DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Canandaigua VA Medical Center

New York

CHIP REPORT | REPORT #19-00037-58 | JANUARY 9, 2020

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Figure 1. *Canandaigua VA Medical Center, NY (Source: https://vaww.va.gov/directory/guide/, accessed on September 18, 2019)*

Abbreviations

ADPNS	associate director for Patient and Nursing 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
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Canandaigua VA Medical Center (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 inspections 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 inspection, 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[1] (specifically the emergency department and urgent care center operations and management).

This unannounced visit was conducted during the week of May 13, 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

[1] The OIG's review of the emergency department and urgent care center (UCC) operations and management focused on the clinical risks of the emergency department /UCC areas. This review was not performed at the Canandaigua VA Medical Center because the facility did not have an emergency department or UCC.

other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, chief of staff, associate director for Patient and Nursing Services (ADPNS), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure, with the Finger Lakes Leadership Council having oversight for several working groups. The Quality, Safety, Value Committee was responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes. However, the OIG noted that the director did not chair or co-chair this committee.

The facility's leadership team had been working together for seven months, although several had served in their position for years. The director had served in an interim capacity for seven months before being permanently assigned on May 12, 2019, the day before the OIG inspection.

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. The two patient experience survey scores applicable to the facility were 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,[2] and disclosures of adverse patient events and did not identify any substantial organizational risk factors. However, the OIG noted continuing leadership and operational challenges with the facility's integration with the Bath VA Medical Center to form the VA Finger Lakes Healthcare System. Despite this, facility leaders were optimistic that given enough time, the merit and opportunities for veterans and staff from this merger will become evident.

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

[2] 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."

and differences between the top and bottom performers" within VHA.[3] Although the leadership team members, except for the associate director, were knowledgeable within their areas of responsibility about selected SAIL metrics and SAIL community living center (CLC) measures, the leaders should continue to take actions to improve and sustain performance of the quality of care metrics and measures likely contributing to the facility's SAIL "4-star" and CLC "5-star" quality ratings.[4]

The OIG noted deficiencies in five of the seven clinical areas reviewed and issued 14 recommendations that are attributable to the director, chief of staff, and associate director. These are briefly described below.

Environment of Care

The facility generally met safety, privacy, women veterans program, and emergency management requirements. The OIG team did not note any issues with the availability of medical equipment and supplies. However, the OIG team identified noncompliance with cleanliness and infection prevention at the parent facility and Rochester VA Clinic and with panic alarm testing and patient privacy at the Rochester VA Clinic.

Medication Management

The facility complied with requirements for most of the performance indicators evaluated for medication management, including the controlled substances coordinator reports, pharmacy operations, requirements for controlled substances inspectors, and review of override reports. However, the OIG identified noncompliance with the monthly controlled substances area and pharmacy inspections.

Mental Health

The facility also 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. However, the inspection team identified noncompliance with establishing and monitoring MST-related staff training, communicating MST-related issues with local leaders, and providers completing MST mandatory training.

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[3] 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.)

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

Geriatric Care

For geriatric patients, clinicians documented reasons for prescribing medications. However, the OIG team identified inadequate patient and/or caregiver education specific to newly prescribed medications, evaluation of patient and/or caregiver understanding when education was provided, and medication reconciliation processes.

Women's Health

The OIG also noted the facility performed adequately on indicators related to women's health, including requirements for a designated women veterans program manager and clinical champion, tracking data related to cervical cancer screenings, communication of results to patients within the required time frame, and follow-up care when indicated. However, the Women Veterans Advisory Committee membership lacked representation from radiology, laboratory, and business office/non-VA medical care; and core members did not consistently attend committee meetings.

Summary

In reviewing key healthcare processes, the OIG issued 14 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 facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 65–66, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendations 6, 7, and 8 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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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 Canandaigua VA Medical Center (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

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

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility: [7]

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

[5] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (The website was accessed on January 24, 2019.)

[6] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (The website was accessed on January 24, 2019.)

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

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

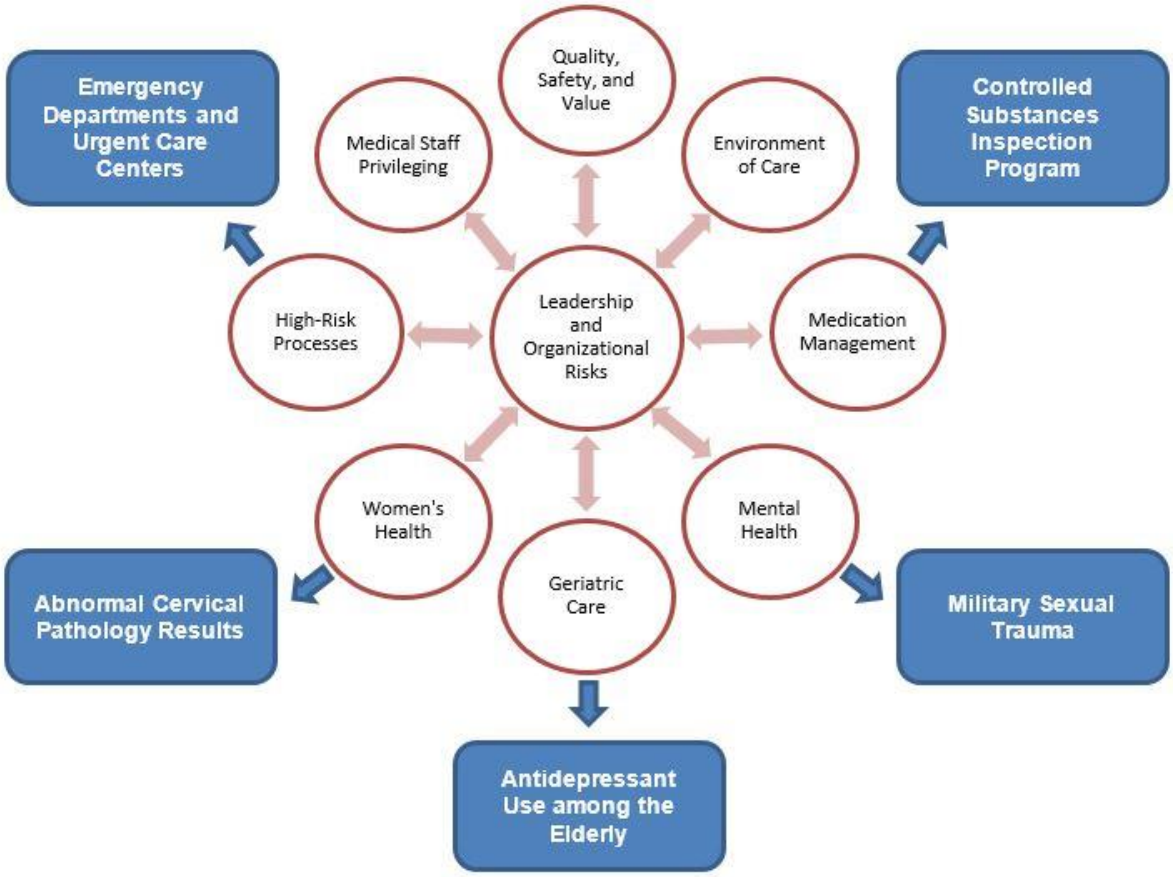

Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

Methodology

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

The inspection period examined operations from October 22, 2016, through May 17, 2019, the last day of the unannounced week-long site visit.[9] While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

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

The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reports and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.[10] To assess the facility's risks, the OIG considered the following indicators:

