DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Chalmers P. Wylie Ambulatory Care Center

Columbus, Ohio

CHIP REPORT | REPORT #19-00051-40 | DECEMBER 18, 2019

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Figure 1. *Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio (Source: https://vaww.va.gov/directory/guide/, accessed on August 15, 2019)*

Abbreviations

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

Report Overview

This Office of Inspector 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 Chalmers P. Wylie Ambulatory Care 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 (specifically the emergency department and urgent care center operations and management).

This unannounced visit was conducted during the week of July 15, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, chief of staff, associate director for Patient Care Services (ADPCS), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure, with the Executive Leadership Board having oversight for several working groups. The director and chief of Quality Management were co-chairs of the Continuous Quality Improvement Board, which was responsible for tracking, trending, and monitoring quality of care and patient outcomes.

The facility's leadership team had been working together for nine months, although several had served in their position for years. The director was permanently assigned October 28, 2018. The chief of staff was permanently assigned April 8, 2012, and served as interim director for three months. The ADPCS and associate director positions were permanently assigned March 18, 2018, and August 20, 2017, respectively.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders were engaged and promoted a culture where employees feel safe bringing forward issues and concerns. The selected patient experience survey scores for facility leaders 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 and disclosures of adverse patient events and did not identify any substantial organizational risk. However, organizational risk factors related to wrong-site/wrong-procedures were noted during OIG's review of sentinel events[1] and institutional disclosure timeliness. At the time of the on-site visit, the facility had closed all recommendations received from accreditation and survey agencies.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[2] Although the leadership

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

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

team members were knowledgeable within their areas of responsibility about selected SAIL metrics, the leaders should continue to take actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "4-star" quality ratings.[3]

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

Quality, Safety, and Value

The OIG found general compliance with requirements for QSV activities.[4] However, the OIG identified noncompliance with implementation of improvement actions recommended by the Peer Review Committee, completion of root cause analyses, and committee review of resuscitation episodes.

Medical Staff Privileging

The facility generally complied with requirements for privileging. However, the OIG identified concerns in the focused and ongoing professional practice evaluation (OPPE) processes.[5] Of note, the facility's November 2015 Combined Assessment Program Review (Report No. 15-04694-80) also identified concerns with the OPPE process.

Medication Management

Overall, the facility complied with requirements for most of the performance indicators evaluated for medication management, including those for controlled substances inspectors, controlled substances area, and pharmacy inspections. Additionally, the OIG found that the individual performing the monthly review of balance adjustments also had the security key to perform balance adjustments, but this was corrected while the OIG was on site. However, the

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

[4] 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.

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

OIG identified noncompliance in the Continuous Quality Improvement Board's review of controlled substances program reports and follow-up of identified corrective actions until completion.

Mental Health

The OIG team also found the facility complied with many of the mental health performance indicators, including the designation of a military sexual trauma (MST) coordinator and tracking of MST-related data. The OIG noted a concern, however, with providers completing MST mandatory training.

Geriatric Care

For geriatric patients, providers documented reasons for initiating medications and validating patient and/or caregiver understanding when education was provided. However, the OIG identified inadequate patient and/or caregiver education specific to the newly prescribed medication. Additionally, clinicians did not reconcile patients' medications.

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, clinical oversight of the women's health program, tracking data related to cervical cancer screenings, and follow-up care when indicated. However, the Women Veterans Health Committee membership lacked representation from medical and/or surgical subspecialties and executive leadership, and abnormal results were not communicated to patients within the required time frame.

Incidental Finding

The OIG noted a trend in a lack of documentation of controlled substance administration by anesthesia providers. This trend was reported through the monthly and quarterly controlled substances reports to leadership; however there had been no resolution of the issue and no current actions had been identified.

Summary

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

Comments

The Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 71–72, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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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 Chalmers P. Wylie Ambulatory Care 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.[6] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[7] Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

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

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

[6] 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.)

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

9. High-risk processes (specifically the emergency department and urgent care center operations and management).[8]

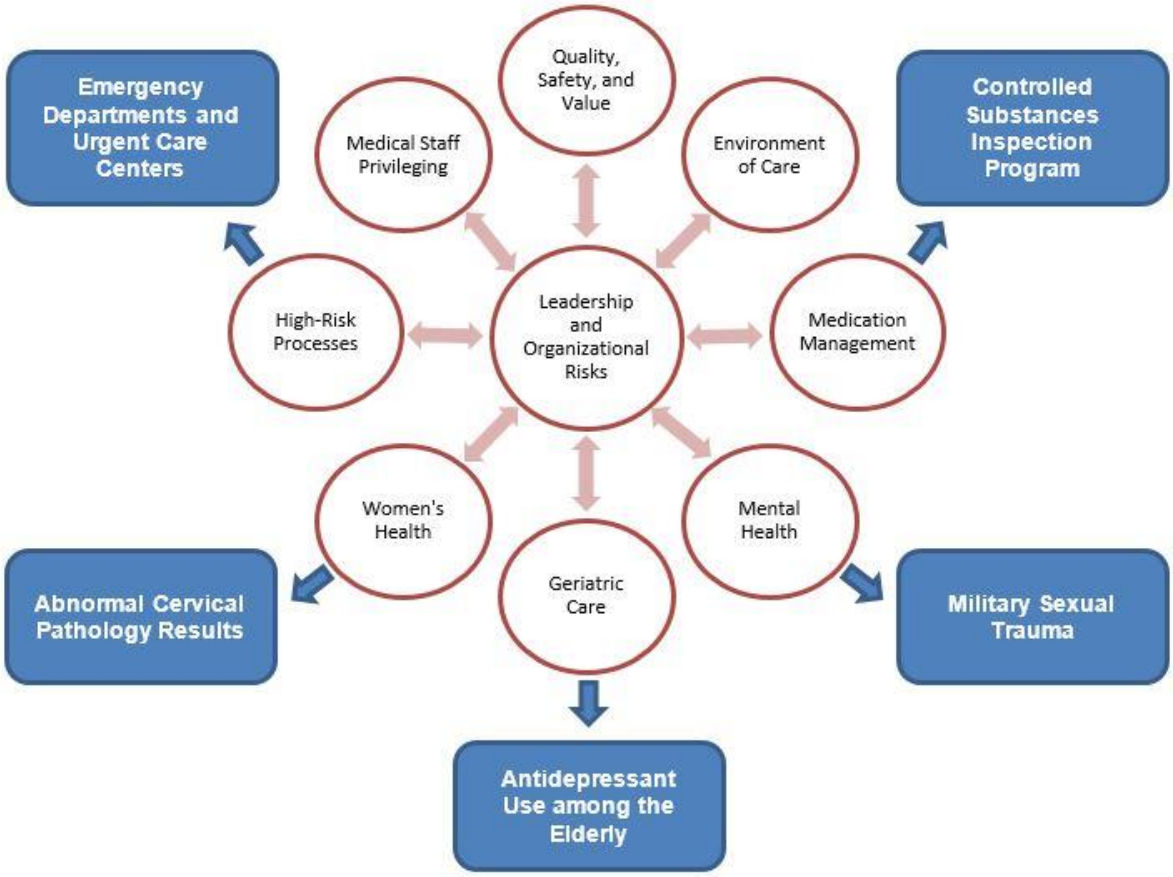

Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

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

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;[9] physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from November 7, 2015, through July 18, 2019, the last day of the unannounced site visit.[10] While on site, the OIG referred issues and concerns beyond the scope of the CHIP review to our Hotline management team for further evaluation.

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.

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.[11] 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 Care Services (ADPCS), and associate director (primarily nonclinical). The chief of staff and ADPCS oversee patient care, which requires managing service directors and chiefs of programs and practices.

[11] 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.)

