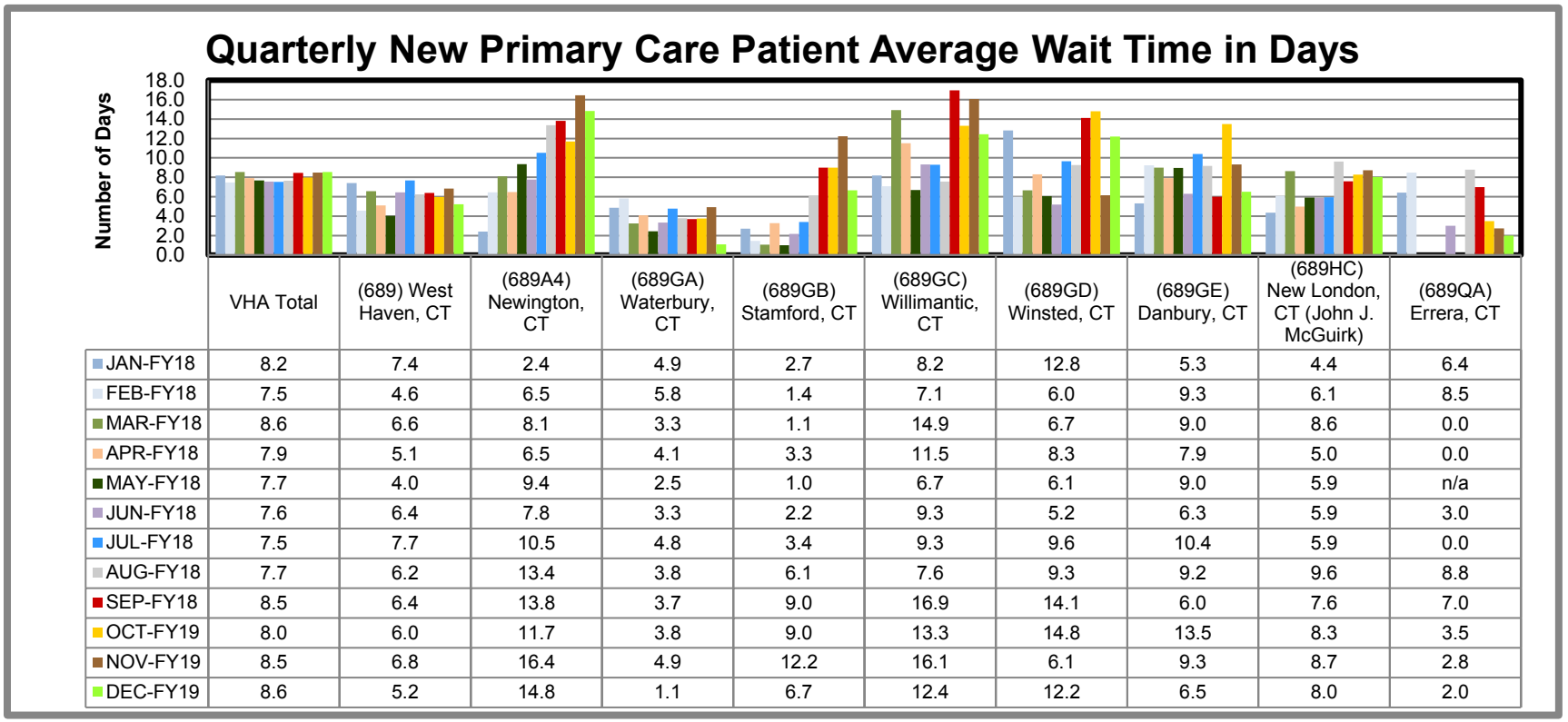
[139] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[137] Provided	Diagnostic Services[138] Provided	Ancillary Services[139] Provided
Newington, CT	689A4	34,961	28,386	Cardiology Dermatology Endocrinology Hematology/ Oncology Infectious disease Nephrology Neurology Pulmonary/ Respiratory disease Rheumatology Poly-Trauma Rehab physician Spinal cord injury Anesthesia Eye General surgery Gynecology Plastic surgery Podiatry Urology Vascular	EKG Laboratory & Pathology Radiology Vascular lab	Nutrition Pharmacy Social work Weight management Dental
New London, CT (John J. McGuirk)	689HC	9,705	3,651	Dermatology Endocrinology Nephrology Neurology General surgery Plastic surgery	n/a	Pharmacy Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[137] Provided	Diagnostic Services[138] Provided	Ancillary Services[139] Provided
Stamford, CT	689GB	3,420	1,309	Dermatology Endocrinology Nephrology	n/a	Pharmacy Weight management
Waterbury, CT	689GA	4,853	1,369	Dermatology Nephrology Neurology General surgery	n/a	Pharmacy Weight management
Willimantic, CT	689GC	4,131	1,750	Dermatology Endocrinology Nephrology Neurology General surgery Plastic surgery	n/a	Pharmacy Weight management
Winsted, CT	689GD	3,394	1,630	Dermatology Nephrology Neurology General surgery	n/a	Pharmacy Weight management