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

Executive Leadership Position Stability and Engagement

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

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

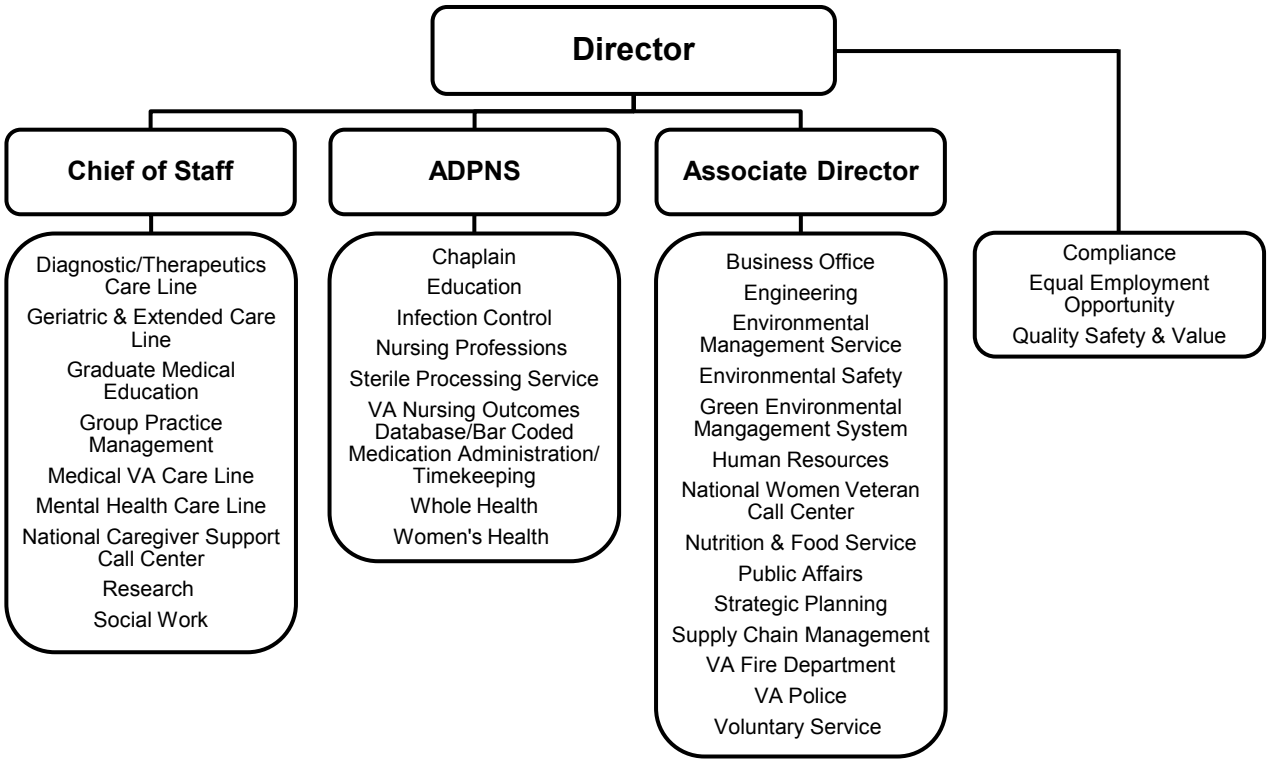

Figure 3. *Facility Organizational Chart*[11]
Source: Canandaigua VA Medical Center (received May 13, 2019)

At the time of the OIG site visit, the executive team had been working together for seven months, although several team members have been in their positions for over two years. It is important to note that the facility director served as interim director for seven months before being permanently assigned the day before the OIG site visit (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	September 2018 (interim) and May 12, 2019 (permanent)
Chief of staff	April 16, 2017
Associate director for Patient and Nursing Services	November 2, 2014
Associate director	June 30, 2013

Source: Canandaigua VA Medical Center human resources officer (received May 13, 2019)

[11] At this facility, the director is responsible for Compliance, Equal Employment Opportunity, and Quality Safety and Value.

To help assess facility executive leaders' engagement, the OIG interviewed the director, chief of staff, ADPNS, and associate director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance. In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders, except for the associate director, were generally knowledgeable within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL community living center (CLC) measures. These are discussed in greater detail below.

The director serves as the chair of the Finger Lakes Leadership Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Finger Lakes Leadership Council oversees various working groups, such as the Executive Committee of Medical Staff; Executive Committee of Nursing Staff; and Resource Board.

These leaders are also engaged in monitoring patient safety and care through the Quality, Safety, Value Committee. The OIG noted that executive leaders attended meetings; however, there was no evidence in meeting minutes or the committee charter that the director chaired or co-chaired the committee. The Quality, Safety, Value committee is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes, and reports to the Finger Lakes Leadership Council. See Figure 4.

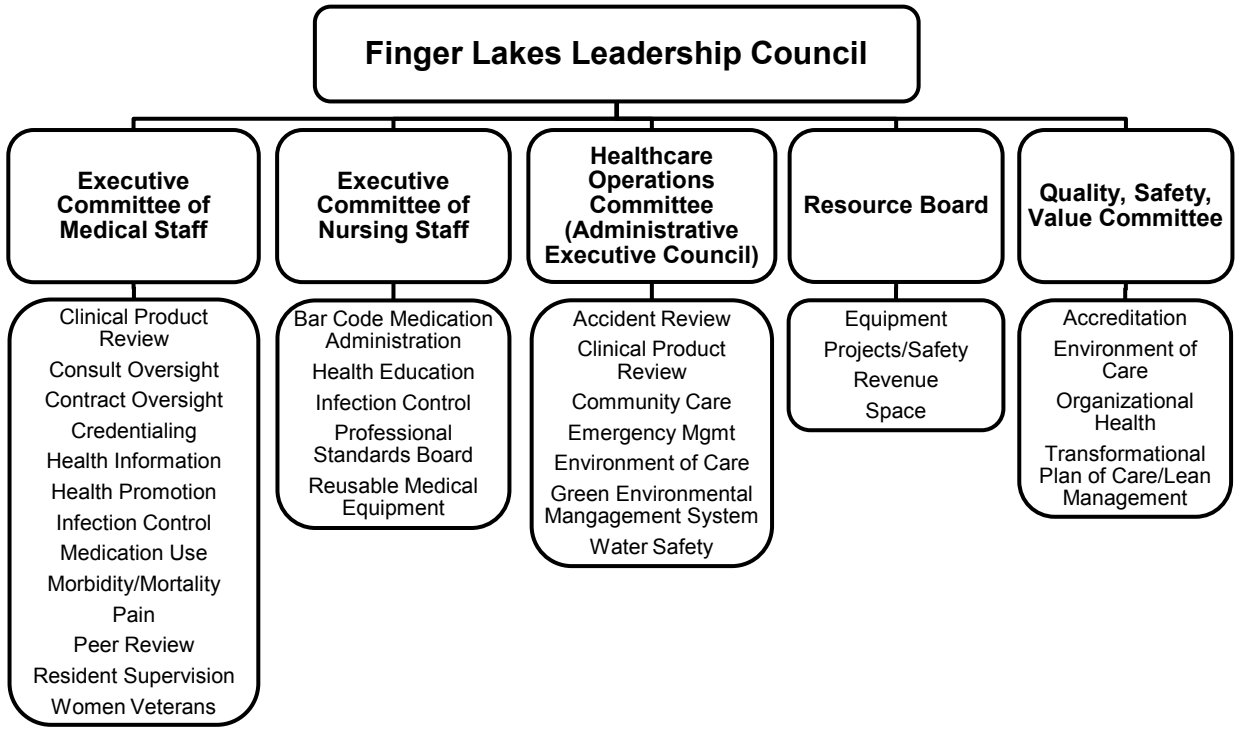

Figure 4. *Facility Committee Reporting Structure*
Source: Canandaigua VA Medical Center (received May 14, 2019)

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 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.[12] 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

[12] Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPNS, and associate director. It is important to note that the 2018 All Employee Survey results are not reflective of employee satisfaction with the current facility director.

for the selected survey leadership questions was generally similar to the VHA average.[13] The results for the members of the executive leadership team were consistently higher than the facility and VHA averages, except those for the director.[14] 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	ADPNS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[15]	0–100 where HIGHER scores are more favorable	71.7	71.9	67.5	86	—[16]	83.5
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	3.3	3.0	4.2	4.0	3.9
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.5	3.3	4.4	4.4	3.8

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

[14] It is important to note that the 2018 All Employee Survey results are not reflective of employee satisfaction with the current facility director.

[15] According to the 2018 VA All Employee Survey Questions by Organizational Health Framework, the 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."

[16] Data were not available because there were not enough respondents for this selected survey leadership question.

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPNS Average	Assoc. Director Average
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.6	3.2	4.2	4.2	3.9

Source: VA All Employee Survey (accessed April 12, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility and executive leadership team averages for the selected survey questions were generally similar to or better than the VHA average, except for the question related to moral distress. 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	ADPNS 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	3.8	4.3	4.6	4.2	4.4
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	3.5	4.7	4.2	—[17]	3.8

[17] Data were not available because there were not enough respondents for this selected survey leadership question.