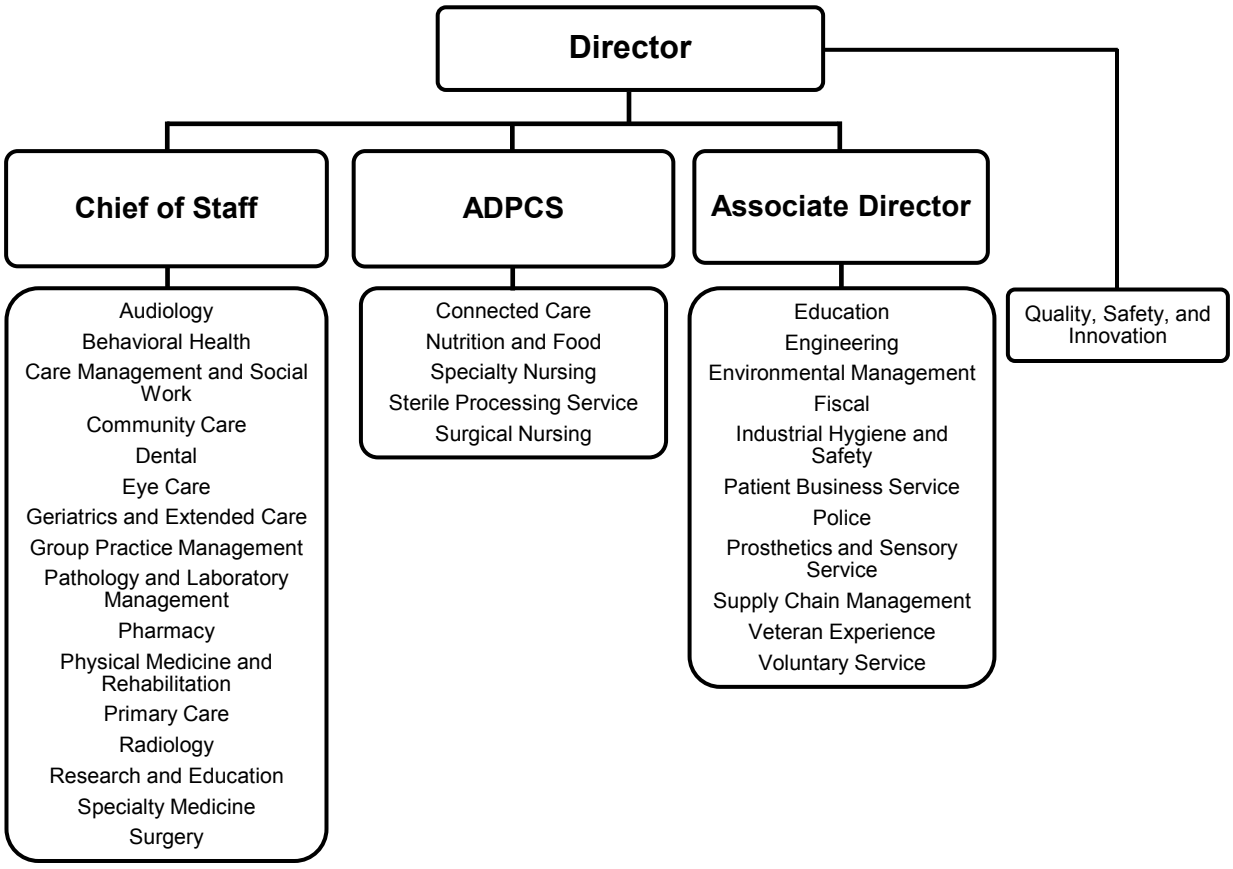

Figure 3. *Facility Organizational Chart*[12]
Source: Chalmers P. Wylie Ambulatory Care Center (received July 16, 2019)

At the time of the OIG site visit, the executive team had been working together for nine months, although several team members have been in their position for over one year (see Table 1). The facility director position had been vacant for three months and one person acted in the role prior to the current director assignment.

[12] At this facility, the director is responsible for Quality, Safety, and Innovation.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	October 28, 2018
Chief of staff	April 8, 2012
Associate director for Patient Care Services	March 18, 2018
Associate director	August 20, 2017

Source: Chalmers P. Wylie Ambulatory Care Center human resources officer (received July 16, 2019)

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

In individual interviews, 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 were generally knowledgeable within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed in greater detail below.

The director serves as the chairperson of the Executive Leadership Board, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Board oversees various working groups, such as the Medical Executive, Administrative Executive, Patient Services Executive, and Organizational Health Boards.

These leaders are also engaged in monitoring patient safety and care through the Continuous Quality Improvement Board, for which the director and chief of Quality Management are co-chairs. The Continuous Quality Improvement Board is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes, and it reports to the Executive Leadership Board. However, the OIG noted a lack of review of data trends and applicable actions in the committee minutes. The director reported that there were several facility committees and working groups responsible for process improvement actions, but they were not formally reporting data and analysis to the Continuous Quality Improvement Board at the time of the OIG visit. See Figure 4.

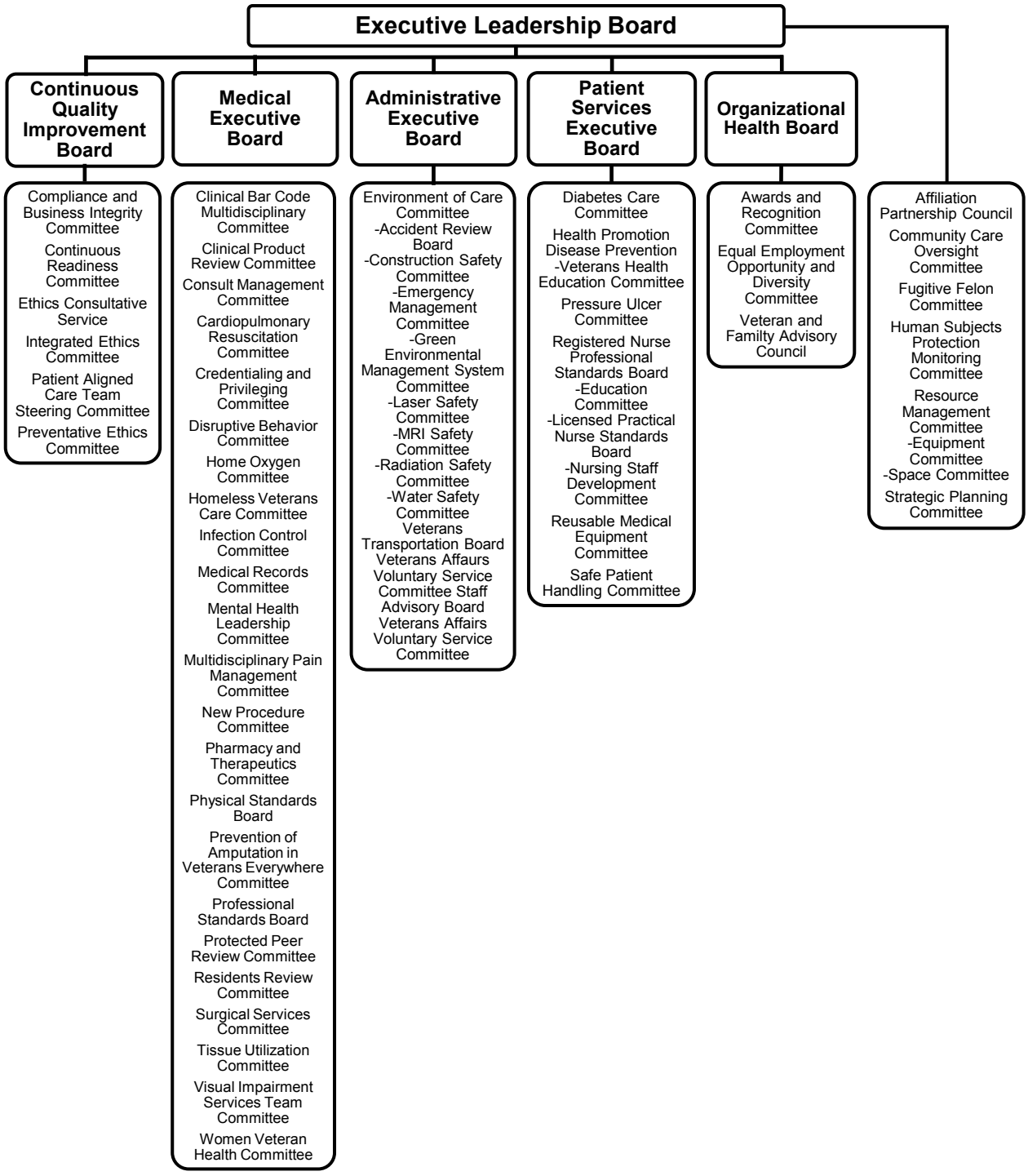

Figure 4. *Facility Committee Reporting Structure*[13]
Source: Chalmers P. Wylie Ambulatory Care Center (received July 16, 2019)

[13] The Executive Leadership Board directly oversees Affiliation Partnership Council; Community Care Oversight Committee; Fugitive Felon Committee; Human Subjects Protection Monitoring Committee; Resource Management Committee; and the Strategic Planning Committee.

