DEPARTMENT OF VETERANS AFFAIRS

# OFFICE OF INSPECTOR GENERAL

VETERANS HEALTH ADMINISTRATION

# Comprehensive Healthcare Inspection of the Sioux Falls VA Health Care System

# South Dakota

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**Figure 1.** *Sioux Falls VA Health Care System, SD (Source: https://vaww.va.gov/directory/guide/, accessed on June 13, 2019)*

# Abbreviations

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|---|---|
| ADPCS | associate director for 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 (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Sioux Falls VA Health Care 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 11, 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 executive team consisted of three leaders in acting positions—the director, associate director for Patient Care Services (ADPCS), and associate director (primarily nonclinical)—and the permanently assigned chief of staff. Organizational communications and accountability were managed through a committee reporting structure, with the Executive Council having oversight for several working groups. The director was chair of the Quality, Safety, and Value Council, which was responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.

The facility's leadership team had been working together less than one month. The three acting leaders—the director (also the permanently assigned ADPCS), ADPCS, and associate director—were all assigned to their positions on February 17, 2019. The chief of staff was permanently assigned January 2, 2018.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders were engaged and promoted a culture of safety where employees feel safe bringing forward issues and concerns. However, opportunities exist for the chief of staff and ADPCS to provide an environment where employees feel encouraged to do the right thing. The facility and executive leadership team averages for the selected patient experience survey questions in most instances were similar to or better than the VHA average, and facility leaders had implemented processes and plans to maintain positive patient experiences.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[1] disclosures of adverse patient events, and patient safety indicator data and did not identify any substantial organizational risk factors.[2] Indicative of effective leadership, the facility has closed all

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[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] 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.

recommendations for improvement derived from the most recent OIG and The Joint Commission (TJC) inspections.[3,4]

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.[5] The OIG noted that opportunities appear to exist for members of the leadership team to improve their knowledge within their scope of responsibility about selected SAIL and Community Living Center (CLC) metrics. Further, they should continue to take actions to sustain and improve performance of measures contributing to the SAIL "4-star" and CLC "1-star" quality ratings.[6]

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

## Quality, Safety, and Value

The OIG found there was general compliance with requirements for protected peer review, patient safety, and resuscitation episode reviews.[7] However, the OIG identified a concern with interdisciplinary committee reviews of utilization management data.

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[3] 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."

[4] 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.

[5] 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.)

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

[7] 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.

## Medical Staff Privileging

The facility generally complied with requirements for privileging and ongoing professional practice evaluations. However, the OIG identified noted noncompliance with including specialty-specific criteria in the focused professional practice evaluation process for nuclear medicine providers.[8]

## Environment of Care

Generally, the facility met safety, privacy, and women veterans program requirements. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified an infection prevention concern related to damaged furnishings and wheelchairs that warranted a recommendation for improvement.

## Medication Management

Overall, the facility complied with requirements for most of the performance indicators evaluated for medication management, including the controlled substance coordinator reports, pharmacy operations, requirements for controlled substances inspectors, and pharmacy inspections. However, the OIG identified noncompliance with the verification of controlled substances orders.

## Mental Health

The OIG also found the facility complied with most of the military sexual trauma (MST) performance indicators, including the designation of an MST coordinator, tracking of MST-related data, and provision of clinical care. The OIG noted a concern, however, with providers completing MST mandatory training within the required time frame.

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[8] 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."

## Geriatric Care

For geriatric patients, clinicians documented reasons for prescribing medications and performed medication reconciliation. However, the OIG identified inadequate patient and/or caregiver education about the safe and effective use of newly prescribed medications.

## Women's Health

The OIG also noted the facility was in compliance with many of the indicators related to women's health, including requirements for a designated women veterans program manager, clinical oversight of the women's health program, tracking of data related to cervical cancer screenings, communication of abnormal results to patients within the required time frame, and follow-up care when indicated. However, the Women Veterans Health Committee lacked representation from required core members.

## High-Risk Processes

The OIG inspection revealed that the facility generally complied with many of the performance indicators used to assess the high-risk process of the operations and management of the emergency department. However, the OIG identified that a minimum of two registered nurses were not always available during all hours of the emergency department's operation.

## Summary

In reviewing key healthcare processes, the OIG issued eight recommendations for improvement directed to the facility director, chief of staff, and associate director. 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 acting facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans.

(See Appendixes F and G, pages 68–69, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.


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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 Sioux Falls VA Health Care 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.[9] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[10] 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)

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[9] 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.)

[10] 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).[11]
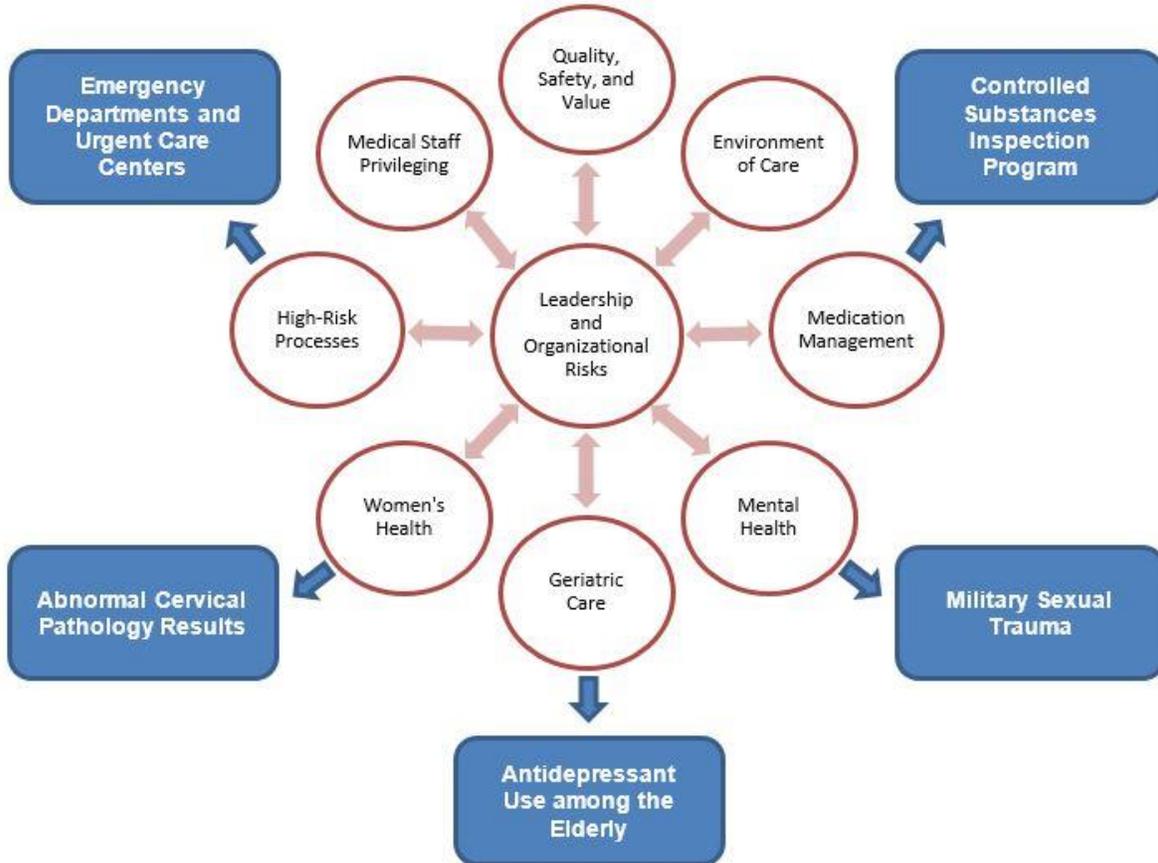


*Figure 2.* *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
*Source: VA OIG*

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[11] 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;[12] 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 November 7, 2015, through March 15, 2019, the last day of the unannounced week-long site visit.[13] 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.

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[12] The OIG did not review VHA's internal survey results, instead focusing on OIG inspections and external surveys that affect facility accreditation status.

[13] The range represents the time period from the last Combined 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 of the selected clinical areas of focus.[14] 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 has a leadership team consisting of a director, chief of staff, associate director for patient care services (ADPCS), and associate director (primarily nonclinical). The chief of staff and ADPCS oversee patient care, which requires managing service directors and chiefs of programs and practices.