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPNS Average	Assoc. Director Average
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.5	1.5	2.5	1.8	1.0	1.6

Source: VA All Employee Survey (accessed April 12, 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 September 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.[18]

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to relevant survey questions that reflected patients' attitudes toward facility leaders (see Table 4). For this facility, the two applicable outpatient survey results reflected higher care ratings than VHA average. Patients seem generally satisfied with the leadership and care provided. Facility leaders appeared to be actively engaged with patients—for example, hiring additional specialty providers, implementing the "Own the Moment" initiative (a customer experience workshop allowing VA staff to connect with, understand, and guide veterans through the moments that matter in their VA journey), and continuing to empower patients with increased access to community care.

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

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?*[19]	The response average is the percent of "Definitely Yes" responses.	67.0	n/a
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	n/a
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	81.2
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.5	76.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28, 2018)
n/a = not applicable

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.[20] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint

[19] The facility does not have inpatient beds.

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

Commission (TJC).[21] Indicative of effective leadership, the facility has closed all recommendations for improvement.[22]

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

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 (*Clinical Assessment Program Review of the Canandaigua VA Medical Center, Canandaigua, New York,* Report No. 16-00575-147, March 27, 2017)	October 2016	8	0
TJC Ambulatory Health Care	May 2018	3	0
TJC Behavioral Health Care Accreditation		7	0
TJC Home Care Accreditation		4	0

Sources: OIG and TJC (Inspection/survey results verified with the accreditation manager and acting chief of Quality Management on May 13, 2019)

[21] 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."

[22] 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.

[23] 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.

[24] 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.)

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 October 22, 2016 (the prior comprehensive OIG inspection), through May 17, 2019.[25]

During the inspection, the OIG learned of ongoing challenges since the May 29, 2018, decision to integrate the Canandaigua facility with Bath VA Medical Center to create one consolidated system, the VA Finger Lakes Healthcare System. This integration resulted in multiple leadership and operational challenges, including increased employee frustrations consistent with the 2018 All Employee Survey comments. However, leaders appeared optimistic that, given sufficient time for the merger, staff will recognize the merit of the integration and the opportunities for veterans and staff.

[25] 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 Canandaigua VA Medical Center is a low complexity (3) affiliated facility as described in Appendix B.)

Table 6. Summary of Selected Organizational Risk Factors (October 22, 2016, through May 17, 2019)

Factor	Number of Occurrences
Sentinel Events[26]	0
Institutional Disclosures[27]	1
Large-Scale Disclosures[28]	0

Source: Canandaigua VA Medical Center's risk manager (received May 14, 2019)

Patient safety indicators, developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services, provide information on potential in-hospital complications and adverse events following surgeries and procedures.[29] These data are not applicable since acute inpatient care is not provided at the facility.

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.[30]

[26] 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."

[27] 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."

[28] 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."

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

[30] 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.)

VA also uses a star rating system where facilities with a "5-star" rating are performing within the top 10 percent of facilities and "1-star" facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.[31] As of June 30, 2018, the facility was rated as "4-star" for overall quality.

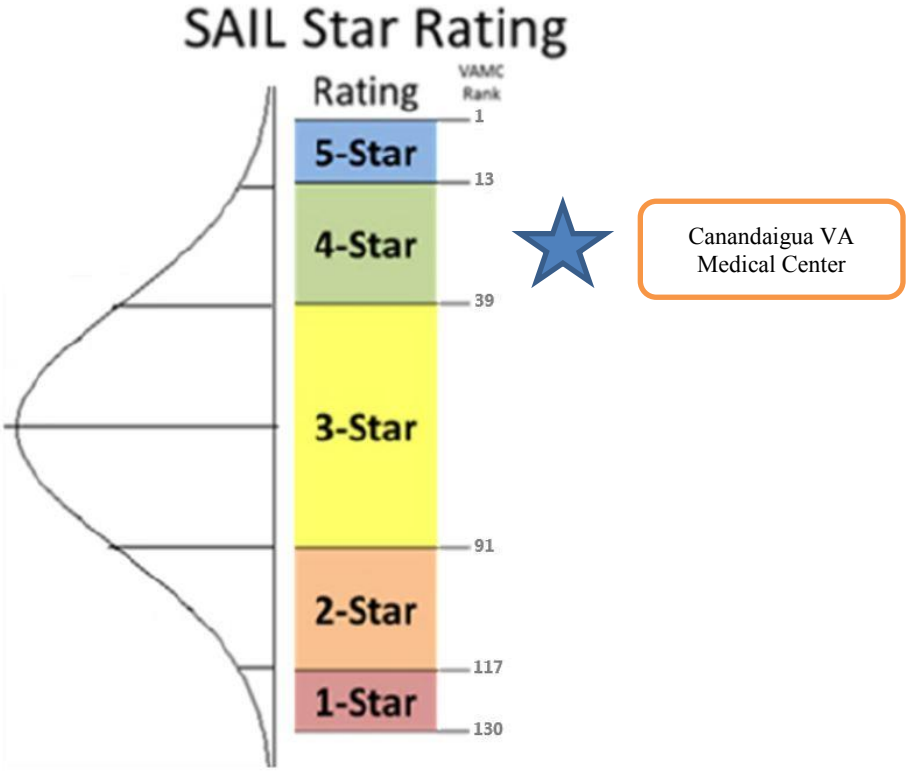

Figure 5. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed April 12, 2019)

Figure 6 illustrates the facility's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of mental health (MH) population (popu) coverage, MH experience (exp) of care, and patient-centered medical home (PCMH) same day appointment (appt)). Metrics that need improvement are denoted in orange and red (for example, best place to work, specialty care (SC) care coordination, and registered nurse (RN) turnover).[32]

[31] 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.

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

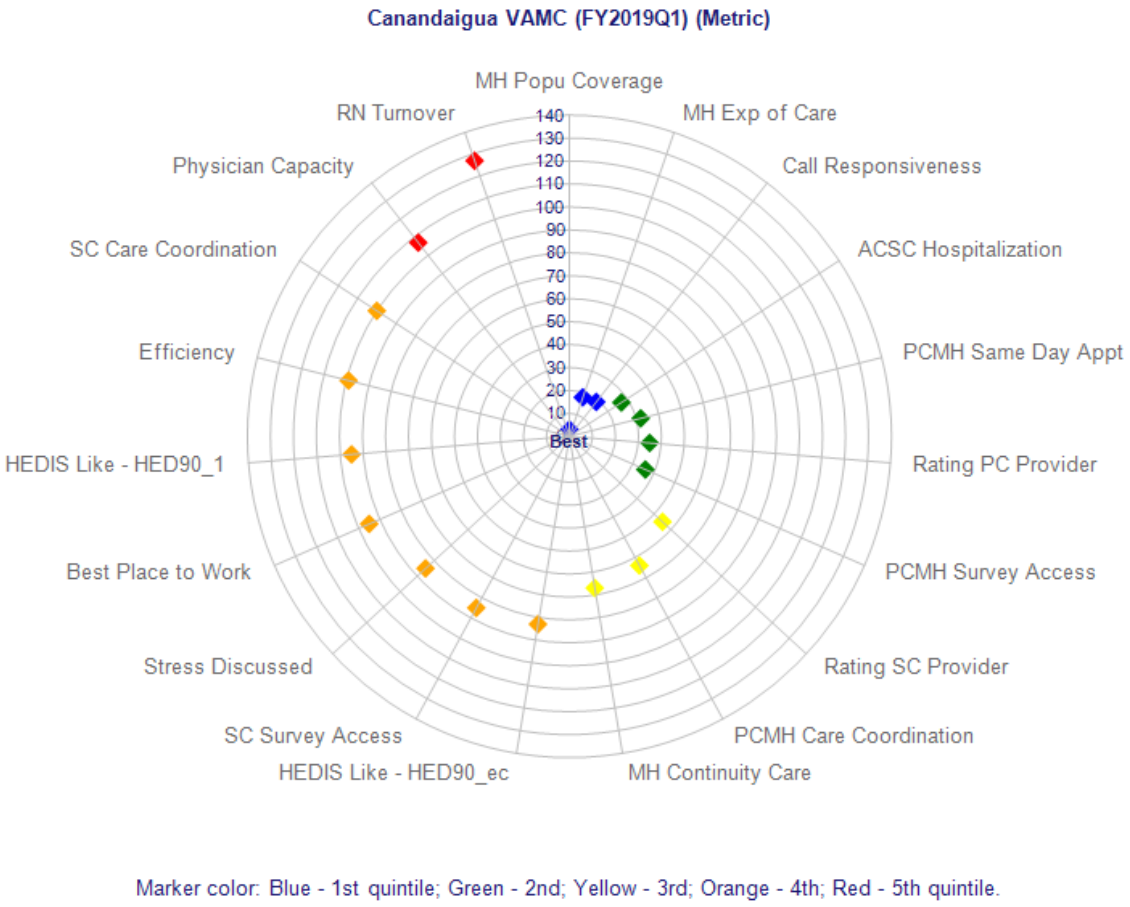

Figure 6. *Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). 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*.[33] The SAIL CLC provides a single resource to review quality measures and health inspection results. It

[33] 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.[34] Table 7 summarizes the rating results for the facility's CLC as of December 31, 2018. Although the facility has an overall "4-star" rating, its rating for quality is a "5-star."