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

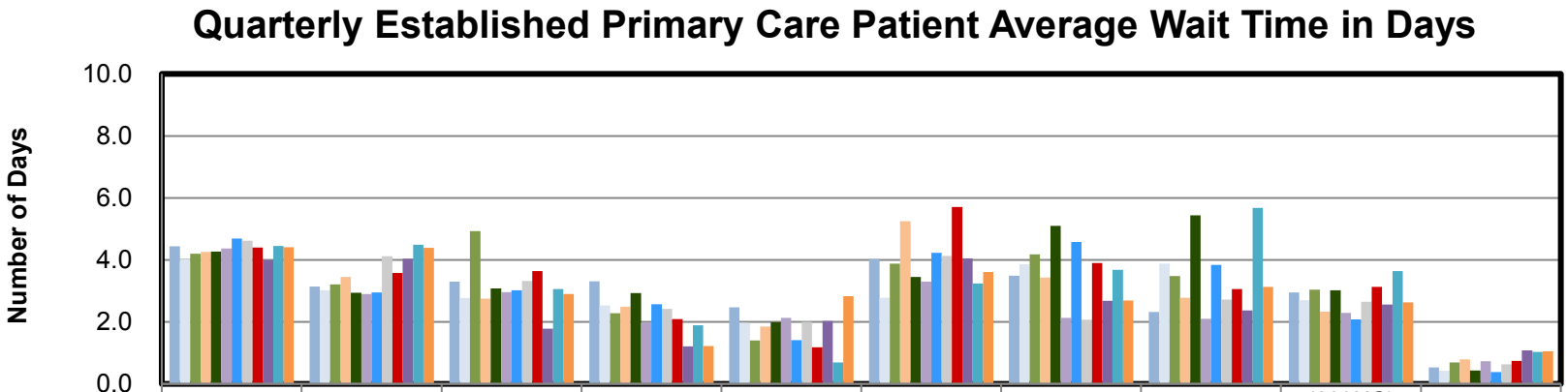
Appendix C: Patient Aligned Care Team Compass Metrics[140]



	VHA Total	(689) West Haven, CT	(689A4) Newington, CT	(689GA) Waterbury, CT	(689GB) Stamford, CT	(689GC) Willimantic, CT	(689GD) Winsted, CT	(689GE) Danbury, CT	(689HC) New London, CT (John J. McGuirk)	(689QA) Errera, CT
JAN-FY18	8.2	7.4	2.4	4.9	2.7	8.2	12.8	5.3	4.4	6.4
FEB-FY18	7.5	4.6	6.5	5.8	1.4	7.1	6.0	9.3	6.1	8.5
MAR-FY18	8.6	6.6	8.1	3.3	1.1	14.9	6.7	9.0	8.6	0.0
APR-FY18	7.9	5.1	6.5	4.1	3.3	11.5	8.3	7.9	5.0	0.0
MAY-FY18	7.7	4.0	9.4	2.5	1.0	6.7	6.1	9.0	5.9	n/a
JUN-FY18	7.6	6.4	7.8	3.3	2.2	9.3	5.2	6.3	5.9	3.0
JUL-FY18	7.5	7.7	10.5	4.8	3.4	9.3	9.6	10.4	5.9	0.0
AUG-FY18	7.7	6.2	13.4	3.8	6.1	7.6	9.3	9.2	9.6	8.8
SEP-FY18	8.5	6.4	13.8	3.7	9.0	16.9	14.1	6.0	7.6	7.0
OCT-FY19	8.0	6.0	11.7	3.8	9.0	13.3	14.8	13.5	8.3	3.5
NOV-FY19	8.5	6.8	16.4	4.9	12.2	16.1	6.1	9.3	8.7	2.8
DEC-FY19	8.6	5.2	14.8	1.1	6.7	12.4	12.2	6.5	8.0	2.0

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 Primary Care 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 FY15, this metric was calculated using the earliest possible create date.

[140] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 13, 2018.



	VHA Total	(689) West Haven, CT	(689A4) Newington, CT	(689GA) Waterbury, CT	(689GB) Stamford, CT	(689GC) Willimantic, CT	(689GD) Winsted, CT	(689GE) Danbury, CT	(689HC) New London, CT (John J. McGuirk)	(689QA) Errera, CT
JAN-FY18	4.4	3.1	3.3	3.3	2.5	4.0	3.5	2.3	2.9	0.5
FEB-FY18	4.0	3.0	2.8	2.5	2.0	2.8	3.9	3.9	2.7	0.4
MAR-FY18	4.2	3.2	4.9	2.3	1.4	3.9	4.2	3.5	3.0	0.7
APR-FY18	4.3	3.5	2.7	2.5	1.9	5.2	3.4	2.8	2.3	0.8
MAY-FY18	4.3	2.9	3.1	2.9	2.0	3.4	5.1	5.4	3.0	0.4
JUN-FY18	4.4	2.9	3.0	2.0	2.1	3.3	2.1	2.1	2.3	0.7
JUL-FY18	4.7	3.0	3.0	2.6	1.4	4.2	4.6	3.8	2.1	0.4
AUG-FY18	4.6	4.1	3.3	2.4	2.0	4.1	2.1	2.7	2.7	0.6
SEP-FY18	4.4	3.6	3.6	2.1	1.2	5.7	3.9	3.1	3.1	0.7
OCT-FY19	4.0	4.0	1.8	1.2	2.0	4.0	2.7	2.4	2.6	1.1
NOV-FY19	4.4	4.5	3.1	1.9	0.7	3.2	3.7	5.7	3.6	1.0
DEC-FY19	4.4	4.4	2.9	1.2	2.8	3.6	2.7	3.1	2.6	1.0