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.[14] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for one of the selected survey leadership questions (servant leadership index composite) was worse than the VHA average, and the facility's results from the other three survey questions were similar to VHA average.[15] The opposite trend was noted for the members of the executive leadership team where all four selected survey questions were better than VHA and facility averages. In all, employees appear generally satisfied with facility leaders.

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

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

Table 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[16]	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: Servant Leader Index Composite[17]	0–100 where HIGHER scores are more favorable	71.7	69.7	91.8	86.3	84.5	92.7
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	4.2	4.3	4.1	4.2
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.4	4.3	4.4	4.1	4.0
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.4	4.2	4.4	4.1	4.2

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

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility and executive leadership team averages for the selected

[16] The 2018 All Employee Survey results do not reflect satisfaction with the current facility director who was not in place at the time of the survey.

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

survey questions were similar to or better than the VHA average. Facility leaders appear to be maintaining an environment where employees feel safe bringing forth issues and concerns.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.7	4.5	4.5	4.4	4.2
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.6	4.5	4.6	4.2	4.0
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.5	1.5	1.3	1.1	1.3	1.5

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

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through 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 four relevant survey questions that reflect patients' attitudes toward facility leaders (see Table 4). The two inpatient survey questions were not applicable to this facility.[19] However, the two outpatient survey results reflected higher care ratings than the VHA average. Patients were generally satisfied with the leadership and care provided. Facility leaders appeared to be actively engaged with patients. For example, the Antibiotic Stewardship Improvement Initiative's goal is to decrease antibiotic use among patients with viral respiratory infections in the outpatient setting. Patients are provided a "viral illness support packet traffic light" card that contains educational information and guidance for treating symptoms and when to contact their provider. The facility noted a nine percent decrease in use of antibiotics when viral support packs were distributed.

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

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.9	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

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

[19] The facility does not provide inpatient care; therefore, two inpatient survey questions are not applicable (n/a).

Questions	Scoring	VHA Average	Facility Average
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	80.6
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.5	78.4

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

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[20] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[21] Indicative of effective leadership, the facility has closed all recommendations for improvement.[22]

[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.

[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.

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[23] and the College of American Pathologists.[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 (*Combined Assessment Program Review of the Chalmers P. Wylie VA Ambulatory Care Center Columbus, Ohio, Report No. 15-04694-80, January 14, 2016*)	November 2015	18	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Chalmers P. Wylie Ambulatory Care Center Columbus, Ohio, Report No. 15-05151-81, January 13, 2016*)	November 2015	7	0
OIG (*Healthcare Inspection Medical Foster Home Program Concerns, Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio, Report No. 17-03860-100, February 13, 2018*)	July 2017	1	0
TJC Ambulatory Health Care Accreditation TJC Behavioral Health Care Accreditation TJC Home Care Accreditation	October 2016	16 1 3	0 0 0
TJC Laboratory Accreditation	June 2017	15	0

Source: OIG and TJC (inspection/survey results verified with the chief of Quality Management on July 16, 2019)

[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.

[24] 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.

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. The risk manager provided a list of sentinel events that occurred since the last OIG site visit in December 2015. There were a total of four sentinel events identified in the past year and all were related to wrong-site surgery/procedures. Two of the four events involved the same provider. Clinical disclosures[25] were completed for all four of these cases. The chief of staff reported that the facility has implemented processes to mitigate future wrong-site surgery/procedure occurrences, such as requiring pictures be taken of all lesions and providers are expected to review the pictures prior to surgery. In addition the OIG found that the facility conducted six institutional disclosures; however, five were not completed within 72 hours of the event, and the facility risk manager provided no reason for the delays.[26] Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from November 7, 2015 (the prior comprehensive OIG inspection), through July 18, 2019.[27]

[25] According to VHA Directive 1004.08, *Disclosure of Adverse Events To Patients*, October 31, 2018, VHA defines a clinical disclosure of adverse events as a "process by which the patient's clinician informs the patient or the patient's personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the patient's care."

[26] According to VHA Directive 1004.08, 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."

[27] 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 Chalmers P. Wylie Ambulatory Care Center is a medium complexity (2) affiliated facility as described in Appendix B.)

Table 6. Summary of Selected Organizational Risk Factors (November 7, 2015, through July 18, 2019)

Factor	Number of Occurrences
Sentinel Events[28]	4
Institutional Disclosures	6
Large-Scale Disclosures[29]	0

Source: Chalmers P. Wylie Ambulatory Care Center patient safety manager provided the sentinel events on July 16, 2019; risk manager provided the disclosures on July 15, 2019; and the chief of Quality Management provided the large-scale disclosures on July 17, 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.[30] These data are not applicable since inpatient care is not provided at the facility.

[28] 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."

[29] According to VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

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

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.[31]

VA also uses a star-rating system where facilities with a "5-star" rating are performing within the top 10 percent of facilities and "1-star" facilities are performing within the bottom 10 percent of facilities. Figure 6 describes the distribution of facilities by star rating.[32] As of June 30, 2018, the facility was rated as "4-star" for overall quality.

[31] 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.)

[32] 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.

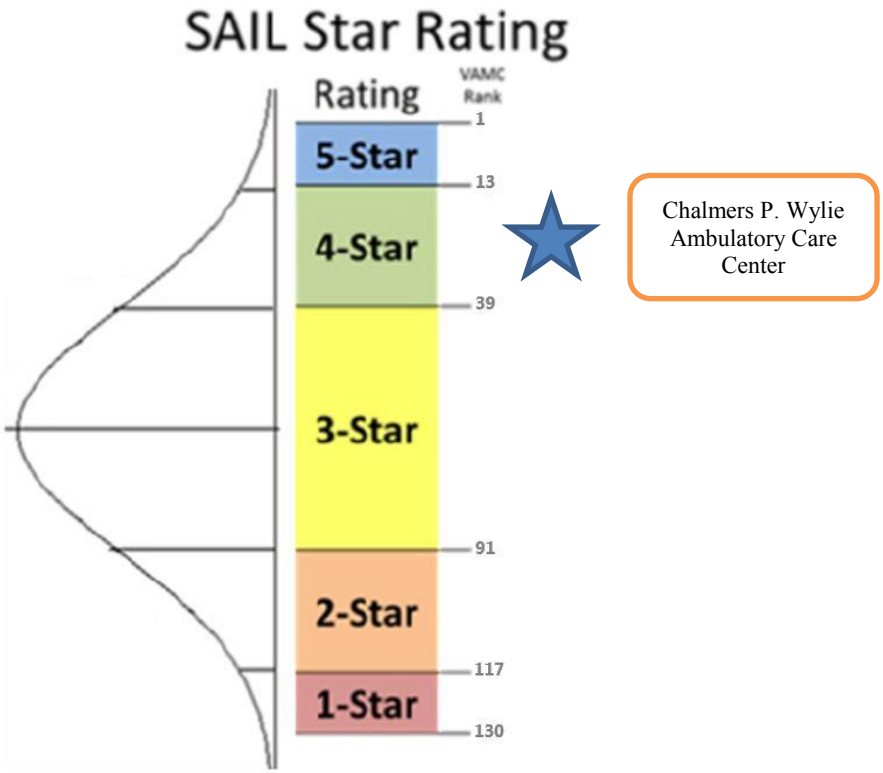

Figure 6. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed June 14, 2019)