Table 7. Facility CLC Star Ratings (as of December 31, 2018)

Domain	Star Rating
Unannounced Survey	2
Staffing	5
Quality	5
Overall	4

Source: VHA Support Service Center

In exploring the reasons for the "5-star" quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 7 illustrates the facility's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of physical restraints–long stay (LS), new or worse pressure ulcer (PU)–short stay (SS), and moderate-severe pain (SS)) and were likely the reasons why the facility had a "5-star" for quality. Metrics that need improvement are denoted in orange and red (for example, falls with major injury (LS), receive antipsychotic (antipsych) medications (meds) (LS), and improvement in function (SS)).[35]

[34] *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.)

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

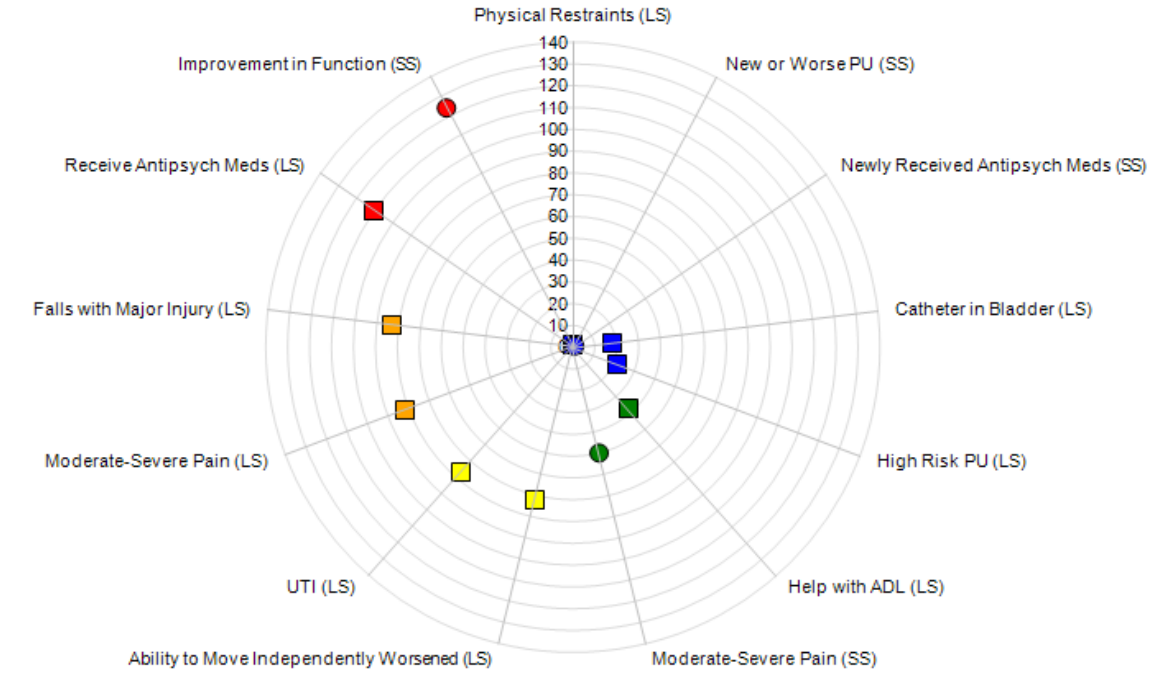

Figure 7. *Facility CLC Quality Measure Rankings (as of December 31, 2018)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

At the time of our review, all four executive leadership positions were permanently filled, and the leadership team had worked together for seven months. The facility director was relatively new to the position but had served as interim director for seven months before being permanently assigned on May 12, 2019, the day before the OIG site visit. In May 2018, VHA approved the integration of the Canandaigua and Bath VA Medical Centers to form the VA Finger Lakes Healthcare System. Facility leaders expressed transitional and operational challenges with the integration but were optimistic that, once enough time has elapsed, the merit of the merger will become evident. Although staff comments from the 2018 All Employee Survey expressed frustrations with the integration, selected survey scores related to employees' satisfaction with the facility executive leaders were generally better than VHA averages. In review of patient experience survey data, patients seemed satisfied with the leadership and care provided. The facility leaders appeared actively engaged with employees and patients and were working to sustain and further improve employee and patient engagement and satisfaction. The leaders also seemed 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, and disclosures did not identify any substantial organizational risk factors. Except for the associate director, the leadership team was knowledgeable within their scope of responsibility about selected SAIL and CLC metrics but should continue to take actions to improve and sustain performance of measures contributing to the SAIL "4-star" and CLC "5-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.[36] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[37] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[38]

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,[39] utilization management (UM) reviews,[40] patient safety incident reporting with related root cause analyses,[41] and cardiopulmonary resuscitation (CPR) episode reviews.[42]

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 nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[43]

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[36] 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.)

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

[38] VHA Directive 1026.

[39] 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.

[40] According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." This directive expired July 31, 2019.

[41] 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."

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

[43] VHA Directive 1190.

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.[44]

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.[45]

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.[46]

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:[47]

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

[44] VHA Directive 1117(2).

[45] VHA Handbook 1050.01.

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

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

  - Peer review of all applicable deaths within 24 hours of admission to the hospital
  - Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[48,49]
- UM[50]
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Annual completion of a minimum of eight root cause analyses[51]
  - Inclusion of required content in root cause analyses (generally)
  - Submission of completed root cause analyses to National Center for Patient Safety within 45 days
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report
- Resuscitation episode review
  - Evidence of a committee responsible for reviewing resuscitation episodes
  - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
  - Evidence of basic or advanced cardiac life support certification for code team responders
  - Evaluation of each resuscitation episode by the CPR Committee or equivalent

[48] The facility did not have an inpatient mental health unit.

[49] VHA Directive 1190.

[50] The facility does not provide inpatient care.

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

Quality, Safety, and Value Conclusion

Generally, the facility met requirements as reflected by the performance indicators above. The OIG team made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[52]

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.[53]

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."[54]

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.[55] 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.[56]

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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[52] 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.)

[53] VHA Handbook 1100.19.

[54] VHA Handbook 1100.19.

[55] 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).

[56] 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.)

- Seven 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[57]
- Three LIPs hired within 18 months before the site visit
- Fourteen LIPs re-privileged within 12 months before the visit
- No providers underwent a FPPE for cause within 12 months prior to the visit

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[58]
  - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
  - Criteria defined in advance
  - Use of required criteria in FPPEs for selected specialty LIPs
  - Results and time frames clearly documented
  - Evaluation by another provider with similar training and privileges
  - Executive Committee of the Medical Staff's consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
  - Criteria specific to the service or section
  - Use of required criteria in OPPEs for selected specialty LIPs

[57] The 18-month period was from November 1, 2017, through May 13, 2019. The 12-month review period covered May 14, 2018, through May 13, 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.

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

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

Medical Staff Privileging Conclusion

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

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.[59]

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.[60]

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.[61]

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.[62] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[63]

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

[60] 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).

[61] 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.)

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

[63] 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,[64] and National Fire Protection Association standards.[65] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[66]

In all, the OIG team inspected seven areas—the domiciliary, two CLC areas (8A and 8B), specialty clinic, behavioral health clinic, geriatric primary care clinic, and primary care clinic. The team also inspected the Rochester VA Clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Community based outpatient clinic
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Locked inpatient mental health unit[67]
  - Mental health environment of care rounds
  - Nursing station security
  - Public area and general unit safety

[64] 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.)

[65] 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.)

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

[67] The facility did not have an inpatient mental health unit.

  - Patient room safety
  - Infection prevention
  - Availability of medical equipment and supplies
- Emergency management
  - Hazard vulnerability analysis (HVA)
  - Emergency operations plan (EOP)
  - Emergency power testing and availability

Environment of Care Conclusion

The OIG noted compliance with safety, privacy, women veterans program, and emergency management requirements at the parent facility. The OIG team did not note any issues with the availability of medical equipment and supplies. However, the OIG identified noncompliance with cleanliness and infection prevention at the parent facility and at the Rochester VA Clinic. Additionally, the team noted deficiencies with panic alarm testing and patient privacy at the Rochester VA Clinic.