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[14] 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.)
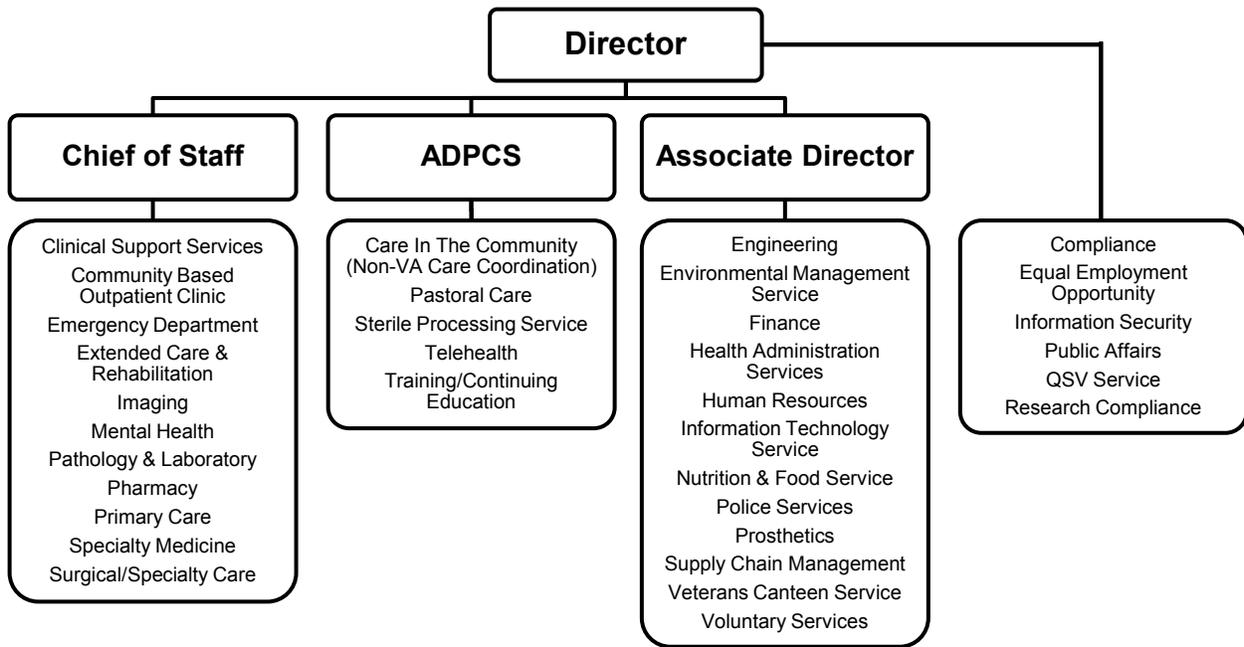
**Figure 3.** *Facility Organizational Chart[15]*
*Source: Sioux Falls VA Health Care System (received March 11, 2019)*

At the time of the OIG site visit, three of the four executive leaders (director, ADPCS, and associate director) were in acting roles and had only been working together with the permanently assigned chief of staff for less than one month. The OIG noted that the permanent ADPCS, who was assigned to that position on September 26, 2010, was in the acting director position (see Table 1).

**Table 1. Executive Leader Assignments**

| Leadership Position | Assignment Date |
| --- | --- |
| Director | February 17, 2019 (acting) |
| Chief of staff | January 2, 2018 |
| Associate director for Patient Care Services | February 17, 2019 (acting) |
| Associate director | February 17, 2019 (acting) |

*Source: Sioux Falls VA Health Care System human resources officer (received March 11, 2019)*

To help assess facility executive leaders' engagement, the OIG interviewed the acting director, ADPCS, and associate director and the permanently assigned chief of staff regarding their

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[15] At this facility, the director is responsible for Compliance, Equal Employment Opportunity, Information Security, Public Affairs, QSV Service, and Research Compliance.

knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, the leaders were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics and community living center (CLC) measures. These are discussed in greater detail below.

The director serves as the chairperson of the Executive Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Council oversees various working groups, such as the Medical Executive Council; Nurse Executive Council; Informatics and Analytics Council; and the Quality, Safety and Value Council.

These leaders are also engaged in monitoring patient safety and care through the Quality, Safety and Value Council, for which the director is the chair and the chief of staff, ADPCS, and associate director are members. The Quality, Safety and Value Council is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes, and it reports to the Executive Council. See Figure 4.

**Executive Council**

**Medical Executive Council**

- Affiliation Partnership Committee
- Clinical Product Review Committee (CPRC)
- Disruptive Behavior Committee
- Graduate Medical Education Committee
- Intensive Care Unit/Emergency Department Committee
- Medical Executive Council Credentialing Committee
- Patient Aligned Care Team Steering Committee
- Pain Committee
- Peer Review Committee
- Pharmacy & Therapeutics (P&T) Committee
- Research & Development (R&D) Committee
- Surgical/Invasive Procedure Workgroup
- Transfusion Committee
- Women Advisory Committee

**Nurse Executive Council**

- Clinical Bar Code Multidisciplinary Committee
- Evidenced Based Nursing Practice Committee
- Health Promotion, Disease Prevention & Veteran Health Education Committee
- Nursing Professional Development & Recognition Committee
- Nursing Senate Committee
- Nutrition Committee
- Prevention of Pressure Ulcer Committee
- Social Work Committee

**Environment of Care Council**

- Accident Review Board
- Construction Safety Committee
- Emergency Management Committee
- Green Environment Management Committee
- Laser Safety Committee
- Magnetic Resonance Imaging (MRI) Safety Committee
- Radiation Safety Committee
- Water Safety Committee

**Infomatics & Analytics Council**

- Clinic Profile Committee
- Consult Review Committee
- Medical Records Committee

**Quality, Safety and Value Council**

- Environment of Care Safety and Engineering
- Equal Employment Opportunity/Diversity Committee
- Infection Prevention Committee
- Integrated Ethics Committee
- Systems Redesign Committee

- Community Care Oversight Committee
- Compliance and Business Integrity Committee
- Contract Review Committee
- Education & Training Committee
- Equipment Committee
- Outreach Committee
- Space Utilization Committee

**Figure 4.** *Facility Committee Reporting Structure[16]*
*Source: Sioux Falls VA Health Care System (received March 11,2019)*

## 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

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[16] The Executive Council oversees the Community Care Oversight Committee, Compliance and Business Integrity, Contract Review Committee, Education and Training Committee, Equipment Committee, Outreach Committee, and Space Utilization Committee.

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.[17] 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 the selected survey leadership questions was similar to or lower than the VHA average, while those for the members of the executive leadership team were similar to or higher than both the VHA and facility averages.[18] In all, employees appear generally satisfied with facility leaders.

**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 | ADPCS Average | Assoc. Director Average |
|---|---|---|---|---|---|---|---|
| All Employee Survey: *Servant Leader Index Composite[19]* | 0–100 where HIGHER scores are more favorable | 71.7 | 68.4 | 78.9 | 71.7 | 78.9 | 90.0 |
| 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 | 3.8 | 3.4 | 3.7 | 4.4 |

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

[18] 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.

[19] 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 | ADPCS Average | Assoc. Director Average |
|---|---|---|---|---|---|---|---|
| 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 | 4.1 | 3.8 | 4.2 | 4.7 |
| 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 | 4.2 | 4.2 | 4.7 | 4.6 |

*Source: VA All Employee Survey (accessed February 11, 2019)*

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The facility and executive leadership team averages for the selected survey questions in most instances were similar to or better than the VHA average. However, opportunities exist for the chief of staff and ADPCS to provide an environment where employees feel encouraged to do the right thing. Overall, facility leaders appear to be maintaining 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 | ADPCS 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 | 4.6 | 4.3 | 4.2 | 4.7 |

| Questions/ Survey Items | Scoring | VHA Average | Facility Average | Director Average | Chief of Staff Average | ADPCS Average | Assoc. Director Average |
|---|---|---|---|---|---|---|---|
| All Employee Survey: *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).* | 1 (Strongly Disagree) – 5 (Strongly Agree) | 3.7 | 3.6 | 3.9 | 3.8 | 3.9 | 4.3 |
| 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 | 1.6 | 1.3 | 2.1 | 2.1 | 1.1 |

*Source: VA All Employee Survey (accessed February 11, 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.[20]

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

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

patients' attitudes toward facility leaders (see Table 4). 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.

**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 | 78.8 |
| 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 | 90.2 |
| 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. | 76.3 | 86.7 |
| 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 | 85.8 |

*Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 9, 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.[21] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[22] Indicative of effective leadership, the facility has closed all recommendations for improvement.[23]

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.[24] Additional results included the Long Term Care Institute's inspection of the facility's CLC.[25]

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[21] 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.

[22] 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."

[23] 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.

[24] 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.