Figure 7 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 ambulatory care sensitive conditions (ACSC) hospitalization, mental health (MH) continuity (of) care, and MH population (Popu) coverage). Metrics that need improvement are denoted in orange and red (for example, patient-centered medical home (PCMH) care coordination and rating specialty care (SC) provider).[33]

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

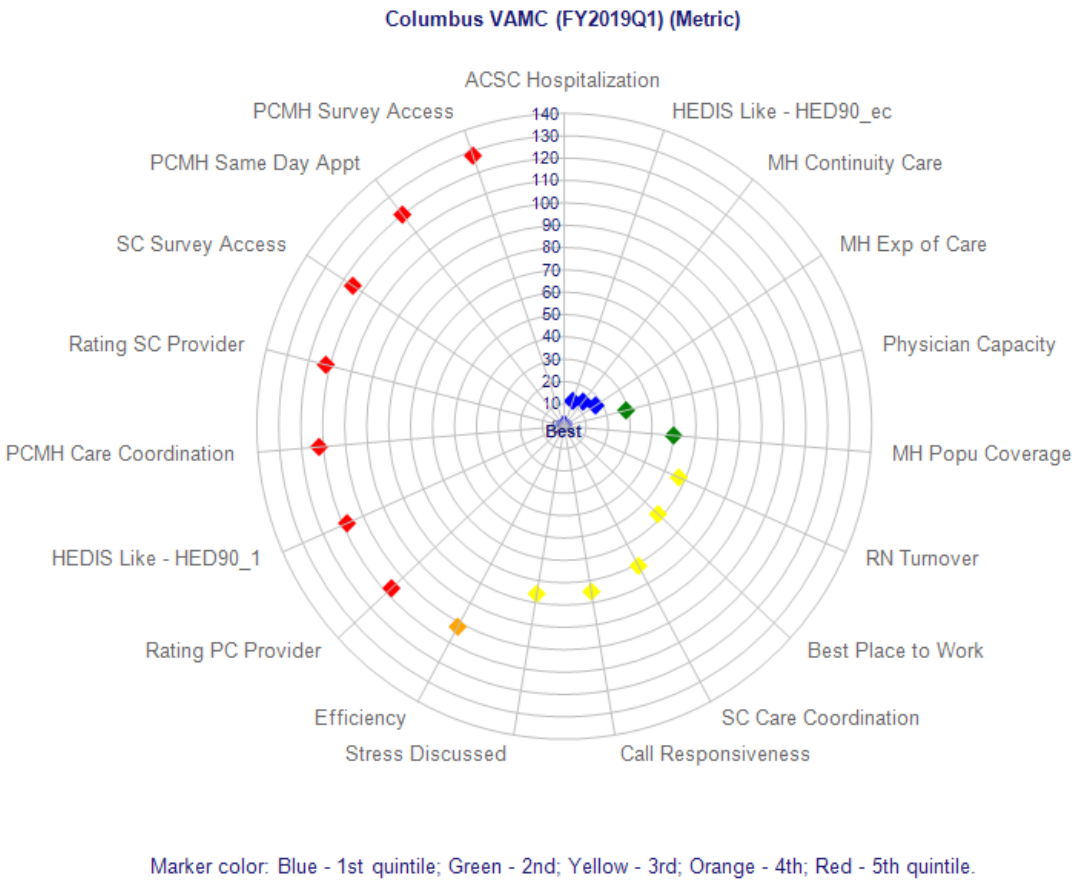

Figure 7. *Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team appeared relatively stable, with the latest vacancy—the director position—permanently filled nine months prior to the OIG's on-site visit. Selected survey scores related to employees' satisfaction with the facility executive leaders were generally better than VHA averages. The selected outpatient experience survey scores were above VHA averages. The facility leaders appeared actively engaged with employees and patients and were working to sustain and further improve employee and patient engagement and satisfaction. The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes through leadership pop-up town hall meetings and implementation of an antibiotic stewardship initiative. The OIG's review of the facility's accreditation findings and disclosures did not identify any substantial organizational risk factors. However, facility leaders have opportunities to evaluate sentinel event trends to ensure processes are effective and

sustained and to conduct timely institutional disclosures. Although the facility leaders have implemented processes to mitigate future risks, an opportunity exists for them to ensure improvements are effective and sustained. The leadership team was knowledgeable within their scope of responsibility about selected SAIL metrics but should continue to take actions to sustain and improve performance of measures contributing to the SAIL "4-star" quality rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care 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.[34] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[35] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[36]

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,[37] utilization management (UM) reviews,[38] patient safety incident reporting with related root cause analyses,[39] and cardiopulmonary resuscitation (CPR) episode reviews.[40]

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.[41]

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[34] 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.)

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

[36] VHA Directive 1026.

[37] 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.

[38] 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.

[39] 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."

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

[41] 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.[42]

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.[43]

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.[44]

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:[45]

- 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

[42] VHA Directive 1117(2).

[43] VHA Handbook 1050.01.

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

[45] For CHIP inspections, 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[46]
- UM[47]
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Annual completion of a minimum of eight root cause analyses[48]
  - Inclusion of required content in root cause analyses (generally)
  - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report to facility leaders
- Resuscitation episode review
  - Evidence of a committee responsible for reviewing resuscitation episodes
  - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
  - Evidence of basic or advanced cardiac life support certification for code team responders
  - Evaluation of each resuscitation episode by the CPR Committee or equivalent

Quality, Safety, Value Conclusion

Generally, the facility achieved the performance indicators listed above. However, the OIG identified concerns with the implementation of improvement actions recommended by the

[46] VHA Directive 1190.

[47] The facility does not provide inpatient care.

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

Protected Peer Review Committee, inclusion of required content in root cause analyses, and committee review of resuscitation episodes that warranted recommendations for improvement.

Specifically, VHA requires that when the Peer Review Committee recommends individual improvement actions, clinical managers implement the actions.[49] Of the 10 peer reviews evaluated, two where a need for improvement actions were identified, the OIG did not find evidence that clinical managers implemented the individual actions. This likely prevented immediate and long-term improvements in patient care in the practice of one or multiple healthcare providers. The risk manager stated that the service chiefs had not provided evidence of completion and that the committee is monitoring the open actions.

Recommendation 1

1. The chief of staff ensures that managers consistently implement improvement actions recommended from peer review activities and monitors managers' compliance.

[49] VHA Directive 1190.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The Chief of Staff is responsible for compliance of this recommendation. The Protected Peer Review Program will continue to require documentation of completed improvement actions recommended from peer review activities to be by both Clinician and Service Chief signature on the peer review improvement action assignment document. On July 15, 2019, the date of inspection, all Service Chiefs with any outstanding peer review improvement actions were notified by the Risk Manager of the non-compliance and all the improvement actions were completed on the same day. Effective August 13, 2019, all improvement actions are required to be completed within 30 days of the peer review improvement action assignment. On October 15, 2019, written notification containing the peer review determination letter and required improvement actions were sent on behalf of the Chief of Staff to both the Clinician and their Service Chief. Completion of all assigned improvement actions will be reported as an open action item and captured within all Peer Review Committee meeting minutes which are reviewed and approved by both the Chief of Staff and Facility Director. Also, effective October 15, 2019, all Peer Review Committee open action items are reported monthly to the Medical Executive Board. Beginning November 12, 2019, written status updates, are required to be submitted at 15 days prior to the assigned peer review improvement action(s) completion due date to the Chief of Staff, by the Clinician's Service Chief.