TJC requires hospitals to minimize the possibility of transmitting infections by ensuring that dirty and used equipment are stored separately from clean equipment.[68] The OIG inspectors found dirty and clean equipment stored together in three of seven patient care storage areas[69] at the parent facility and in the dental instrument drop-off room at the Rochester VA Clinic. This resulted in a lack of assurance of a clean and safe patient care environment that minimizes the spread of infection. The facility unit nurse managers and the Rochester VA Clinic operations manager were aware and attributed the noncompliance to employees not following proper storage procedures.

Recommendation 1

1. The associate director makes certain that managers store clean and dirty medical equipment separately and monitors managers' compliance.

[68] TJC. Environment of Care standards IC.02.02.01 and EC.02.06.01.

[69] Domiciliary, CLC 8A, and behavioral health clinic.

Facility concurred.

Target date for completion: May 2020

Facility response: In November 2019, a multidisciplinary workgroup convened to address discrepancies in clean and dirty storage. The workgroup identified alternative storage areas for specific items that were consistently stored improperly and provided education for staff working in those areas. The facility will initiate bi-weekly rounds in clinical areas to identify, correct, and remediate any improper storage of clean or dirty items; compliance will be recorded on an audit tool. The associate director will ensure compliance at 90 percent or greater for a minimum of six months, and results of the bi-weekly audit will be reported to the Environment of Care Committee.

VHA requires that the facility ensures appropriate physical security precautions and panic alarm equipment are implemented, used, and tested.[70] Facility staff stated that panic alarms at the Rochester VA Clinic are monitored by VA Police who provide immediate support to staff in the event of a disruptive patient event; however, from November 2018 through April 2019, the OIG team found no evidence of panic alarm testing. Absence of testing may result in a lack of assurance of a safe environment for patients, visitors, and staff. A VA Police Officer responsible for oversight and operations of panic alarms was unaware of the documentation requirement for panic alarm testing.

Recommendation 2

2. The associate director makes certain that VA police conduct and document monthly panic alarm testing at the Rochester VA clinic and monitors VA police compliance.

[70] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

Facility concurred.

Target date for completion: May 2020

Facility Response: In April 2019, the Canandaigua VAMC and the Rochester Clinic implemented the LYNX (network-based emergency notification) Duress System on every networked computer and equipment. A new Rochester Clinic opened in October 2019, and we have established the Panic Alarms on every computer at the Rochester Calkins VA Clinic; the first test of the LYNX Duress System at the new clinic was conducted in November 2019. The LYNX Duress System at Rochester Calkins and Westfall VA Clinics will be tested each month and printed and filed with the Physical Security Specialist in the Police Department. The Chief of Police will ensure 100 percent compliance of documentation of monthly panic alarm testing for a minimum of six months; this will be reported to the Environment of Care Committee.

Furthermore, VHA and TJC require facilities to provide a safe, clean, and functional environment and to keep furnishings and equipment safe and in good repair.[71] At the Rochester VA clinic, the OIG noted that the waiting room carpet edge was loose and unsafely secured with duct tape. The inspection team also noted a loose bathroom cabinet drawer handle in a women's health exam room, a loose chair arm cushion in an exam room, and a broken chart rack.[72] These conditions may potentially affect the safety and physical well-being of patients, staff, and visitors. Facility managers attributed the carpeting issue to the contracted property manager's unresponsiveness to repeated requests for repair; however, the managers were unaware of furnishings in poor condition.

Recommendation 3

3. The associate director makes certain that managers maintain a safe environment and ensure furnishings are in good repair at the Rochester VA clinic and monitors managers' compliance.

[71] VHA Directive 1608; TJC Environment of Care standard EC.02.06.01.

[72] Rochester VA Clinic.

Facility concurred.

Target date for completion: May 2020

Facility Response: A new VA clinic was opened in Rochester in October 2019 with brand new furnishings and equipment. Environment of Care (EOC) rounds are conducted to assess the condition of equipment and furnishings. The clinic managers and staff were trained on expectations regarding ongoing monitoring of furnishings and reporting any needed repairs. Monthly environment of care rounds will be conducted at the Rochester clinics and all related work orders will be closed within 14 days. The clinic operations manager is responsible for continued compliance and will ensure compliance at 90 percent or greater for a minimum of six months.

TJC requires facilities to protect patient information "against unauthorized access, use, and disclosure of health information."[73] The OIG team found that Rochester VA clinic staff did not properly secure the specimen box containing personally identifiable information during transport to the parent facility's laboratory.[74] This may result in unauthorized access to personally identifiable information. The associate director and the Rochester VA Clinic operations manager believed that the requirement was met when a latched but unlocked specimen box is transported by a VA employee.

Recommendation 4

4. The associate director ensures that Rochester VA clinic staff secure laboratory transport boxes containing personally identifiable information and monitors clinic staff compliance.

Facility concurred.

Target date for completion: March 2020

Facility Response: In September 2019, the laboratory manager instituted a new process to secure laboratory transport boxes containing personally identifiable information with zip ties; this will be incorporated into the laboratory standard operating procedure (CN LAB SND-2). The laboratory staff will monitor compliance with use of zip ties for secure transport using a daily monitor and report results to the Environment of Care Committee monthly. The associate director will ensure compliance at 90 percent or greater for a minimum of six months.

[73] TJC. Information Management standard IM.02.01.03.

[74] Rochester CBOC.

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.[75] 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.[76]

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.[77]

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;[78] and other relevant documents. The OIG team 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[79]
- Requirements for controlled substances inspectors

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

[76] 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.

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

[78] The two quarters were from October 1, 2018, through March 31, 2019.

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

  - No conflicts of interest
  - Appointed in writing by the director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required annual competency assessment
- Controlled substances area inspections
  - Completion of monthly inspections
  - Rotations of controlled substances inspectors
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of controlled substances orders
  - Performance of routine controlled substances inspections
- Pharmacy inspections
  - Monthly physical counts of the controlled substances in the pharmacy
  - Completion of inspections on day initiated
  - Security and verification of drugs held for destruction[80]
  - Accountability for all prescription pads in pharmacy
  - Verification of hard copy controlled substances prescriptions
  - Verification of twice a week (three days apart) inventories of the main vault[81]
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[82]

[80] 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."

[81] 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*.)

[82] 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 team 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 review of override reports. However, the OIG identified noncompliance with controlled substances area and pharmacy inspections that warranted recommendations for improvement.

Specifically, VHA requires program staff to conduct monthly inspections in each nonpharmacy and pharmacy area that stores controlled substances, which includes conducting physical inventories and reconciling one random day's dispensing and return of stock activities for automated dispensing cabinets.[83] The OIG found that all nine non-pharmacy areas had no evidence of reconciliation of one random day's dispensing from pharmacy to each dispensing area for two of the six months of inspection reports reviewed. This could result in missed opportunities to identify potential drug diversion activities and discrepancies related to controlled substances. The controlled substances coordinator was aware of the requirement and cited an ineffective transition process with the former controlled substances coordinator as the reason for noncompliance.

Recommendation 5

5. The facility director ensures that controlled substances program staff consistently reconcile one day's dispensing from the pharmacy to each automated dispensing unit and monitors controlled substance inspectors' compliance.

Facility concurred.

Target date for completion: June 2020

Facility Response: Following the OIG CHIP survey, the controlled substance coordinator identified an improved process in use at another VA facility for reconciling dispensing from pharmacy to automated dispensing units (pyxis). Weekly pyxis reports will be automatically generated and sent from pharmacy to the controlled substance coordinator, who will randomly select dispensing activities for each automated dispensing unit to be reconciled by controlled substance inspectors on the day of audit. Preparations have started to have this process in place starting in January 2020. The controlled substance coordinator will ensure greater than 90 percent compliance with this process for at least six consecutive months and report monthly to the director and quarterly to the Quality, Safety, Value Committee.

[83] VHA Directive 1108.02(1).

For the verification of controlled substances orders, VHA requires inspectors to select five random dispensing activities from an automated dispensing cabinet and verify the presence of an order in each patient's medical record.[84] The OIG found that in eight of the nine non-pharmacy areas, controlled substances inspectors did not consistently verify five random dispensing orders. Failure to verify orders may cause delays in identifying potential drug diversion activities. The controlled substances coordinator cited a lack of understanding of this requirement as the reason for noncompliance.