[25] 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 Royal C. Johnson Veterans Memorial Medical Center, Sioux Falls, South Dakota, Report No. 15-04699-65, December 22, 2015*) | November 2015 | 2 | 0 |
| OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of the Royal C. Johnson Veterans Memorial Medical Center, Sioux Falls, South Dakota, Report No. 15-05156-69, December 22, 2015*) | November 2015 | 0 | n/a |
| TJC Hospital Accreditation | July 2016 | 11 | 0 |
| TJC Nursing Care Center Accreditation | | 1 | 0 |
| TJC Behavioral Health Care Accreditation | | 0 | 0 |
| TJC Home Care Accreditation | | 3 | 0 |

*Source: OIG and TJC (Inspection/survey results verified with the survey readiness coordinator March 11, 2019)*

*n/a = Not applicable*

## 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 November 7, 2015 (the prior comprehensive OIG inspection), through March 15, 2019.[26]

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[26] 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 Sioux Falls VA Health Care System is a medium complexity (2) affiliated facility as described in Appendix B.)

**Table 6. Summary of Selected Organizational Risk Factors
(November 7, 2015, through March 15, 2019)**

| Factor | Number of Occurrences |
|---|---|
| Sentinel Events[27] | 7 |
| Institutional Disclosures[28] | 2 |
| Large-Scale Disclosures[29] | 0 |

*Source: Sioux Falls VA Health Care System's survey readiness
coordinator (received March 11, 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.[30] 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.

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[27] 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."

[28] 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."

[29] 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."

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

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

| Indicators | Reported Rate per 1,000 Hospital Discharges | | |
|---|---|---|---|
| | VHA | VISN 23 | Facility |
| Pressure ulcer | 0.74 | 0.99 | 0.00 |
| Death among surgical inpatients with serious treatable conditions | 113.42 | 129.03 | 0.00 |
| Iatrogenic pneumothorax[31] | 0.17 | 0.14 | 0.38 |
| Central venous catheter-related bloodstream infection | 0.16 | 0.09 | 0.00 |
| In-hospital fall with hip fracture | 0.09 | 0.22 | 0.00 |
| Perioperative hemorrhage or hematoma | 2.61 | 2.14 | 0.00 |
| Postoperative acute kidney injury requiring dialysis | 0.89 | 0.79 | 0.00 |
| Postoperative respiratory failure | 4.54 | 4.28 | 2.38 |
| Perioperative pulmonary embolism or deep vein thrombosis | 2.97 | 2.99 | 0.00 |
| Postoperative sepsis | 3.55 | 1.96 | 2.26 |
| Postoperative wound dehiscence (rupture along incision) | 0.82 | 1.29 | 10.64 |
| Unrecognized abdominopelvic accidental puncture or laceration | 1.00 | 1.75 | 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 iatrogenic pneumothorax and postoperative wound dehiscence show a higher reported rate than VISN 23 and VHA, and postoperative sepsis shows a higher rate than VISN 23.

A single patient developed a pneumothorax; however, no case review was completed. During the site visit, OIG reviewed the case with the quality manager and determined that the patient was admitted in April 2018 with acute respiratory failure with hypoxia and sustained a postprocedural pneumothorax during the admission. According to data provided by the survey readiness coordinator, this was the first case in 24 months and no trends were identified.

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[31] 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.)

One patient experienced postoperative wound dehiscence. The patient's care was reviewed at the Surgical Case Review Conference, and care was found to be 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.
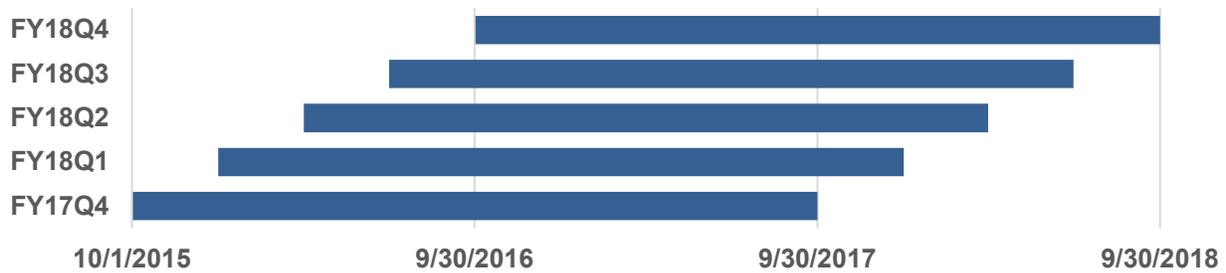


*Figure 5.* Associated Time Frames for Quarterly Patient Safety Indicator Data
Source: VA OIG
*FY18Q4 = fiscal year 2018, quarter 4*
*FY18Q3 = fiscal year 2018, quarter 3*
*FY18Q2 = fiscal year 2018, quarter 2*
*FY18Q1 = fiscal year 2018, quarter 1*
*FY17Q4 = fiscal year 2017, quarter 4*

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[32] | 0.76 | 0.74 |
| | Facility | 0.00 | 0.00 | n/a | 0.00 | 0.00 |
| Death among surgical inpatients with serious treatable conditions | VHA | 100.97 | 118.96 | 113.92 | 114.89 | 113.42 |
| | Facility | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Iatrogenic pneumothorax | VHA | 0.19 | 0.19 | 0.17 | 0.15 | 0.17 |
| | Facility | 0.00 | 0.00 | 0.00 | 0.39 | 0.38 |
| Central venous catheter-related bloodstream infection | VHA | 0.15 | 0.14 | 0.15 | 0.16 | 0.16 |
| | Facility | 0.00 | 0.00 | 0.00 | 0.00 | 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 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Postoperative acute kidney injury requiring dialysis | VHA | 0.88 | 0.80 | 0.65 | 0.96 | 0.89 |
| | Facility | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Postoperative respiratory failure | VHA | 5.55 | 5.34 | 5.11 | 4.88 | 4.54 |
| | Facility | 5.49 | 4.62 | 2.49 | 2.43 | 2.38 |
| Perioperative pulmonary embolism or deep vein thrombosis | VHA | 3.29 | 3.26 | 3.09 | 3.05 | 2.97 |
| | Facility | 3.59 | 3.17 | 1.75 | 0.00 | 0.00 |
| Postoperative sepsis | VHA | 4.00 | 3.96 | 3.72 | 3.70 | 3.55 |
| | Facility | 4.93 | 4.25 | 2.32 | 2.28 | 2.26 |
| Postoperative wound dehiscence (rupture along incision) | VHA | 0.52 | 1.04 | 1.00 | 0.93 | 0.82 |
| | Facility | 16.13 | 15.63 | 9.35 | 9.90 | 10.64 |
| Unrecognized abdominopelvic accidental puncture or laceration | VHA | 0.53 | 1.21 | 1.02 | 1.07 | 1.00 |
| | Facility | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

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

Two measures, iatrogenic pneumothorax and postoperative wound dehiscence, have trended above the VHA average. According to the acting chief of QSV, patient safety indicator results

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[32] 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.

are reported through the QSV Council. Low denominators and sporadic single patient events have impacted iatrogenic pneumothorax and postoperative wound dehiscence. No trends or specific process improvement opportunities were identified.

## 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.[33]

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.[34] As of June 30, 2018, the facility was rated as "4-star" for overall quality.

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[33] 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.)

[34] 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.
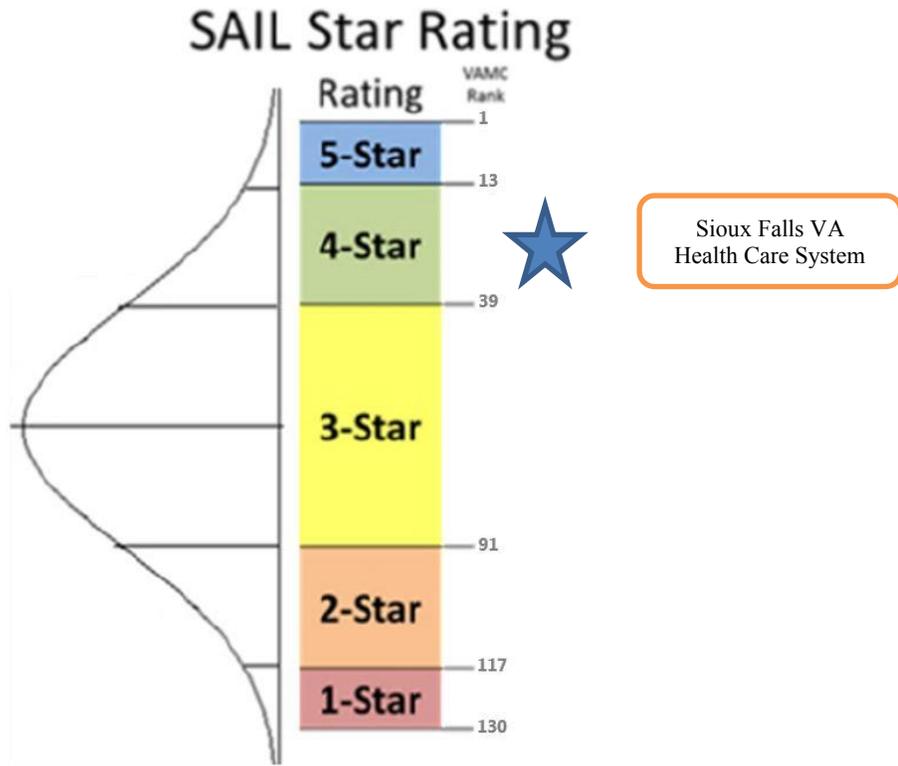
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*Figure 6.* Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed February 11, 2019)

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 specialty care (SC) care coordination, registered nurse (RN) turnover, rating (of) hospital, care transition, and ambulatory care sensitive condition (ACSC) hospitalization).[35] Metrics that need improvement are denoted in orange and red (for example, complications and mental health (MH) population (popu) coverage).