Numerator = Total number of peer review improvement actions completed timely

Denominator = Number of open peer review improvement actions assigned by the Peer Review Committee

Monthly monitoring of compliance will be performed by the Risk Manager and Peer Review Committee Members and will be reported monthly as an open action item of the Peer Review Committee until a compliance rate of 90% is achieved for no less than six consecutive months.

To ensure credibility, VHA requires a root cause analysis to include several factors, such as participation by leadership, "analysis of the underlying systems through a series of "why" questions to determine where redesigns might reduce risk," exclusion of individuals involved in the event under review, consideration of relevant literature, and identification of at least one root cause with a corresponding action and outcome measure.[50] Of the five individual root cause analyses reviewed, the OIG found that four did not include a review "of the underlying systems through a series of "why" questions." This resulted in insufficient evaluation of patient safety events and limited the analysis of system vulnerabilities that may lead to further patient harm. The patient safety manager stated the "why" questions are documented on a paper worksheet and

[50] VHA Handbook 1050.01.

was unaware of the need to explicitly document the "why" elements in the root cause analysis database.

Recommendation 2

2. The facility director makes certain that the patient safety manager or designee includes all required components in each root cause analysis to ensure quality and consistency of reviews and monitors the patient safety manager's compliance.

Facility concurred.

Target date for completion: January 30, 2020

Facility response: The Patient Safety Manager is responsible for compliance of this recommendation. Effective July 25, 2019, all Root Cause Analysis documentation includes documentation of the series of "why" questions within the cause and effect diagram generated within the Root Cause Analysis, SPOT Program.

Numerator = Documentation of "Why" Questions within the Root Cause Analysis Cause and Effect Diagram

Denominator = Number of Root Cause Analysis's Performed by the Patient Safety Manager

A 100% review of all Root Cause Analysis documentation of underlying systems and "why" analysis documentation will be reviewed by the Chief of Quality and reported to the Facility Director and will continue until a compliance rate of 100% is achieved for six consecutive months.

For resuscitation episode reviews, VHA requires that the facility's Cardiopulmonary Resuscitation Committee review each resuscitative episode occurring in the facility and involving its clinical staff.[51] The OIG reviewed the facility's sole resuscitation episode and found no evidence of committee review. This likely resulted in missed opportunities for the identification of errors or deficiencies in technique or procedures; availability or malfunction of equipment; or clinical or patient care issues, such as failure to rescue, that can contribute to the occurrence of a cardiopulmonary event. The Cardiopulmonary Resuscitation Committee chair stated the code was not reviewed by the committee since most of its members were involved in the code and present at the debriefing meeting.

Recommendation 3

3. The facility director ensures that the appropriate committee reviews all resuscitative episodes, to include the required components, and monitors committee's compliance.

[51] VHA Directive 1177(2).

Facility concurred.

Target date for completion: March 31, 2020

Facility response: The Chief of Quality is responsible for compliance of this recommendation. On October 4, 2019, the Cardiopulmonary Resuscitation Committee Charter was revised by the Committee Chair to reflect the Committee's responsibility to ensure that each resuscitative episode is reviewed during Committee meetings and the review and evaluation is documented within Committee meeting minutes. Additionally, the Committee Charter was revised to illustrate the requirement of the Quality Manager to review all resuscitative episodes. The Chief of Quality was also added as a Cardiopulmonary Resuscitation Committee member to the Committee Charter. Prior to each Committee meeting, the Patient Safety Manager will submit all completed Code Blue De-Brief documents to the Committee Chair for review and inclusion within the Committee Agenda and ensure the discussion is captured in the meeting minutes. The Quality Chief will review all resuscitative episode documentation and Cardiopulmonary Resuscitation Committee meeting minutes for compliance and will provide a written report of any deficiencies to the Facility Director.

Numerator = Number of Facility Resuscitation Episodes Reviewed by the Committee with Documentation of Analysis of the Resuscitative Events

Denominator = Total Number of Facility Resuscitative Episodes

A 100% audit of all resuscitative episode documentation will be performed by the Chief of Quality to monitor for compliance and sustainment until a compliance rate of 95% is achieved for a period of six months.

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.)

- One solo or few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months[57]
- Eight LIPs hired within 18 months before the site visit
- Twenty LIPs re-privileged within 12 months before the visit
- No providers underwent a FPPE for cause within 12 months prior to the visit

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[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 January 15, 2018, through July 15, 2019. The 12-month review period covered July 15, 2018, through July 15, 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

The OIG found general compliance with requirements for privileging. However, the OIG identified concerns with FPPE and OPPE processes which warranted recommendations for improvement.

Specifically, VHA requires the criteria for the FPPE process "to be defined in advance, using objective criteria accepted by the practitioner."[59] The OIG reviewed eight profiles and found that all of them lacked evidence that providers were aware of the criteria for evaluation before initiation of the FPPE process. This could result in providers misunderstanding the FPPE expectations. The chief of staff and chief of Specialty Care believed the verbal presentation during the providers' orientation met the standard and stated they did not document discussion of the FPPE process.

Recommendation 4

4. The chief of staff ensures that clinical managers define the focused professional practice evaluation process in advance and monitors clinical managers' compliance.

[59] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The Chief of Staff is responsible for compliance of this recommendation. On August 14, 2019 all Focused Professional Practice Evaluation forms were updated to include an attestation statement, signature line and date to confirm that the Focused Professional Practice evaluation criteria was reviewed with the Provider during service specific Provider orientation. On August 21, 2019, a Service Level Provider Folder Checklist was created for all Clinical Services to utilize as a guide to provide a reference of required documentation to ensure Provider attestations are completed and present in every Provider's Service Level Provider Folder. All Service Chiefs are required to utilize the Service Level Provider Folder Checklist effective September 9, 2019. 100% review of all new Provider FPPE forms are tracked through a Focused Professional Practice Evaluation Provider Roll Up Database that is maintained by the Credentialing & Privileging Coordinator and is reviewed and reported monthly within the Credentialing & Privileging Committee that is led by the Chief of Staff. On August 21, 2019 an auditing process was implemented. A random audit of ten percent of all Service Level Focused Professional Practice Provider files will be performed on designated service areas on a monthly basis by the Credentialing & Privileging Coordinator and the Chief of Quality to verify that Focused Professional Practice Evaluation forms are signed by Providers.

Numerator = Number of Focused Professional Practice Evaluation Forms Signed by Providers

Denominator = One Hundred Percent of the Randomly Sampled Focused Professional Practice Evaluation Forms Submitted to the Credentialing & Privileging Committee

Monthly audits will be performed by the Credentialing & Privileging Coordinator and Chief of Quality and the results will be reported to the Credentialing & Privileging Committee's monthly meeting to monitor for compliance and sustainment until a compliance rate of 90% is achieved for six months. The Credentialing and Privileging Committee will report audit results monthly to the Medical Executive Board that is chaired by the Chief of Staff.

Specific to the OPPE process, VHA requires that at the time of re-privileging, service chiefs consider relevant data when determining and recommending the continuation of LIPs' privileges to the Executive Committee of the Medical Staff, referred to as the Medical Executive Board at this facility.[60] Such data are maintained as part of the practitioner's profile and may include direct observations, clinical discussions, and clinical record reviews. The OPPE process "is essential to confirm the quality of care delivered. This allows the facility to identify professional practice trends that impact the quality of care and patient safety."[61]

[60] VHA Handbook 1100.19.

[61] VHA Handbook 1100.19.

For 9 of 21 LIP OPPE profiles (including one solo allergist), the OIG noted insufficient evidence that the service chiefs' determinations to continue privileges were based on results of OPPE activities. Additionally, for these nine profiles, the facility's Medical Executive Board recommended continuation of privileges without OPPE data or service chief determination. As a result, these providers continued to deliver care without a thorough evaluation of their professional practice trends. This is a repeat finding from the OIG Combined Assessment Program review in November 2015.[62] The chief of staff and chief of specialty care reported a lack of oversight for ensuring standardized methods for collecting and documenting OPPE evidence and for maintaining data for presentation.