Recommendation 6

6. The facility director ensures that controlled substances inspectors verify controlled substances orders for five random dispensing activities during monthly inspections and monitors inspectors' compliance.[85]

Facility concurred.

Target date for completion: November 2019

Facility Response: Immediately following the OIG CHIP survey, the controlled substance coordinator updated the process for verifying controlled substance orders to ensure five random dispensing activities are verified from each automated dispensing unit. Weekly pyxis reports are automatically generated and sent from pharmacy to the controlled substance coordinator, who randomly selects the five dispensing activities for each automated dispensing unit to be verified with the computerized medical record system or bar code medication administration system by controlled substance inspectors on the day of audit. The controlled substance coordinator will ensure 100 percent compliance with this process for at least six consecutive months and report any discrepancies monthly to the director and quarterly to the Quality, Safety, Value Committee. 100 percent has been maintained from June through November 2019, and the facility requests closure of this recommendation based on evidence provided.

VHA also requires that controlled substances coordinators refrain from conducting routine monthly inspections.[86] This ensures that the coordinator focuses on program oversight activities, such as preparing monthly inspection summaries and quarterly trend reports, resolving all discrepancies until completion, and training new inspectors.[87] From October 2018 through March 2019, the coordinator conducted 8 of 54 (15 percent) routine monthly inspections. When controlled substances coordinators conduct routine monthly inspections, program oversight may

[84] VHA Directive 1108.02(1).

[85] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

[86] VHA Directive 1108.02(1).

[87] VHA Directive 1108.02(1).

be compromised. The controlled substances coordinator cited insufficient number of controlled substances inspectors for backup coverage as a contributing factor for noncompliance.

Recommendation 7

7. The facility director makes certain that controlled substances coordinators refrain from conducting routine inspections and monitors coordinators' compliance.[88]

Facility concurred.

Target date for completion: August 2019

Facility Response: Immediately following the OIG CHIP survey, additional controlled substance inspectors were recruited, and the controlled substance coordinator updated the process for tracking assignments of auditors. The controlled substance coordinator has not conducted an inspection since February 2019. The facility recommends closure of this recommendation based on evidence provided.

VHA requires that during controlled substances area inspections, inspectors "must verify written wet signature (nonelectronically prescribed) controlled substance prescriptions."[89] For one of the three pharmacy areas reviewed, the OIG found that inspectors did not confirm hard copy (nonelectronic) prescriptions for three of the six monthly inspections. Inspectors' failure to verify hard copy prescriptions can result in missed opportunities to identify potential drug diversion activities and discrepancies related to controlled substances. The controlled substances coordinator cited an inefficient transition process with the former controlled substances coordinator as the reason for noncompliance.

Recommendation 8

8. The facility director certifies that controlled substances inspectors verify hard copy controlled substances prescriptions during monthly pharmacy inspections and monitors inspectors' compliance.[90]

[88] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

[89] VHA Directive 1108.02(1).

[90] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

Facility concurred.

Target date for completion: November 2019

Facility Response: Immediately following the OIG CHIP survey, the controlled substance coordinator created a checklist to be included in prepared folders for controlled substance inspectors to ensure compliance and review of hard copy prescriptions. The controlled substance coordinator reviews all the monthly audit paperwork completed by controlled substance inspectors for accuracy and completeness against the checklist; if incomplete, the controlled substance inspector must return to the area of inspection to complete. The controlled substance coordinator will ensure compliance and has maintained 100 percent compliance from June through November 2019. The facility requests closure of this recommendation based on evidence provided.

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."[91] 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.[92]

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.[93] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[94]

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.[95] Those who screen positive must have access to appropriate MST-related care.[96] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. All new 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 and treatment planning evaluation within 30 days.[97]

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

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

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

[93] VHA Directive 1115.

[94] 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.)

[95] 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."

[96] VHA Directive 1115.

[97] VHA Handbook 1160.01.

providers.[98] All mental health and primary care providers must complete MST mandatory training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[99]

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 49 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

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

Mental Health Conclusion

The OIG team found many of the performance indicators were achieved, including the designation of an MST coordinator, tracking of MST-related data, and provision of clinical care. The team noted concerns, however, with requirements for establishing and monitoring MST-related staff training, communicating MST-related issues with local leaders, and providers completing MST mandatory training that warranted recommendations for improvement.

[98] VHA Directive 1115.

[99] 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, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers,* February 2, 2016.

Specifically, VHA requires MST coordinators to establish and monitor MST-related staff training and communicate the status of MST services and initiatives with local leadership.[100] The OIG inspectors determined that the facility had no process in place for establishing and monitoring MST-related staff training or communicating services and initiatives with leadership. This may hinder the coordinator's efforts to enhance staff training and leadership's ability to identify and address improvement opportunities. The MST coordinator was unaware of these requirements and reported that due to competing priorities, administrative time designated for program oversight was used to fulfill clinical duties.

Recommendation 9

9. The facility director ensures the military sexual trauma coordinator establishes and monitors military sexual trauma-related staff training and monitors the coordinator's compliance.

Facility concurred.

Target date for completion: May 2020

Facility Response: In June 2019, the military sexual trauma coordinator implemented a new process for ensuring compliance with military sexual trauma related staff training. The military sexual trauma coordinator identifies new primary care and mental health staff at the start of each month via human resources and communicates directly to all new hires about role of military sexual trauma coordinator and the related computer-based trainings. In September 2019, the military sexual trauma coordinator additionally began receiving an automatically generated monthly report on the mandatory computer-based military sexual trauma training and other related training for all primary care and mental health staff; the military sexual trauma coordinator identifies those who are at risk for becoming delinquent and communicates with them directly regarding the training requirement. The military sexual trauma coordinator will ensure compliance with monitoring military sexual coordinator training and has maintained this 100 percent of the time since June 2019. Ongoing compliance of 90 percent or greater will be monitored and reported to the Executive Committee of Medical Staff for a minimum of six consecutive months.

Recommendation 10

10. The facility director ensures the military sexual trauma coordinator communicates the status of military sexual trauma-related services and initiatives with leadership and monitors the coordinator's compliance.

[100] VHA Directive 1115.

Facility concurred.

Target date for completion: December 2019

Facility Response: In July 2019, the military sexual trauma coordinator began reporting the status of military sexual trauma-related services and initiatives to the Executive Committee of Medical Staff at least quarterly and as needed. Additionally, the military sexual trauma coordinator shared outcomes of Military Sexual Trauma Comprehensive Data Summary in November 2019. The facility director will ensure 100 percent compliance with this reporting structure via a review of committee minutes for a minimum of six consecutive months.

VHA also 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 assuming their position.[101] The OIG found 5 of 14 clinicians hired after July 1, 2012, did not complete the required training within 90 days of hire. Without timely MST training, providers could lack the ability to provide appropriate counseling, care, and services to veterans. The MST coordinator was aware of the 90-day requirement but believed that all new providers received training during the orientation process and was not tracking provider training.

Recommendation 11

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

[101] VHA Memorandum, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers (VAIQ 7663786)*, February 2, 2016, refers to specific MST training requirements for providers assuming their position before or after July 1, 2012.

Facility concurred.

Target date for completion: May 2020

Facility Response: In June 2019, the military sexual trauma coordinator implemented a new process for ensuring compliance with military sexual trauma mandatory training. The military sexual trauma coordinator identifies new primary care and mental health providers at the start of each month (via human resources) and communicates directly about role of military sexual trauma coordinator and mandatory computer-based trainings. In September 2019, the military sexual trauma coordinator began receiving an automatically generated monthly report on the mandatory computer-based military sexual trauma training for all primary care and mental health staff, including providers. The military sexual trauma coordinator identifies providers who are at risk for becoming delinquent and communicates with them directly regarding completion of the training requirement. The military sexual trauma coordinator will ensure greater than 90 percent compliance for a minimum of six months and has achieved this since June 2019. Ongoing compliance of 90 percent or greater will be monitored and reported to the Executive Committee of Medical Staff for a minimum of six 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."[102] 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.[103]

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."[104]

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.[105] 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."[106] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[107] 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.[108] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[102] 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.)

[103] *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.)

[104] 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.)

[105] 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.)

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

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

[108] 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.[109]

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 18 selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[110] The OIG evaluated the following performance indicators:

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

Geriatric Care Conclusion

The OIG team found compliance with clinicians documenting reasons for medication initiation. However, the OIG team identified that clinicians did not provide adequate patient and/or caregiver education specific to newly prescribed medications, assess patient and/or caregiver understanding of the education provided, and reconcile the patients' medications that warranted recommendations for improvement.