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 Primary Care 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."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[141]

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	Percent acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
APP Capacity	Advanced Practice Provider Capacity	A lower value is better than a higher value
Best Place to Work	All Employee Survey Best Places to Work score	A higher value is better than a lower value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	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	Percent 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

[141] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL),* (last updated December 26, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

Measure	Definition	Desired Direction
HC Assoc Infections	Health care 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	Mental health 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	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	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 Care Coordination	PCMH Care Coordination	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
Physician Capacity	Physician Capacity	A lower value is better than a higher 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

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

Measure	Definition	Desired Direction
SC Care Coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Survey Access	Timely Appointment, care and information (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
Seconds Pick Up Calls	Average speed of call center responded to calls in seconds	A lower value is better than a higher 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
Telephone Abandonment Rate	Telephone abandonment rate	A lower value is better than a higher value

Source: VHA Support Service Center

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions[142]

Measure	Definition
Ability to Move Independently Worsened (LS)	Long-Stay Measure: Percentage of residents whose ability to move independently worsened.
Catheter in Bladder (LS)	Long-Stay Measure: Percent of residents who have/had a catheter inserted and left in their bladder.
Falls with Major Injury (LS)	Long-Stay Measure: Percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-Stay Measure: Percent of residents whose need for help with activities of daily living has increased.
High Risk PU (LS)	Long-Stay Measure: Percent of high-risk residents with pressure ulcers.
Improvement in Function (SS)	Short-Stay Measure: Percentage of residents whose physical function improves from admission to discharge.
Moderate-Severe Pain (LS)	Long-Stay Measure: Percent of residents who self-report moderate to severe pain.
Moderate-Severe Pain (SS)	Short-Stay Measure: Percent of residents who self-report moderate to severe pain.
New or Worse PU (SS)	Short-Stay Measure: Percent of residents with pressure ulcers that are new or worsened.
Newly Received Antipsych Meds (SS)	Short-Stay Measure: Percent of residents who newly received an antipsychotic medication.
Physical Restraints (LS)	Long-Stay Measure: Percent of residents who were physically restrained.
Receive Antipsych Meds (LS)	Long-Stay Measure: Percent of residents who received an antipsychotic medication.
UTI (LS)	Long-Stay Measure: Percent of residents with a urinary tract infection.

[142] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on September 3, 2019, but is not accessible by the public.)

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 4, 2019

From: Director, VA New England Healthcare System (10N1)

Subj: Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System, West Haven, CT

To: Director, Chicago Office of Healthcare Inspections (54CH02)

Director, GAO/OIG Accountability Liaison (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System, West Haven, CT. I appreciate the Office of Inspector General's oversight and the extensive work done as part of this review. We acknowledge there are improvements to be made and we are committed to ensuring correction to identified opportunities for improvement.

2. I have reviewed the Healthcare System Director's action plan and projected completion dates. I concur with the plan and have complete confidence that the plan will be effective. VISN 1 will assist the Healthcare System's leadership in reaching full compliance in a timely manner.

(Original signed by:)

Ryan S. Lilly, MPA

Network Director, VA New England Healthcare System

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 G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 1, 2019

From: Director, VA Connecticut Healthcare System (689/00)

Subj: Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System, West Haven, CT

To: Director, VA New England Healthcare System (10N1)

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System, West Haven, CT.
2. I have reviewed and concur with the recommendations, findings and action plans set forth in this report.

(Original signed by:)

Alfred A, Montoya, Jr., MHA, FACHE, VHA-CM

Medical Center Director

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

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Review Team	Schzelle Spiller-Harris, MSN, RN, Team Leader Bruce Barnes Sheila Cooley, MSN, GNP Rose Griggs, MSW Carrie Jeffries, DNP, FACHE Renay Montalbano, MSN, RN Valerie Zaleski, BSN, RN
Other Contributors	Judy Brown Alicia Castillo-Flores, MBA, MPH Lin Clegg, PhD Justin Hanlon, BS LaFonda Henry, MSN, RN-BC Gayle Karamanos, MS, PA-C Yoonhee Kim, PharmD Susan Lott, MSA, RN Scott McGrath, BS Larry Ross, Jr., MS Marilyn Stones, BS Erin Stott, MSN, RN Mary Toy, MSN, RN Robert Wallace, ScD, MPH

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 1: VA New England Healthcare System
Director, VA Connecticut Healthcare System (689/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Richard Blumenthal, Christopher Murphy
U.S. House of Representatives: Joe Courtney, Rosa L. DeLauro, Jahana Hayes, James A. Himes, John B. Larson

OIG reports are available at www.va.gov/oig.