Additionally, VHA requires that re-privileging "must be conducted at least every 2 years" and include ongoing monitoring of privileges for that time frame. The monitoring must be "practitioner specific, reliable, easily retrievable, timely, justifiable, comparable, and risk adjusted where appropriate."[63] One provider's profile included a summary document, however there was no clinically pertinent evidence to support the OPPE. This provider's evaluation was not based on data or patient encounters during the re-privileging period due to the provider functioning in an administrative role. This results in an inability to accurately assess a provider's current competency to deliver quality and safe patient care. The chief of staff believed that clinical privileges were required for the provider's administrative duties.

Recommendation 5

5. The chief of staff confirms that clinical managers ensure ongoing professional practice evaluations include service chief's determination to continue privileges based on the results of the evaluations within the re-privileging period and monitors clinical managers' compliance.

[62] VA Office of Inspector General, *Combined Assessment Program Review of the Chalmers P. Wylie VA Ambulatory Care Center*, Report No. 15-04694-80, January 14, 2016.

[63] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The Chief of Staff is responsible for compliance of this recommendation. On August 21, 2019, a Service Level Provider Folder checklist was created for all Clinical Services to utilize as a guide to provide a reference of required documentation to include the presence of clinical pertinence reviews for Service Chief's confirmation of review of Ongoing Professional Practice Evaluations. The checklist must be completed at least every six months confirming review of all required documentation and placed in Providers' Service Level Provider folder. At the time of Provider re-privileging, each Service Chief will be required to provide evidence of clinical pertinence review that includes documented evidence of the required components of the checklist in addition to completion of the checklist when presenting recommendations for privileging to the Credentialing & Privileging Committee. Compliance of evidence of clinical pertinence review by the Credentialing & Privileging Committee will be reported to the Medical Executive Board that is chaired by the Chief of Staff.

Numerator = Number of Re-Privileging Requests Presented with Evidence of Clinical Pertinence Review

Denominator = One Hundred Percent of Re-Privileging Requests per Month

Monthly monitoring of compliance will be performed by Credentialing & Privileging Committee members who will perform a 100% review during each Committee meeting of all re-privileging requests by Service Chiefs to monitor for compliance and sustainment until a compliance rate of 95% is achieved for six months.

Recommendation 6

6. The chief of staff makes certain that the facility's Medical Executive Board considers ongoing professional practice evaluation results in its decision to recommend continuation of provider privileges and monitors compliance.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The Chief of Staff is responsible for compliance of this recommendation. At the time of Provider re-privileging, each Service Chief will be required to provide evidence of clinical pertinence review when presenting recommendations for privileging to the Credentialing & Privileging Committee and compliance will be reported monthly at the Medical Executive Board that is chaired by the Chief of Staff.

Numerator = Number of Re-Privileging Requests Presented with Evidence of Clinical Pertinence Review

Denominator = Number of Re-Privileging Requests Reported to the Medical Executive Board per Month

Monthly monitoring of compliance will be performed by Credentialing & Privileging Committee members who will perform a 100% review during each Committee meeting of all re-privileging requests by Service Chiefs to monitor for compliance and sustainment until a compliance rate of rate of 95% is achieved for six months.

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.[64]

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.[65]

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.[66]

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

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

[65] 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).

[66] 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.)

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

[68] 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,[69] and National Fire Protection Association standards.[70] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[71]

In all, the OIG team inspected 20 patient care areas—women's clinic, chiropractic and acupuncture, geriatrics, primary care north, primary care south, dermatology, nutrition, endocrinology, renal, cardiology, pulmonary, neurology, gastrointestinal clinic, gastrointestinal procedures, surgical pre and post-operative, prosthetics, optometry clinic, podiatry, mental health outpatient, and audiology and speech. The team also inspected the Newark 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[72]
  - Mental health environment of care rounds

[69] 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.)

[70] 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.)

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

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

  - 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

Environment of Care Conclusion

Generally, the facility met requirements as reflected by the above performance indicators. The OIG did not note any issues with the availability of medical equipment and supplies. The OIG made no recommendations.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.[73] 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.[74]

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.[75]

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;[76] and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
  - Monthly summary of findings to the director
  - Quarterly trend reports to the director
  - Quality Management Committee's review of monthly and quarterly trend reports
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Staff restrictions for monthly review of balance adjustments[77]
- Requirements for controlled substances inspectors

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

[74] 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.

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

[76] The two quarters were from January 1, 2019, through June 30, 2019.

[77] 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[78]
  - 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[79]
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[80]

[78] 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."

[79] 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*.)

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

Medication Management Conclusion

The OIG found general compliance with requirements for most of the performance indicators evaluated, including the requirements for controlled substances inspectors, controlled substances area, and pharmacy inspections. The OIG found that the individual performing the monthly review of controlled substances balance adjustments also had the security key to perform balance adjustments, but this was corrected while the OIG was on site. The OIG identified deficiencies in the Continuous Quality Improvement Board's review of monthly and quarterly trend reports and follow-up of identified corrective actions until completion that warranted recommendations for improvement.

VHA requires that monthly and quarterly controlled substances inspection program reports are reviewed for adherence with controlled substances inspection program requirements; this must be performed at least quarterly by the committee responsible for quality oversight. Additionally, VHA expects the committee to identify corrective actions and track until completion.[81] The OIG found that for FY 2019, the Continuous Quality Improvement Board had not reviewed the controlled substances inspection program reports at least quarterly and had not established corrective actions or follow-up for the trends identified by the controlled substances coordinator. This may result in inadequate oversight and follow-up on identified trends that could create opportunities for diversion of controlled substances. The chief of Quality Management stated that a change in the committee reporting calendar may have contributed to the controlled substances report not being presented quarterly to the committee and reported that insufficient documentation of corrective actions was due to work done outside of and not tracked through the committee.

Recommendation 7

7. The facility director makes certain that monthly and quarterly controlled substances inspection reports are reviewed at least on a quarterly basis by the facility committee responsible for quality oversight and that identified corrective actions are followed up until completion and monitors compliance.

[81] VHA Handbook 1108.02(1).

Facility concurred.

Target date for completion: January 30, 2020

Facility response: The Chief of Quality is responsible for compliance of this recommendation. On July 25, 2019, the Controlled Substance Inspection Program reports and findings from fiscal year 2019, quarter one through quarter three were reviewed within the facility's Continuous Quality Improvement Board meeting that is chaired by the Facility Director and Co-chaired by the Chief of Quality. Controlled Substance Inspection Program reporting has been revised to reflect monthly reporting (previously quarterly reporting) as a standing monthly agenda item within the Quality, Safety, Value Board (formerly named the Continuous Quality Improvement Board). All Quality, Safety, Value Board meeting minutes will be reviewed by the Facility Director for compliance and sustainment. All Controlled Substance Inspection Items were reviewed by the Quality, Safety Value Board as presented by the facility's Compliance Officer who serves as the organization's Controlled Substance Inspection Coordinator. Trends identified within fiscal year 2019, quarter one through quarter three within the Controlled Substance Inspection Program were addressed and corrective actions were taken. All Controlled Substance Inspection Program actions are now tracked within the Board's open action item tracker.

Numerator = Number of Controlled Substance Inspection Program Corrective Actions Tracked to Completion

Denominator = Number of Controlled Substance Inspection Program Corrective Action Items Identified

The Quality, Safety, Value Board members will track all Controlled Substance Inspection Program corrective action items to monitor for compliance and sustainment until a compliance rate of 90% is achieved for six months.

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

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

VHA requires that the facility director 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.[84] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[85]

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

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

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

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

[84] VHA Directive 1115.

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

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

[87] VHA Directive 1115.

[88] VHA Handbook 1160.01.

[89] VHA Directive 1115.