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

**Sioux Falls VAMC (FY2018Q4) (Metric)**

Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.
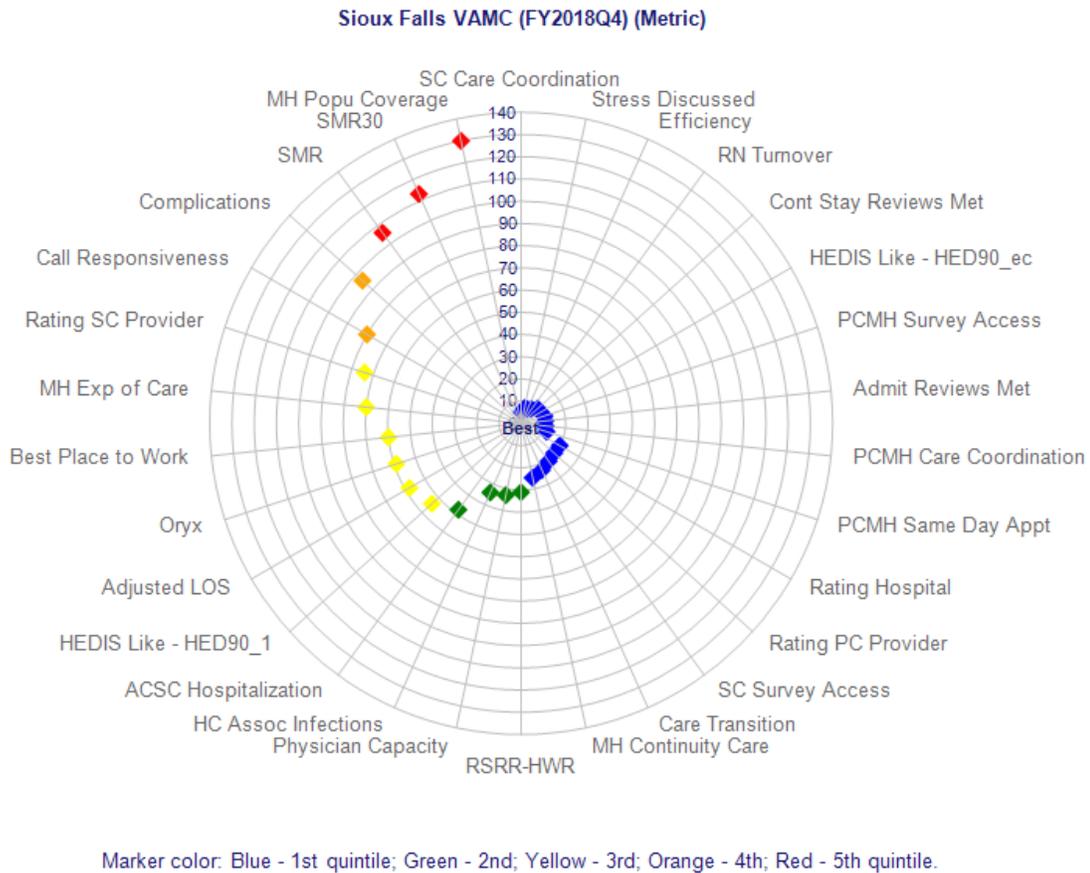
***Figure 7.*** *Facility Quality of Care and Efficiency Metric Rankings (as of September 30, 2018)*
*Source: VHA Support Service Center*
*Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (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 The Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare*.[36] The SAIL CLC provides a single resource to review quality measures and health inspection results. It

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[36] 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."

includes star ratings for an unannounced survey, staffing, quality, and overall results.[37] Table 9 summarizes the rating results for the facility's CLC as of September 30, 2018. The facility has an overall "1-star" rating.

**Table 9. Facility CLC Star Ratings
(as of September 30, 2018)**

| Domain | Star Rating |
|---|---|
| Unannounced Survey | 1 |
| Staffing | 5 |
| Quality | 1 |
| **Overall** | 1 |

*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 physical restraints–long stay (LS), improvement in function–short stay (SS), and falls with major injury (LS)). Metrics that need improvement and were likely the reasons why the facility had a "1-star" for quality are denoted in orange and red (for example, high risk pressure ulcer (PU) (LS), new or worse pressure ulcer (PU) (SS), and urinary tract infection (UTI) (LS)).[38]

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[37] *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.)

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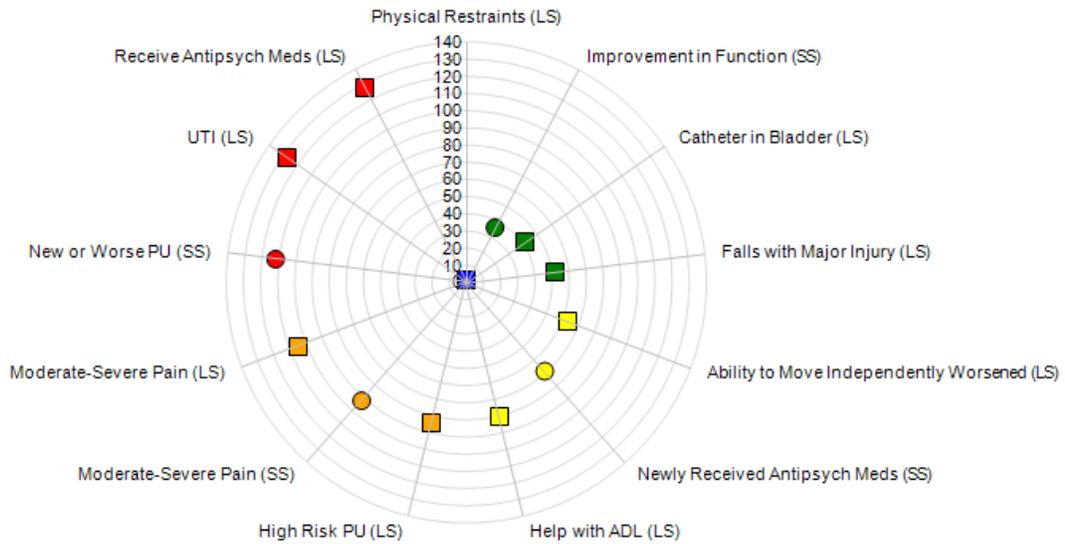
*Figure 8.* *Facility CLC Quality Measure Rankings (as of September 30, 2018)*
*LS = Long-Stay Measure          SS = Short-Stay Measure*
*Source: VHA Support Service Center*
*Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.*

## Leadership and Organizational Risks Conclusion

At the time of the OIG's review, three of four executive leaders were serving in an acting capacity. Selected survey scores related to employees' satisfaction with the facility executive leaders were generally better than VHA averages. Patient experience survey data revealed that scores related to satisfaction with the facility were above VHA averages. 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 leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to maintain positive perceptions of the facility through active stakeholder engagement). The OIG's review of the facility's accreditation findings, sentinel events, disclosures, and patient safety indicator data did not identify any substantial organizational risk factors. However, opportunities appear to exist for members of the leadership team to improve their knowledge within their scope of responsibility about selected SAIL and CLC metrics. Further, the leaders should continue to take actions to sustain and improve performance of measures contributing to the SAIL "4-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.[39] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[40] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[41]

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,[42] utilization management (UM) reviews,[43] patient safety incident reporting with related root cause analyses,[44] and cardiopulmonary resuscitation (CPR) episode reviews.[45]

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

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[39] 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.)

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

[41] VHA Directive 1026.

[42] 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.

[43] 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.

[44] 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."

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

nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[46]

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.[47]

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.[48]

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.[49]

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:[50]

- 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

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[46] VHA Directive 1190.

[47] VHA Directive 1117(1).

[48] VHA Handbook 1050.01.