Specifically, TJC requires that clinicians educate patients and families about safe and effective use of medications and evaluate patient/caregiver understanding of the education provided.[111] The OIG determined that clinicians provided education in 72 percent of the electronic health records reviewed.[112] In addition, the OIG found that clinicians assessed understanding of the education provided in 62 percent of the electronic health records reviewed.[113] Providing medication education and ensuring it is understood are critical to ensuring that patients have the information they need to manage their health at home. The chief of Primary Care and the Mental Health medical director acknowledged inconsistent documentation but believed that clinicians conducted education and assessed understanding of the education provided.

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

[110] The seven selected antidepressant medications are amitriptyline, clomipramine, desipramine, doxepin (>6mg/day), imipramine, nortriptyline, and paroxetine.

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

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

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

Recommendation 12

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

Facility concurred.

Target date for completion: June 2020

Facility Response: Canandaigua VA clinicians were educated regarding the Clinical Practice Guidelines for tricyclic antidepressants or paroxetine in elderly patients; the academic detailing pharmacist will distribute appropriate patient education and promote continuing clinician education regarding these medications. Verbiage consistent with the guidelines will be added to the VISN drug file. The Associate Chief of Medicine will ensure development of a documentation template to ensure compliance. The Chief of Pharmacy will monitor for compliance greater than 90 percent for a minimum of six consecutive months and report to the Executive Committee of Medical Staff.

According to TJC, the required process of medication reconciliation is when "a clinician compares the medications a patient should be taking (and is actually taking) to the new medications that are ordered for the patient and resolve any discrepancies."[114] TJC also requires patients' medical records contain information that reflects the patient's care, treatment, and services.[115] Furthermore, VHA requires that clinicians review and reconcile medications relevant to the episode of care.[116]

The OIG determined that clinicians performed medication reconciliation for 83 percent of the patients at the facility, based on electronic health records reviewed.[117] Failure to maintain and communicate accurate patient medication information and reconcile medications increases the risk of duplications, omissions, and negative interactions in the patient's actual drug regimen. The chief of Primary Care and Mental Health medical director were aware of the requirement and reported that challenges with telephone appointments contributed to inconsistent documentation of medication reconciliation.

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

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

[116] VHA Directive 1164.

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

Recommendation 13

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

Facility concurred.

Target date for completion: June 2020

Facility Response: Canandaigua VA clinicians were educated regarding the requirements for medication reconciliation with emphasis on visits wherein a new tricyclic antidepressant or paroxetine are started with an elderly patient. The Chief of Pharmacy will monitor all newly prescribed tricyclic antidepressants and paroxetine for elderly patients to ensure compliance greater than 90 percent for a minimum of 6 months and report to the Executive Committee of Medical Staff.

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.[118] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[119] 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.[120] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[121]

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.[122]

VHA requires that each facility have a "full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health care." VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women's health program. Each facility must also have a "Women Veterans Health Committee (WVHC) comprised of appropriate facility leadership and program directors, which develops and implements a Women's Health Program strategic plan." The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.[123]

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

[118] 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.)

[119] 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.)

[120] 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.)

[121] 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.)

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

[123] 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.[124]

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 two 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
  - Core membership
  - Quarterly meetings
  - Reports to clinical executive leaders
- Collection and tracking of cervical cancer screening data
  - Notification of patients due for screening
  - Completed screenings
  - Results reporting
  - Follow-up care
- Communication of abnormal results to patients within required time frame
- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women's Health Conclusion

Generally, the OIG team found compliance with many of the performance indicators, including requirements for a designated women veterans program manager and clinical champion, tracking of data related to cervical cancer screenings, communication of results to patients within the required time frame, and follow-up care when indicated. The OIG team noted a noncompliance with the Women Veterans Health Committee core membership that warranted a recommendation for improvement.

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

[124] VHA Directive 1330.01(2).

"representatives from 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."[125] The OIG found that from March 2018 through January 2019, the Women Veterans Health Committee lacked representation from laboratory, radiology, and business office/non-VA medical care services. Additionally, the OIG noted inconsistent meeting attendance of core committee members.[126] This resulted in a lack of expertise and oversight 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 was unaware of the membership requirements for the missing disciplines and cited lack of attention to detail due to competing priorities.

Recommendation 14

14. The facility director makes certain that the Women Veterans Health Committee includes required core members and that members consistently attend meetings and monitors the committee's compliance.

Facility concurred.

Target date for completion: May 2020

Facility Response: The Women Veterans Program Manager revised the Women Veterans Health Committee charter in November 2019 to include all required core committee members as per Directive 1330.01. The Women Veterans Committee set the attendance compliance target at 90 percent. The Women Veterans Program Manager will monitor compliance for a minimum of six consecutive months and report to Quality, Safety, Value Committee.

[125] VHA Directive 1330.01(2).

[126] Quality management, medical and/or surgical subspecialties, and executive leadership representatives.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Healthcare Processes	Performance Indicators	Conclusion	
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation and/or for-cause surveys and oversight inspections • Factors related to possible lapses in care • VHA performance data	Fourteen 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 • UM reviews • Patient safety • Resuscitation episode review	• None	• None
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent facility
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Community based outpatient clinic
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Locked inpatient mental health unit
	  ○ Mental health environment of care rounds
	  ○ Nursing station security
	  ○ Public area and general unit safety
	  ○ Patient room safety
	  ○ Infection prevention
	  ○ Availability of medical equipment and supplies
	• Emergency management
	  ○ Hazard vulnerability analysis (HVA)
	  ○ Emergency operations plan (EOP)
	  ○ Emergency power testing and availability
		• Managers store clean and dirty medical equipment separately.	• VA Police conduct and document monthly panic alarm testing at the Rochester VA Clinic.
			• Managers maintain a safe environment and ensure furnishings are in good repair at the Rochester VA clinic.
			• Rochester VA Clinic staff secure laboratory transport boxes containing personally identifiable information.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• Controlled substances inspectors verify orders for five random dispensing activities during monthly inspections.	• Controlled substances program staff reconcile one random day's dispensing/refilling from the pharmacy to each automated dispensing unit. • Controlled substances coordinators refrain from conducting routine inspections. • Controlled substances inspectors verify hard copy controlled substances prescriptions during monthly pharmacy inspections.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers	• None	• MST coordinator establishes and monitors MST-related staff training. • MST coordinator communicates the status of MST-related information to leadership. • Providers complete MST mandatory training within the required time frame.

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

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) affiliated[127] facility reporting to VISN 2.[128]

Table B.1. Facility Profile for Canandaigua VA Medical Center (528A5/00) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[129]	Facility Data FY 2017[130]	Facility Data FY 2018[131]
Total medical care budget in dollars	$168,079,926	$141,171,711	$157,830,344
Number of:			
• Unique patients	20,361	20,233	20,016
• Outpatient visits	242,624	238,839	239,286
• Unique employees[132]	1,146	788	801
Type and number of operating beds:			
• Community living center	138	106	106
• Domiciliary	48	48	48
Average daily census:			
• Community living center	104	81	89
• Domiciliary	33	31	31

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

[127] Associated with a medical residency program.
[128] The VHA medical centers are classified according to a facility complexity model; a designation of "3" indicates a facility with "low volume, low-risk patients, few or no complex clinical programs, and small or no research and teaching programs."
[129] October 1, 2015, through September 30, 2016.
[130] October 1, 2016, through September 30, 2017.
[131] October 1, 2017, through September 30, 2018.
[132] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[133]

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)[134]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[135] Provided	Diagnostic Services[136] Provided	Ancillary Services[137] Provided
Rochester, NY	528QD	—	3	—	—	—

[133] Includes all outpatient clinics in the community that were in operation as of February 8, 2019. The OIG omitted (528QC) Clinton Crossings, NY, as no data were reported.

[134] 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."