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

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 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

Generally, the OIG found compliance with many of the performance indicators, including the designation of an MST coordinator, tracking of MST-related data, and provision of clinical care. There was concern noted, however, with providers completing MST mandatory training that warranted a recommendation for improvement.

VHA requires that all primary care and mental health providers complete the MST mandatory training; for those hired after July 1, 2012; this training must be completed no later than 90 days

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

after entering their position.[91] The OIG found that three employees hired prior to July 1, 2012, had not completed the training and for those employees hired after July 1, 2012, 9 of 13 did not complete training within 90 days of their hire date. With timely training, clinicians are more likely to provide a consistent level of counseling, care, and service to veterans who experienced MST. The chief of Quality, Safety, and Innovations reported that manual corrections of staff education accounts may have been missed after a training course assignment change. Additionally, one staff member had not been assigned the training.

Recommendation 8

8. The chief of staff ensures that mental health and primary care providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Chief of Education Service is responsible for compliance of this recommendation. On July 30, 2019 an auditing process in collaboration with the organization's Human Resources Service was established to identify all newly hired and internally transferred mental health providers and mental health staff. Subsequent to the finding identified, the Chief of Education Service conducted a manual review of all the mental health staff training assigned within the Talent Management System platform to ensure that all Military Sexual Trauma mandatory trainings were assigned to the appropriate staff. Military Sexual Trauma training compliance is now reviewed monthly and any identified deficiencies are reported to the employee and their direct supervisor. Compliance of employee completion of Military Sexual Trauma training is reported monthly by the Chief of Education to the Administrative Executive Board that is led by the facility's Associate Director.

Numerator = Confirmation of Mental Health Completed Military Sexual Trauma Training

Denominator = Number of Newly Hired/Transferred Mental Health Staff

Auditing of compliance will continue to be reviewed monthly by the Chief of Education Service until a compliance rate of 90% is maintained for a period of six months.

[91] 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.

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."[92] 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.[93]

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."[94]

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.[95] 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."[96] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[97] 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.[98] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[92] 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.)

[93] *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.)

[94] 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.)

[95] 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.)

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

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

[98] 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.[99]

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 38 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[100] The OIG evaluated the following performance indicators:

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

Geriatric Care Conclusion

The OIG found compliance with providers documenting reasons for medication initiation and validating patient and/or caregiver understanding when education was provided. However, the OIG identified two areas warranting recommendations for improvement—clinicians not providing adequate patient and/or caregiver education specific to the newly prescribed medication and not reconciling patients' medications.

TJC requires that clinicians educate patients and families about safe and effective use of medications and that the patient's medical record contains information that reflects the patient's care, treatment, and services.[101] The OIG estimated that clinicians provided this education to 74 percent of the patients at the facility, based on electronic health records reviewed.[102] Providing medication education is important for patients to be able to manage their own health at home.[103] The chiefs of Primary Care, Behavioral Health, and Pharmacy reported that providers have developed their own documentation templates which may have lacked required elements.

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

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

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

[102] The OIG is 95 percent confident that the true compliance rate is somewhere between 59.0 and 87.2 percent, which is statistically significantly below the 90 percent benchmark.

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

Recommendation 9

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

Facility concurred.

Target date for completion: August 30, 2020

Facility response: The Chief of Staff is responsible for compliance with this recommendation. An antidepressant medication prescribing template is in development for Provider use and will be utilized for documentation of patient and/or caregiver education regarding the use, benefits, risks and potential side effects/interactions of antidepressant medication use. Upon template implementation, monthly audits will be performed within each service area to monitor for compliance. Compliance utilization rate per Service will be reported monthly to the facility Quality, Performance Improvement Council and is subsequently reported and reviewed monthly within the Quality, Safety, Value Board that is chaired by the Facility Director.

Numerator = Number of Completed Antidepressant Medication Prescribing Template Completions

Denominator = Number of Antidepressants Newly Prescribed to Veterans Age 65 and Older

Monthly audits will be performed by the Administrative Officers in each service and reported to the Quality, Performance Improvement Council Chair and Co-Chair until a compliance rate of 90% is maintained for at least six consecutive months.

According to TJC, medication reconciliation "is a process of comparing the medications a patient is taking (and should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications."[104] The OIG estimated that clinicians performed medication reconciliation for 66 percent of the patients at the facility, based on electronic health records reviewed.[105] Failure to maintain and communicate accurate patient medication information and reconcile medications increases the risk of "duplications, omissions, and interactions" in the patient's actual drug regimen.[106] The chiefs of Behavioral Health and Primary Care reported a lack of proper documentation procedures for medication reconciliation as the reason for noncompliance.

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

[105] The OIG is 95 percent confident that the true compliance rate is somewhere between 49.9 and 80.5 percent, which is statistically significantly below the 90 percent benchmark.

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

Recommendation 10

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

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Chief of Staff is responsible for compliance with this recommendation. A standardized medication reconciliation template will be utilized by all prescribing Providers within the Primary Care Service and Behavioral Health Service for documentation of patient medication reconciliation. Training sessions will be provided to prescribing Providers on the use of the template. Audits of a random sample of 10% of daily patient visits will be performed within each service area and reported to the Quality Department to monitor for compliance. Compliance rates per service area will be reported monthly to the facility's Quality Performance Improvement Council for monitoring and compliance until a compliance rate of at least 90% is achieved. Audits results identified within in the Quality/Performance Improvement Council are reported and reviewed monthly within the Quality, Safety, Value Board that is chaired by the Facility Director.

Numerator = Number of Medication Reconciliation Medication Templates Completed by Prescribers

Denominator = A Random sample of 10% of Primary Care and Behavioral Health Patient Visits

Monthly audits will be performed by service area Administrative Officers until a compliance rate of 90% is maintained for a period of six consecutive months.

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

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.[107] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[108] In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.[109] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[110]

VA is authorized to provide "gender-specific services, such as Papanicolaou tests (Pap smears)" to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.[111]

VHA requires that each facility have a "full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health care." VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women's health program. Each facility must also have a "Women Veterans Health Committee (WVHC) comprised of appropriate facility 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.[112]

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

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

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.[113]

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of 41 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 found compliance with many of the performance indicators, including requirements for a designated women veterans program manager and clinical champion, clinical oversight of the women's health program, and follow-up care when indicated. It was noted that the facility is collecting and tracking cervical cancer screening data, however there was no evaluation of data regarding notification of patients due for screening. The OIG noted concerns with the Women Veterans Health Committee membership and communication of abnormal results that warranted recommendations for improvement.

[113] VHA Directive 1330.01(2).

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; "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, emergency department, radiology, laboratory, quality management, business office/non-VA medical care; and a member from executive leadership."[114] From January 2019 through April 2019, the committee lacked representation from medical and/or surgical subspecialties and executive leadership. 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 stated the need for medical and/or surgical representation was inadvertently overlooked, and the ADPCS is the designated representative for executive leadership but had not attended any of the meetings due to scheduling conflicts.

Recommendation 11

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

Facility concurred.

Target date for completion: September 30, 2020

Facility response: The Women's Health Program Manager is responsible for compliance of this recommendation. Membership of the Women Veterans Health Committee and the Committee Charter were reviewed and revised to add a Provider member from medical/subspecialty areas. Executive membership attendance availability was confirmed, and the scheduled time and dates of Committee meetings were changed to better accommodate membership attendance. Attendance will be tracked and reported quarterly to the organization's Medical Executive Board that is chaired by the Chief of Staff.

Numerator = Number of required members attending the Women Veterans Health Committee

Denominator = Number of required members of the Women Veterans Health Committee

Quarterly attendance review will be performed by the Women's Health Program Manager and reported to the Quality, Safety, Value Board until a compliance rate of 90% is maintained for a period of six consecutive months.