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

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

- o Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee

- o Peer review of all applicable deaths within 24 hours of admission to the hospital

- o No completed suicides occurred within seven days after discharge from an inpatient mental health unit within 12 months prior to the visit[51]

- UM

  - o Completion of at least 75 percent of all required inpatient reviews

  - o Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database

  - o Interdisciplinary review of UM data

- Patient safety

  - o Annual completion of a minimum of eight root cause analyses[52]

  - o Inclusion of required content in root cause analyses (generally)

  - o Submission of completed root cause analyses to the National Center for Patient Safety within 45 days

  - o Provision of feedback about root cause analysis actions to reporting employees

  - o Submission of annual patient safety report to facility leaders

- Resuscitation episode review

  - o Evidence of a committee responsible for reviewing resuscitation episodes

  - o Confirmation of actions taken during resuscitative events being consistent with patients' wishes

  - o Evidence of basic or advanced cardiac life support certification for code team responders

  - o Evaluation of each resuscitation episode by the CPR Committee or equivalent

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[51] VHA Directive 1190.

[52] According to VHA Handbook 1050.01, "the requirement for a total of <u>eight</u> [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 analysis 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

The OIG found general compliance with requirements for protected peer reviews, patient safety, and resuscitation episode review. However, the OIG identified a concern with the interdisciplinary review of UM data that warranted a recommendation for improvement.

Specifically, VHA requires that an interdisciplinary group review UM data. This group must include, but not be limited to, participation by representatives from UM, medicine, nursing, social work, case management, mental health, and chief business office revenue-utilization review (CBO R-UR).[53]

From February 2018 through February 2019, the QSV Committee, the facility group that reviews UM data, lacked representation from social work and consistent participation by CBO R-UR. As a result, the QSV Committee performed reviews and analyses of UM data without the perspectives of key social work and utilization review colleagues.[54] The acting chief of Quality Management reported a UM policy review resulted in the facility adding a UM social work representative to the QSV Committee in November 2018, and the UM CBO R-UR representative remained as an ad hoc QSV Committee member. The acting chief of Quality Management and UM manager had no explanation for the noncompliance.

## Recommendation 1

1. The facility director makes certain that all required representatives consistently participate in interdisciplinary reviews of utilization management data and monitors representatives' compliance.

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[53] VHA Directive 1117(1).

[54] VHA Directive 1117(1).

Facility concurred.

Target date for completion: September 2019

Facility response: The facility reviewed and discussed VHA Directive 1117 – Utilization Management Program at the September 2018 QSV Council meeting. In response to the identified gap in required attendance, a case manager and a social worker were invited to attend the QSV Council meetings when UM reports are being reviewed. They began attending the council to review UM data in November 2018. In June 2019, an RN representing revenue utilization review also started attending the QSV Council meetings when UM reports are being reviewed and has been present for the past 2 quarterly reports by UM.

UM data continues to be reviewed quarterly at the QSV Council meeting with the involvement of UM, medicine, nursing, social work, case management, mental health, and CBO R-UR. If one of the required individuals is unavailable, the UM report and discussion is deferred until all members can be present. An example of this practice can be seen in the meeting minutes from the August 2019 QSV Council meeting. The UM report was on the agenda to be discussed but was deferred to the September 2019 meeting due to one required member's absence. When the report was presented in September 2019, all necessary individuals were present.

The Facility Director and Chief of QSV as co-chairs of QSV Council will continue to ensure that 100% of required members are in attendance for review and discussion of UM quarterly reports for 4 consecutive quarters. UM reports will be deferred until all members are present.

## 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).[55]

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.[56]

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 Evaluation (OPPE), is essential to confirm the quality of care delivered."[57]

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.[58] 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.[59]

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:

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[55] 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.)

[56] VHA Handbook 1100.19.

[57] VHA Handbook 1100.19.

[58] 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).

[59] 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.)

- Five 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[60]

- 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

  o Privileges requested by the provider

    - Facility-specific

    - Service-specific

    - Provider-specific[61]

  o Approval of privileges for a period of less than, or equal to, two years

- Focused professional practice evaluations[62]

  o Criteria defined in advance

  o Use of required criteria in FPPEs for selected specialty LIPs

  o Results and time frames clearly documented

  o Evaluation by another provider with similar training and privileges

  o Executive Committee of the Medical Staff's consideration of FPPE results in its decision to recommend continuing the initially granted privileges

- Ongoing professional practice evaluations

  o Criteria specific to the service or section

  o Use of required criteria in OPPEs for selected specialty LIPs

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[60] The 18-month period was from September 11, 2017, through March 11, 2019. The 12-month review period covered March 11, 2018, through March 11, 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.

[61] 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.

[62] No providers underwent a FPPE for Cause between March 11, 2018, through March 11, 2019.

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- o Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities

- o Evaluation by another provider with similar training and privileges

- o Executive Committee of the Medical Staff's decision to recommend continuing privileges based on OPPE results

- Focused professional practice evaluations for cause

- o Clearly defined expectations/outcomes

- o Time-limited

- o Provider's ability to practice independently not limited for more than 30 days

- o Shared with the provider in advance

- Reporting of privileging actions to National Practitioner Data Bank

## Medical Staff Privileging Conclusion

The OIG found general compliance with requirements for privileging and OPPEs. However, the OIG identified noncompliance with including specialty-specific criteria in the FPPE process for nuclear medicine providers that warranted a recommendation for improvement.

Despite VHA defining the minimum required specialty-specific criteria to be used, where appropriate, for gastroenterology, pathology, nuclear medicine, and radiation oncology specialties,[63] the facility did not include the standard elements for nuclear medicine. This FPPE process ensures a consistent approach to evaluating providers in these specialties and is essential to confirming the quality of care delivered.

The OIG reviewed LIP profiles for two nuclear medicine providers (radiologists) and found no documented evidence of nuclear medicine specific criteria or data within their FPPEs. This allowed the practitioners to continue to deliver care without evidence of the provider's practice.[64] Even though both radiologists were privileged and provided specialty services in nuclear medicine, the chief of staff informed the OIG that VHA's nuclear medicine specialty criteria was irrelevant to both radiologists' practice.

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[63] VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.
[64] VHA Handbook 1100.19.

## Recommendation 2

2. The chief of staff ensures that the imaging service chief includes the minimum required specialty-specific criteria for focused professional practice evaluations of nuclear medicine practitioners and monitors imaging service chief's compliance.

Facility concurred.

Target date for completion: October 2019

Facility response: The Radiology FPPE forms have been revised to include all required elements as specified in VHA Memorandum, Requirements for Peer Review of Solo Practitioners, August 29, 2016. It is important to note that two of the required criteria are for Radionuclide Therapy and apply only to radiologists who hold privileges for therapeutic administration of radioactive materials. These two criteria are not applicable to radiologists who hold privileges for interpretation of diagnostic Nuclear Medicine studies but not therapeutic administration. The revised FPPE form was approved by the Medical Executive Council (MEC) in October 2019 and is in effect for all new radiologists granted privileges at the SFVAHCS.

The Chief of Staff ensures that FPPE is monitored by the MEC Credentialing Committee on a monthly basis and audited semi-annually to ensure inclusion of required elements and completion within specified timelines. All newly privileged radiologists in the next 6 months will be reviewed to ensure 100% have the required FPPE elements.

# 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.[65]

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 unit. The inspection team also looked at facility compliance with emergency management processes.[66]

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.[67]

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.[68] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[69]

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

[66] 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).

[67] 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.)

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

[69] 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,[70] and National Fire Protection Association standards.[71] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[72]

In all, the OIG team inspected 13 areas—medical/surgical units 2-south and 3-south; community living centers 2 and 3; intensive care unit; post-anesthesia care unit; mental health unit, emergency department; same day surgery; and the primary care, specialty care, endoscopy, and dental clinics. The team also inspected the Watertown VA Clinic and reviewed the emergency management program. 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

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[70] 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.)

[71] 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.)

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

- o Public area and general unit safety

- o Patient room safety

- o Infection prevention

- o Availability of medical equipment and supplies

- Emergency management

    - o Hazard vulnerability analysis (HVA)

    - o Emergency operations plan (EOP)

    - o Emergency power testing and availability

## Environment of Care Conclusion

Generally, the OIG found compliance with many of the performance indicators including safety, privacy, and women veterans program requirements. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified an infection prevention concern that warranted a recommendation for improvement.