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

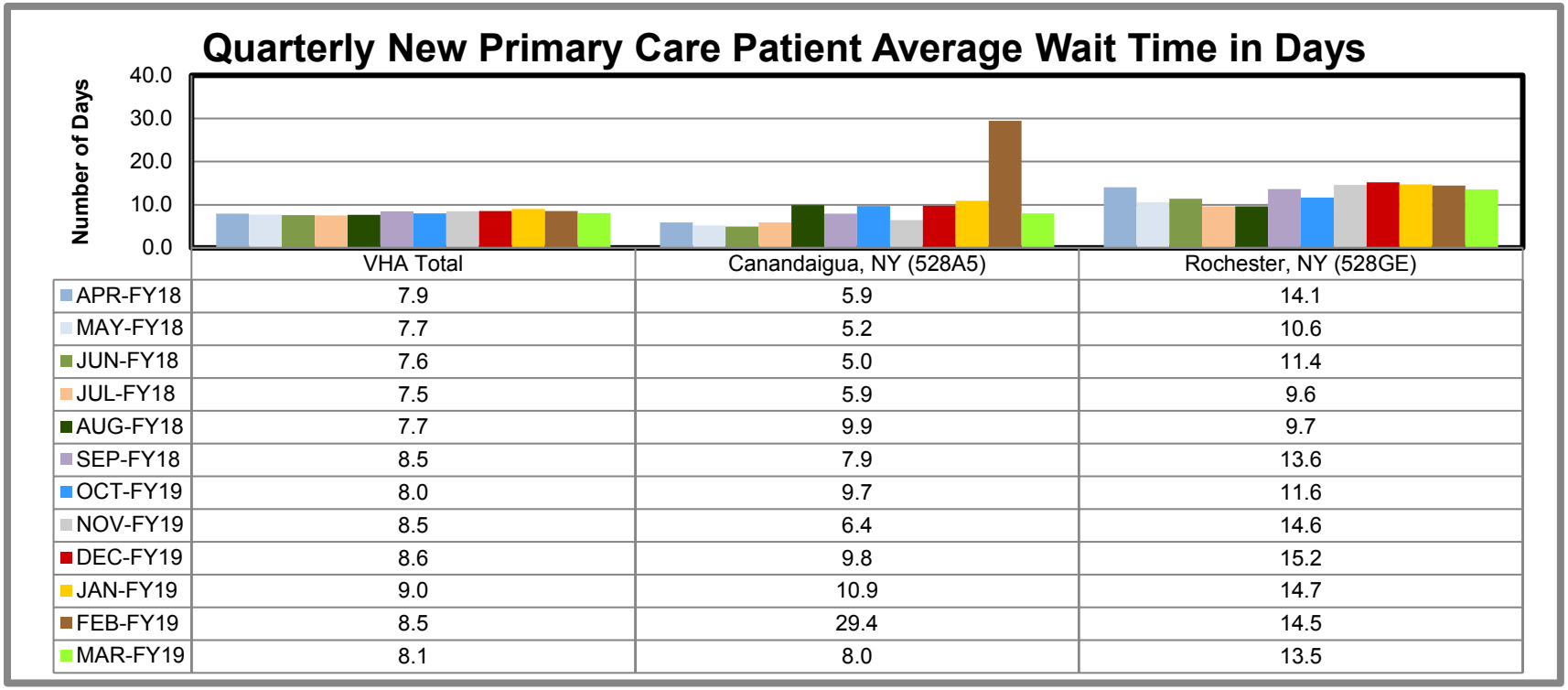
[136] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

[137] 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[135] Provided	Diagnostic Services[136] Provided	Ancillary Services[137] Provided
Rochester, NY	528GE	22,883	16,965	Hematology/ Oncology Infectious disease Pulmonary/ Respiratory Disease Poly-Trauma Rehab physician Anesthesia General surgery Otolaryngology Urology Vascular	EKG Radiology	Nutrition Pharmacy Prosthetics Weight management Dental

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

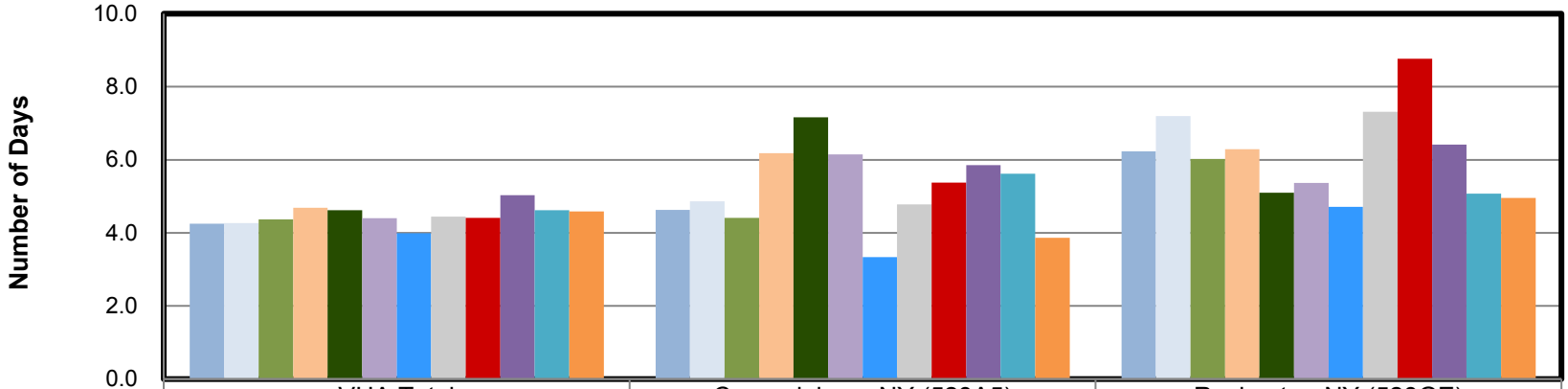
Appendix C: Patient Aligned Care Team Compass Metrics[138]



	VHA Total	Canandaigua, NY (528A5)	Rochester, NY (528GE)
APR-FY18	7.9	5.9	14.1
MAY-FY18	7.7	5.2	10.6
JUN-FY18	7.6	5.0	11.4
JUL-FY18	7.5	5.9	9.6
AUG-FY18	7.7	9.9	9.7
SEP-FY18	8.5	7.9	13.6
OCT-FY19	8.0	9.7	11.6
NOV-FY19	8.5	6.4	14.6
DEC-FY19	8.6	9.8	15.2
JAN-FY19	9.0	10.9	14.7
FEB-FY19	8.5	29.4	14.5
MAR-FY19	8.1	8.0	13.5

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (528QC) Clinton Crossings, NY; and (528QD) Rochester, NY, as no data were reported.
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.

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



	VHA Total	Canandaigua, NY (528A5)	Rochester, NY (528GE)
APR-FY18	4.3	4.6	6.2
MAY-FY18	4.3	4.9	7.2
JUN-FY18	4.4	4.4	6.0
JUL-FY18	4.7	6.2	6.3
AUG-FY18	4.6	7.2	5.1
SEP-FY18	4.4	6.1	5.4
OCT-FY19	4.0	3.3	4.7
NOV-FY19	4.4	4.8	7.3
DEC-FY19	4.4	5.4	8.8
JAN-FY19	5.0	5.9	6.4
FEB-FY19	4.6	5.6	5.1
MAR-FY19	4.6	3.9	5.0

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (528QC) Clinton Crossings, NY; and (528QD) Rochester, NY, as no data were reported. 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[139]

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

[139] 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[140]

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.

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

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 29, 2019

From: Director, New York/New Jersey Health Care Network (10N2)

Subj: Comprehensive Healthcare Inspection of the Canandaigua VA Medical Center, NY

To: Director, Los Angeles Office of Healthcare Inspections (54CH01)

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Canandaigua VA Medical Center, New York. I appreciate the Office of Inspector General's oversight and the extensive work done as part of this review. We acknowledge there are improvements to be made and we are committed to ensuring correction of identified opportunities for improvement.
2. I have reviewed the Healthcare System Director's action plan and projected completion dates. I concur with the plan and have complete confidence that the plan will be effective. VISN2 will assist the Healthcare System's leadership in reaching full compliance in a timely manner.

(Original signed by:)

Joan E. McInerney, MD, MBA, MA, FACEP
Network Director, VISN 2

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

Appendix G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 26, 2019

From: Director, Canandaigua VA Medical Center (528A5/00)

Subj: Comprehensive Healthcare Inspection of the Canandaigua VA Medical Center, NY

To: Director, New York/New Jersey Health Care Network (10N2)

I have reviewed the draft report of the Office of Inspector General (OIG) and I concur with the recommendations 1-14 from the CHIP review on May 13-17. The Medical Center has developed action plans to address the recommendations which are included in the comments.

I would like to thank the OIG Survey Team for the consultative visit. The recommendations will strengthen our processes to deliver consistent quality care to our Veterans.

Please contact me if you have additional questions or comments.

(Original signed by:)

Bruce Tucker, LCSW-R
Medical Center Director

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

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