Specifically, TJC requires hospitals to minimize the possibility of transmitting infections by ensuring that furnishings and equipment are safe and in good repair.[73] The OIG found in 12 of 28 CLC patient rooms inspected, bedside table tops were worn to bare wood. The OIG also found wheelchairs with damaged armrests and vinyl coverings located in the facility's main lobby/atrium, CLC units, primary care waiting area, and corridors outside of the mental health clinic.[74] These conditions resulted in a lack of assurance of a clean and safe patient care environment that minimizes the spread of infection. Prior to the OIG site visit, facility managers identified the conditions of the furnishings and equipment (bedside tables and wheelchairs). However, facility managers stated that the bedside tables and damaged wheelchairs had not been replaced due to work order priorities within the facility.[75]

## Recommendation 3

3. The associate director confirms that facility managers replace or remove damaged furnishings and wheelchairs from service and monitors compliance.

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[73] TJC. Infection Control standard IC.02.02.01; Environment of Care standard EC.02.06.01.

[74] Main lobby/atrium, primary care clinic waiting area, and corridor outside of mental health unit.

[75] Acting chief, Engineering Services; chief, Environmental Management Services; infection preventionist.

Facility concurred.

Target date for completion: September 2019

Facility response:

Wheelchairs: A workgroup inventoried and evaluated all facility wheelchairs. New wheelchairs were ordered and all wheelchairs in the facility have been replaced with new wheelchairs. The facility has created a process for maintenance, cleaning, and repairs. This process has been communicated to staff. This was completed in August 2019.

CLC bedside tables: CLC Leadership worked with Logistics, Interior Designer and Facility Planner to order 58 new bedside tables. The old bedside tables were removed, and the new ones were placed into service in September 2019.

The Associate Director ensures continuous, on-going monitoring of the condition of facility's furnishing and equipment through Environment of Care (EOC) Rounds Team inspections. The EOC Rounds team performs these inspections bi-annually in all clinical areas and annually in non-clinical areas. In March 2019 the following was added to the checklist for specific evaluation of facility wheelchairs, "Are wheelchairs clean and fabric/cushions surfaces intact? Are there any visible signs of defects or other mechanical issues not being addressed?" The Associate Director ensures that EOC Rounds data is reviewed for trends by the EOC Committee monthly. The facility will demonstrate ongoing reporting and review of this data for trends with furnishings and wheelchairs at EOC Committee for 6 months.

## 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.[76] 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.[77]

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.[78]

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;[79] 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[80]
- Requirements for controlled substances inspectors

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

[77] 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.

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

[79] The two quarters were from July 1, 2018, through December 31, 2018.

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

- o No conflicts of interest

- o Appointed in writing by the director for a term not to exceed three years

- o Hiatus of one year between any reappointment

- o Completion of required annual competency assessment

- Controlled substances area inspections

  - o Completion of monthly inspections

  - o Rotations of controlled substances inspectors

  - o Patterns of inspections

  - o Completion of inspections on day initiated

  - o Reconciliation of dispensing between pharmacy and each dispensing area

  - o Verification of controlled substances orders

  - o Performance of routine controlled substances inspections

- Pharmacy inspections

  - o Monthly physical counts of the controlled substances in the pharmacy

  - o Completion of inspections on day initiated

  - o Security and verification of drugs held for destruction[81]

  - o Accountability for all prescription pads in pharmacy

  - o Verification of hard copy controlled substances prescriptions

  - o Verification of twice a week (three days apart) inventories of the main vault[82]

  - o Quarterly inspections of emergency drugs

  - o Monthly checks of locks and verification of lock numbers

- Facility review of override reports[83]

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[81] 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."

[82] VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (This handbook was rescinded on May 1, 2019, and replaced by VHA Directive 1108.01, *Controlled Substances Management*.)

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

## Medication Management Conclusion

The OIG found general compliance with requirements for most of the performance indicators evaluated, including the controlled substances coordinator reports, pharmacy operations, requirements for controlled substances inspectors, and pharmacy inspections. However, the OIG identified noncompliance with the verification of controlled substances orders.

VHA requires that controlled substance inspectors must "verify [that] there is a hard copy order (electronic or written) in the patient's medical record, there is documentation of administration, and documentation of two signatures for any wasting of partial doses for five randomly selected dispensing activities" on a monthly basis.[84]

The OIG noted that during July to December 2018, 4 of 10 areas lacked evidence of verification of written or electronic controlled substances orders. Failure to verify orders may cause delays in identifying any potential drug diversion activities. The controlled substance coordinator was newly assigned to the position in October 2018 and was unaware that verification of controlled substances orders was required.

## Recommendation 4

4. The facility director makes certain that the controlled substances inspectors and coordinator carry out all required responsibilities for the verification of controlled substance orders and monitors inspectors' compliance.

> Facility concurred.
>
> Target date for completion: November 2019
>
> Facility response: The new Controlled Substance Coordinator created new forms for Controlled Substance Inspectors to utilize that include all required inspection elements. All inspectors have been educated on new process and importance of completing every field. Forms will be sent back to inspectors if not fully completed.
>
> The Controlled Substance Coordinator will ensure 100% compliance for 6 months through monthly audits. Audits are reported quarterly to QSV Council.

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[84] VHA Directive 1108.02(1).

## 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."[85] 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.[86]

VHA requires that the facility director designates 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.[87] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[88]

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.[89] Those who screen positive must have access to appropriate MST-related care.[90] 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.[91]

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.[92] All mental health and primary care providers must complete MST mandatory

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

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

[87] VHA Directive 1115.

[88] 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.)

[89] 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."

[90] VHA Directive 1115.

[91] VHA Handbook 1160.01.

[92] 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.[93]

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

    o Establishes and monitors MST-related staff training

    o Establishes and monitors informational outreach

    o Communicates MST-related issues, services, and initiatives with local leaders

- Evidence of tracking MST-related data

- Provision of clinical care

    o Referral for MST-related care to patients with positive MST screens

    o Initial evaluation within 24 hours of referral for mental health services

    o 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. A concern was noted, however, with providers completing 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 than 90 days after entering their position.[94] The OIG found that 3 of 11 providers hired after July

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[93] 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.

[94] VHA Directive 1115.01; 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.

1, 2012, did not complete training within 90 days. This could potentially prevent clinicians from providing appropriate counseling, care, and service to veterans who experienced MST. The mental health director cited an ineffective monitoring process as the reason for noncompliance.

## Recommendation 5

5. The chief of staff confirms that providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: December 2019

Facility response: All new Primary Care and Mental Health employees are automatically assigned per T&L coded in HRSmart to complete the mandatory training. All new staff are emailed by the MST Coordinator introducing services and informing them of the required TMS training to be completed within 90 days of start date by all Mental Health and Primary Care staff. Monthly TMS training reports are generated and forwarded to MST coordinator to monitor completions/deficiencies on an ongoing basis. The MST Coordinator emails individuals and/or their supervisors if they have not completed the training.

The Chief of Staff will ensure continuous monitoring of compliance of completion of MST training within 90 days of start date through monthly progress reports provided to the Medical Executive Committee by the MST Coordinator. This will be monitored until at least 90% compliance is met for 6 consecutive months.

# 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."[95] 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.[96]

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."[97]

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.[98] 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."[99] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[100] 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.[101] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[95] 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.)

[96] *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.)

[97] 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.)

[98] 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.)

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

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

[101] 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.[102]

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.[103] 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 found compliance with providers justifying the reason for medication initiation and medication reconciliation. However, the OIG identified inadequate patient and/or caregiver education about the safe and effective use of newly prescribed medications that warranted a recommendation for improvement.

TJC requires that clinicians educate patients and families about safe and effective use of medications and that the patient's medical record contains information that reflects the patient's care, treatment, and services.[104] The OIG estimated that clinicians provided this education in 25 percent of the patients at the facility, based on electronic health records reviewed.[105] Providing medication education is critical to ensuring that patients or their caregivers have the information they need to successfully engage in their healthcare decisions.[106] Program managers stated that clinicians documented medication education; however, they acknowledged that the education was not specific to the prescribed medication as required. The chief of Primary Care cited a lack of attention to detail as the reason for noncompliance.

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

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

[104] TJC. Provision of Care standard PC.02.03.01 and Record of Care, Treatment, and Services standard RC.02.01.01.

[105] The OIG is 95 percent confident that the true compliance rate is somewhere between 11.5 and 40.1 percent, which is statistically significantly below the 90 percent benchmark.

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

## Recommendation 6

6. The chief of staff makes certain that clinicians provide and document patient and/or caregivers education about the safe and effective use of newly prescribed medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: November 2019

Facility response: The Chief of Pharmacy worked with the Clinical Applications Coordinators (CACs) to develop an ordering dialogue template that restricts ordering of these seven medications. The ordering template includes a return to clinic order to facilitate follow-up within 30 days. The template includes documentation of risks, benefits, potential side effects, precautions, and drug-drug interactions and a Pharmacy education chart on medications is imbedded for provider to review. The template also includes documentation demonstrating patient/caregiver has demonstrated understanding to education. Education to providers and pharmacy regarding the new ordering template was completed and the new template was implemented in May 2019.

Pharmacy will perform audits of 30-day follow-up and required documentation until 90% or greater compliance is achieved for 6 consecutive months.

## 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.[107] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[108] 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.[109] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[110]

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.[111]

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 leaders 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.[112]

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

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[107] 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.)

[108] 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.)

[109] 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.)

[110] 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.)

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

[112] 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.[113]

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 nine 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 veterans program manager

- Appointment of a women's health medical director or clinical champion

- Facility Women Veterans Health Committee

  o Core membership

  o Quarterly meetings

  o Reports to clinical executive leaders

- Collection and tracking of cervical cancer screening data

  o Notification of patients due for screening

  o Completed screenings

  o Results reporting

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

VHA requires that the core membership of the Women Veterans Health Committee includes a women veterans program manager; a women's health medical director, "representatives from

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[113] VHA Directive 1330.01(2).

primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership."[114]

For October 2018 and January 2019 quarterly minutes, the committee lacked consistent representation from the women's health medical director, pharmacy, and radiology. This resulted in a lack of expertise in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans. The women veterans program manager acknowledged the requirements for representation and stated that lack of attendance was due to scheduling conflicts and patient care priorities.

## Recommendation 7

7. The facility director ensures the Women Veterans Health Committee is comprised of the required core members and monitors committee's compliance.

Facility concurred.

Target date for completion: July 2020

Facility response: The Women Veterans Advisory Committee charter has been rewritten to ensure compliance with required core membership. Core membership attendance will be tracked and reported to MEC by the Women Veteran Program Manager through quarterly reports until 90% compliance is maintained for 4 quarters.

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[114] VHA Directive 1330.01(2).

## 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."[115] 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.[116]

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."[117]

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 emergency department or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care."[118]

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement 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.[119]

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

[116] VHA Directive 1101.05(2).

[117] VHA Directive 1101.05(2).

[118] TJC. Leadership standard LD.04.03.11.

[119] 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.[120] Managers must ensure medications are securely stored,[121] a psychiatric intervention room is available,[122] 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.[123]

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 departments/UCC
  - Access during regular hours, off hours, weekends, and holidays
  - On-call list for staff required to respond

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[120] VHA Directive 1101.05(2).

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

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

[123] VHA Directive 1101.05(2).

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- - Licensed independent mental health provider available as required for the facility's complexity level
  - 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[124]
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency departments 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

The facility generally complied with many of the performance indicators used to assess the operations and management of emergency departments. However, the OIG identified a concern in the emergency department staffing that warranted a recommendation for improvement.

VHA requires that VA emergency departments have appropriately educated and qualified emergency care professionals physically present in the emergency department during all hours of operation. This includes a licensed physician and a minimum of two registered nurses.[125] The OIG reviewed staffing schedules for a 90-day period and identified only one registered nurse on

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

[125] VHA Directive 1101.05(2).

duty during the overnight hours of 11:00 p.m. to 8:00 a.m. This could result in potentially unsafe situations in the emergency department when a single registered nurse may need to provide urgent care to multiple patients. The Emergency Department Director cited a staffing shortage as the reason for the lack of coverage as required.

## Recommendation 8

8. The facility director makes certain that the emergency department is staffed with a minimum of two registered nurses during all hours of operation and monitors compliance.

Facility concurred.

Target date for completion: September 2019

Facility response: As of September 2019, the emergency department has been staffed with a minimum of two registered nurses during all hours of operation. The staffing methodology calculator is being used to evaluate that the FTEE allocated to the emergency department is adequate to always staff two registered nurses. The recommendations from the staffing methodology calculator are reported to facility panel and senior leadership for evaluation. The Off-Tour Coordinator Nurse is utilized as an emergent back-up for ED staffing during evenings and weekends. Additionally, options for a facility nurse float pool are being considered.

Emergency department certified schedules are monitored daily by the Emergency Department Nurse Manager and Associate Chief of Nursing to ensure staffing needs are met. The Emergency Department Nurse Manager will ensure 100% compliance for 6 months through monthly audits of certified schedule.

# 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 <br> • Employee satisfaction <br> • Patient experience <br> • Accreditation and/or for-cause surveys and oversight inspections <br> • Factors related to possible lapses in care <br> • VHA performance data | Eight 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, associate 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 <br> • UM reviews <br> • Patient safety <br> • Resuscitation episode review | • None | • All required representatives consistently participate in interdisciplinary reviews of UM data. |
| Medical Staff Privileging | • Privileging <br> • FPPEs <br> • OPPEs <br> • FPPEs for cause <br> • Reporting of privileging actions to National Practitioner Data Bank | • None | • Service chiefs include the minimum required specialty-specific criteria for FPPEs of nuclear medicine practitioners. |

| Healthcare Processes | Performance Indicators | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|---|---|
| Environment of Care | • Parent facility<br>  ○ General safety<br>  ○ Environmental cleanliness and infection prevention<br>  ○ General privacy<br>  ○ Women veterans program<br>  ○ Availability of medical equipment and supplies<br><br>• Community based outpatient clinic<br>  ○ General safety<br>  ○ Environmental cleanliness and infection prevention<br>  ○ General privacy<br>  ○ Women veterans program<br>  ○ Availability of medical equipment and supplies<br>• Locked inpatient mental health unit<br>  ○ Mental health environment of care rounds<br>  ○ Nursing station security<br>  ○ Public area and general unit safety<br>  ○ Patient room safety<br>  ○ Infection prevention<br>  ○ Availability of medical equipment and supplies<br>• Emergency management<br>  ○ Hazard vulnerability analysis (HVA)<br>  ○ Emergency operations plan (EOP)<br>  ○ Emergency power testing and availability | • None | • Facility managers replace or remove damaged furnishings and wheelchairs from service. |

| Healthcare Processes | Performance Indicators | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|---|---|
| Medication Management: Controlled Substances Inspections | • Controlled substances Coordinator reports<br>• Pharmacy operations<br>• Controlled substances inspector requirements<br>• Controlled substances area inspections<br>• Pharmacy inspections<br>• Facility review of override reports | • None | • Controlled substances inspectors and coordinator carry out all required responsibilities for the verification of controlled substance orders. |
| Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training | • Designated facility MST coordinator<br>• Evidence of tracking MST-related data<br>• Provision of clinical care<br>• Completion of MST mandatory training requirement for mental health and primary care providers | • None | • Providers complete MST mandatory training within the required time frame. |
| Geriatric Care: Antidepressant Use among the Elderly | • Justification for medication initiation<br>• Evidence of patient and/or caregiver education specific to the medication prescribed<br>• Clinician evaluation of patient and/or caregiver understanding of the education provided<br>• Medication reconciliation | • None | • Clinicians provide and document patient and/or caregiver education about the safe and effective use of newly prescribed medications. |
| Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up | • Appointment of a women veterans program manager<br>• Appointment of a women's health medical director or clinical champion<br>• Facility Women Veterans Health Committee<br>• Collection and tracking of cervical cancer screening data | • None | • The Women Veterans Health Committee is comprised of the required core members. |

| Healthcare Processes | Performance Indicators | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|---|---|
| | • Communication of abnormal results to patients within required time frame<br><br>• Provision of follow-up care for abnormal cervical pathology results, if indicated | | |
| High-Risk Processes: Operations and Management of Emergency Departments \ and UCCs | • General<br><br>• Staffing for emergency department /UCC<br><br>• Support services for emergency department /UCC<br><br>• Patient flow<br><br>• General safety<br><br>• Medication security and labeling<br><br>• Management of patients with mental health disorders<br><br>• Emergency department participation in local/regional EMS system<br><br>• Women veteran services<br><br>• Life support equipment | • The emergency department is staffed with a minimum of two registered nurses during all hours of operation. | • None |

# Appendix B: Facility Profile and VA Outpatient Clinic Profiles

## Facility Profile

The table below provides general background information for this medium complexity (2) affiliated[126] facility reporting to VISN 23.[127]

**Table B.1. Facility Profile for Sioux Falls VA Health Care System (438) (October 1, 2015, through September 30, 2018)**

| Profile Element | Facility Data FY 2016[128] | Facility Data FY 2017[129] | Facility Data FY 2018[130] |
|---|---|---|---|
| Total medical care budget in dollars | $187,885,280 | $202,605,989 | $229,132,063 |
| Number of: | | | |
| • Unique patients | 27,536 | 27,601 | 27,541 |
| • Outpatient visits | 298,297 | 301,218 | 301,311 |
| • Unique employees[131] | 950 | 930 | 928 |
| Type and number of operating beds: | | | |
| • Community living center | 58 | 58 | 58 |
| • Medicine | 19 | 19 | 19 |
| • Mental health | 6 | 6 | 6 |
| • Surgery | 3 | 3 | 3 |
| Average daily census: | | | |
| • Community living center | 56 | 56 | 57 |
| • Medicine | 12 | 11 | 13 |
| • Mental health | 5 | 4 | 4 |
| • Surgery | 4 | 3 | 3 |

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

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[126] Associated with a medical residency program.

[127] The VHA medical centers are classified according to a facility complexity model; a designation of "2" indicates a facility with "medium volume, low-risk patients, few complex clinical programs, and small or no research and teaching programs."

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

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

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

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

## VA Outpatient Clinic Profiles[132]

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)[133]**

| Location | Station No. | Primary Care Workload/ Encounters | Mental Health Workload/ Encounters | Specialty Care Services[134] Provided | Diagnostic Services[135] Provided | Ancillary Services[136] Provided |
|---|---|---|---|---|---|---|
| Aberdeen, SD | 438GD | 5,346 | 1,080 | Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious disease Nephrology Neurology | n/a | Pharmacy Weight management Nutrition |

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

[133] 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."

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

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

[136] 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[134] Provided | Diagnostic Services[135] Provided | Ancillary Services[136] Provided |
|---|---|---|---|---|---|---|
| Aberdeen, SD (continued) | | | | Pulmonary/ Respiratory disease<br>Rheumatology<br>Anesthesia<br>Eye<br>General surgery<br>Orthopedics<br>Vascular | | |
| Sioux City, IA | 438GC | 10,703 | 1,217 | Cardiology<br>Dermatology<br>Endocrinology<br>Gastroenterology<br>Hematology/ Oncology<br>Infectious disease<br>Nephrology<br>Neurology<br>Pulmonary/ Respiratory disease<br>Anesthesia<br>General surgery<br>Orthopedics<br>Vascular | n/a | Pharmacy<br>Weight management<br>Nutrition |

| Location | Station No. | Primary Care Workload/ Encounters | Mental Health Workload/ Encounters | Specialty Care Services[134] Provided | Diagnostic Services[135] Provided | Ancillary Services[136] Provided |
|---|---|---|---|---|---|---|
| Spirit Lake, IA | 438GA | 5,962 | 922 | Cardiology Dermatology Endocrinology Hematology/ Oncology Infectious disease Nephrology Neurology Pulmonary/ Respiratory disease Anesthesia General surgery Orthopedics Vascular | n/a | Pharmacy Weight management Nutrition |
| Wagner, SD | 438GE | 1,414 | 64 | Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Nephrology Neurology Pulmonary/ Respiratory disease Anesthesia Orthopedics | n/a | Weight management Nutrition |

| Location | Station No. | Primary Care Workload/ Encounters | Mental Health Workload/ Encounters | Specialty Care Services[134] Provided | Diagnostic Services[135] Provided | Ancillary Services[136] Provided |
|---|---|---|---|---|---|---|
| Watertown, SD | 438GF | 4,448 | 1,550 | Cardiology<br>Dermatology<br>Endocrinology<br>Hematology/ Oncology<br>Infectious disease<br>Nephrology<br>Neurology<br>Pulmonary/ Respiratory disease<br>Anesthesia<br>Eye<br>General surgery<br>Orthopedics<br>Vascular | n/a | Nutrition<br>Pharmacy<br>Weight management |

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

# Appendix C: Patient Aligned Care Team Compass Metrics[137]

## Quarterly New Primary Care Patient Average Wait Time in Days

| | VHA Total | (438) Sioux Falls, SD (Royal C. Johnson) | (438GA) Spirit Lake, IA | (438GC) Sioux City, IA | (438GD) Aberdeen, SD | (438GE) Wagner, SD | (438GF) Watertown, SD |
|---|---|---|---|---|---|---|---|
| JAN-FY18 | 8.2 | 5.4 | 1.0 | 1.5 | 0.0 | 33.0 | 3.0 |
| FEB-FY18 | 7.5 | 1.2 | 0.3 | 2.7 | 0.0 | 14.2 | 2.9 |
| MAR-FY18 | 8.6 | 2.0 | 0.4 | 3.4 | 4.0 | 17.5 | 4.9 |
| APR-FY18 | 7.9 | 1.4 | 0.1 | 3.6 | 2.9 | 7.2 | 1.3 |
| MAY-FY18 | 7.7 | 0.7 | 3.5 | 0.7 | 4.6 | 12.0 | 2.0 |
| JUN-FY18 | 7.6 | 1.4 | 3.8 | 0.8 | 1.4 | 9.7 | 3.5 |
| JUL-FY18 | 7.5 | 1.6 | 1.2 | 1.8 | 1.5 | 0.0 | 0.7 |
| AUG-FY18 | 7.7 | 0.8 | 1.5 | 1.5 | 0.1 | 2.5 | 0.2 |
| SEP-FY18 | 8.5 | 0.5 | 3.3 | 2.4 | 1.9 | 0.5 | 0.9 |
| OCT-FY19 | 8.0 | 0.5 | 0.5 | 0.9 | 0.0 | 16.0 | 2.9 |
| NOV-FY19 | 8.5 | 1.1 | 1.0 | 4.0 | 2.3 | 10.0 | 4.9 |
| DEC-FY19 | 8.6 | 1.1 | 0.0 | 1.6 | 5.9 | 1.0 | 5.3 |

*Source: VHA Support Service Center*

*Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the facility's explanation for the increased wait times for the (438GE) Wagner, SD, VA Clinic.*

*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."*

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

## Quarterly Established Primary Care Patient Average Wait Time in Days

| | VHA Total | (438) Sioux Falls, SD (Royal C. Johnson) | (438GA) Spirit Lake, IA | (438GC) Sioux City, IA | (438GD) Aberdeen, SD | (438GE) Wagner, SD | (438GF) Watertown, SD |
|---|---|---|---|---|---|---|---|
| JAN-FY18 | 4.4 | 3.1 | 1.2 | 1.4 | 2.8 | 10.6 | 1.0 |
| FEB-FY18 | 4.0 | 2.7 | 3.3 | 2.0 | 2.3 | 8.4 | 1.2 |
| MAR-FY18 | 4.2 | 3.1 | 3.7 | 1.2 | 3.9 | 9.1 | 0.9 |
| APR-FY18 | 4.3 | 3.1 | 4.0 | 1.2 | 3.3 | 5.8 | 1.0 |
| MAY-FY18 | 4.3 | 3.7 | 3.5 | 1.3 | 3.2 | 4.9 | 1.5 |
| JUN-FY18 | 4.4 | 4.6 | 4.2 | 1.4 | 2.4 | 4.4 | 2.3 |
| JUL-FY18 | 4.7 | 4.9 | 4.6 | 1.7 | 4.4 | 3.4 | 1.1 |
| AUG-FY18 | 4.6 | 3.5 | 17.7 | 1.6 | 5.4 | 2.9 | 1.0 |
| SEP-FY18 | 4.4 | 3.2 | 4.9 | 1.5 | 5.6 | 3.9 | 1.5 |
| OCT-FY19 | 4.0 | 2.8 | 3.5 | 1.1 | 3.9 | 2.3 | 1.1 |
| NOV-FY19 | 4.4 | 4.1 | 6.3 | 1.9 | 5.8 | 4.0 | 1.9 |
| DEC-FY19 | 4.4 | 8.2 | 3.5 | 1.3 | 7.1 | 3.8 | 1.6 |

*Source: VHA Support Service Center*

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

*Data Definition: "The average number of calendar days between 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[138]

| 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 |

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[138] 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[139]

| 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. |

[139] *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 to the public.)

# Appendix F: VISN Director Comments

## Department of Veterans Affairs Memorandum

Date: October 23, 2019

From: Director, VA Midwest Health Care Network (10N23)

Subj: Comprehensive Healthcare Inspection of the Sioux Falls VA Health Care System, SD

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

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

I have reviewed and concur with the findings and recommendations in the report of the Comprehensive Healthcare Inspection Review.

Corrective action plans have been established with planned completion dates.

*(Original signed by:)*

Robert P. McDivitt, FACHE

*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: Acting Facility Director Comments

## Department of Veterans Affairs Memorandum

Date: October 17, 2019

From: Acting Director, Sioux Falls VA Health Care System (438/00)

Subj: Comprehensive Healthcare Inspection of the Sioux Falls VA Health Care System, SD

To: Director, VA Midwest Health Care Network (10N23)

1. The purpose of this memorandum is to provide facility concurrence with the 8 recommendations in the draft report of the Comprehensive Healthcare Inspection Program (CHIP) review of the Sioux Falls VA Healthcare System.

2. The facility's responses for each recommendation are provided.

*(Original signed by:)*

Timothy L. Pendergrass, MD
Acting Director

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

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# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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