VHA requires the ordering provider notify patients of abnormal cervical pathology results within seven calendar days from the date the results are available.[115] The OIG estimated that providers

[114] VHA Directive 1330.01(2).
[115] VHA Directive 1330.01(2).

notified patients of abnormal results within seven calendar days in 85 percent of the electronic health records reviewed.[116] This resulted in delayed patient notification and possible necessary follow-up care. The women veterans program manager stated the providers believed the requirement for patient notification was within seven business days, not calendar days.

Recommendation 12

12. The chief of staff ensures that ordering providers notify patients of abnormal results within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The Chief of Staff is responsible for compliance of this recommendation. A conversion from paper laboratory order forms to electronic orders for all cervical pathology that identifies the ordering provider for notification purposes was implemented. Effective July 18, 2019, a cervical cancer testing tracking standard operating procedure was implemented to provide guidance for oversight of test tracking results notification to patients by nursing staff and review by the Women's Health Program Manager. Women's Health Provider surrogate assignments within the electronic medical record system (CPRS) has been assigned to all covering Providers to ensure all covering Providers receive notification of patient test results for instances in which patient assigned Women's Health Providers may be out of the office to allow for covering Providers to receive and act upon patient abnormal cervical pathology results. Monthly audits of all abnormal cervical pathology result patient notification will be performed by the Women's Health Program Coordinator and reported to the Quality/Performance Improvement Council. Evidence of compliance will be reported by the Quality/Performance Improvement Council to the Quality, Safety, Value Board (formerly named the Continuous Quality Improvement Board).

Numerator = Number of Patients Who Received Notification of Abnormal Cervical Pathology Results Within 7 Calendar Days

Denominator = Number of Abnormal Cervical Pathology Result Reports

Audits of abnormal cervical pathology result patient notification will be conducted monthly until a compliance rate of 95% is achieved for a period of six months.

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

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

VHA defines an emergency department as a "unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations." An urgent care center (UCC) "provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries."[117] A variety of emergency services may exist, dependent on "capability, capacity, and function of the local VA medical facility;" however, emergency care must be uniformly available in all VHA emergency departments and UCCs.[118]

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide "unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week." VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that "evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care."[119]

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can "undermine the timeliness of care and, ultimately, patient safety." Effective management processes that "support patient flow [in the emergency department or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care."[120]

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software (EDIS) tracking program to document and manage the flow of patients.[121]

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

[118] VHA Directive 1101.05(2).

[119] VHA Directive 1101.05(2).

[120] TJC. Leadership standard LD.04.03.11.

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

VA emergency departments and UCCs must also be designed to promote a safe environment of care.[122] Managers must ensure medications are securely stored,[123] a psychiatric intervention room is available,[124] and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also requires emergency departments to have communication systems available to accept requests by local emergency medical services for transporting unstable patients to VA emergency departments.[125]

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

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

[122] VHA Directive 1101.05(2).

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

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

[125] VHA Directive 1101.05(2).

  - Licensed independent mental health provider available as required for the facility's complexity level
  - Telephone message system during non-operational hours
  - Inpatient provider available for patients requiring admission
- Patient flow
  - EDIS tracking program
  - Emergency department patient flow evaluation
  - Diversion policy
  - Designated bed flow coordinator
- General safety
  - Directional signage to after-hours emergency care
  - Fast tracks[126]
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
  - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

The facility generally complied with most of the performance indicators used by the OIG team to assess the operations and management of the UCC. However, the OIG identified the lack of signage directing patients to after-hours emergency care or to the suicide prevention hotline phone number which the facility leaders corrected while OIG was still on site.

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

Incidental Finding

Documentation of Controlled Substances Usage in Anesthesia

VHA requires that facility chief of staff and chief nursing executives or their designees are responsible for "ensuring that all requirements for handling, storage, and security of controlled substances under control of clinical services are followed."[127] The OIG reviewers noted a trend in a lack of documentation of controlled substance administration by anesthesia providers which was reported to facility leaders through the monthly and quarterly controlled substances reports; however there had been no resolution of the issue and no current actions had been identified. Facility leaders had noted this trend and conducted an investigation in 2017. It was reported to OIG that as a result, the provider was retrained, but facility leaders had not conducted any additional follow-up or evaluation to ensure sustained improvement. This resulted in an inability to accurately evaluate the administration of controlled substances and created a risk for controlled substances diversion. The OIG was not provided with a reason for noncompliance, but it was noted that no actions had been taken beyond retraining.

Recommendation 13

13. The facility director ensures that the chief of staff makes certain that all anesthesia providers follow required steps to ensure consistent and safe handling, storage, and security of controlled substances and monitors compliance.

[127] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The Chief of Staff is responsible for compliance with this recommendation. Effective August 19, 2019, a 100% review of all Anesthesia Provider's documentation of controlled substance administration and handling is reviewed by the Chief of Anesthesia and reported to the Credentialing & Privileging Committee that reports to the Medical Executive Board by the Chief of Staff. Monthly reports of controlled substance handling, storage and security will be monitored monthly within the Controlled Substance Inspection Program and results will be reported to the Executive Quality, Safety, Value Board that is chaired by the Facility Director.

Numerator = Number of Controlled Substance Usage and Administration documented Accurately

Denominator = Number of Controlled Substances Accessed and Utilized by Anesthesia Providers

Monthly audits of all controlled substance usage and documentation by Anesthesia Providers will be performed until a sustained compliance rate of 90% is maintained for no less than six months.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• Managers consistently implement improvement actions recommended from peer review activities. • The patient safety manager or designee includes all required components in each root cause analysis to ensure quality and consistency of reviews. • The appropriate committee reviews all resuscitative episodes, to include the required components.	• None
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• Clinical managers define the FPPE process in advance. • Clinical managers ensure OPPEs include service chief's determination to continue privileges based on the results of the evaluations within the re-privileging period. • The facility's Medical Executive Board considers OPPE results in its decision to recommend continuation of provider privileges.	• 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
		• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• None	• Monthly and quarterly controlled substances inspection reports are reviewed at least quarterly by the facility committee responsible for quality oversight and that identified corrective actions are followed up until completion.
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	• Mental health and primary care providers complete military sexual trauma mandatory training within the required time frame.
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 about the safe and effective use of newly prescribed medications. • Clinicians maintain and communicate accurate patient medication information in patients' electronic health record and reconcile medications.	• 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	• Ordering providers notify patients of abnormal results within the required time frame.	• The Women Veterans Health Committee is comprised of the required core members.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• 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		
High-Risk Processes: Operations and Management of Emergency Departments and UCCs	• General • Staffing for emergency department/UCC • Support services for emergency department/UCC • Patient flow • General safety • Medication security and labeling • Management of patients with mental health disorders • Emergency department participation in local/regional EMS system • Women veteran services • Life support equipment	• None	• None
Incidental Finding		• Anesthesia providers follow required steps to ensure consistent and safe handling, storage, and security of controlled substances.	• None

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this medium complexity (2) affiliated[128] facility reporting to VISN 10.[129]

Table B.1. Facility Profile for Chalmers P. Wylie Ambulatory Care Center (757) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[130]	Facility Data FY 2017[131]	Facility Data FY 2018[132]
Total medical care budget in dollars	$248,211,904	$255,044,889	$317,934,711
Number of:			
• Unique patients	41,433	42,081	42,663
• Outpatient visits	521,159	536,490	554,701
• Unique employees[133]	1,001	1,042	1,153
Type and number of operating beds:	0	0	0

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

[128] Associated with a medical residency program.

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

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

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

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

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

VA Outpatient Clinic Profiles[134]

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)[135]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[136] Provided	Diagnostic Services[137] Provided	Ancillary Services[138] Provided
Zanesville, OH	757GA	8,191	2,580	Cardiology Dermatology Endocrinology Gastroenterology Pulmonary/ Respiratory disease Eye General surgery	EKG	Nutrition Pharmacy Prosthetics Social work Weight management

[134] Includes all outpatient clinics in the community that were in operation as of February 8, 2019.

[135] 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."

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

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

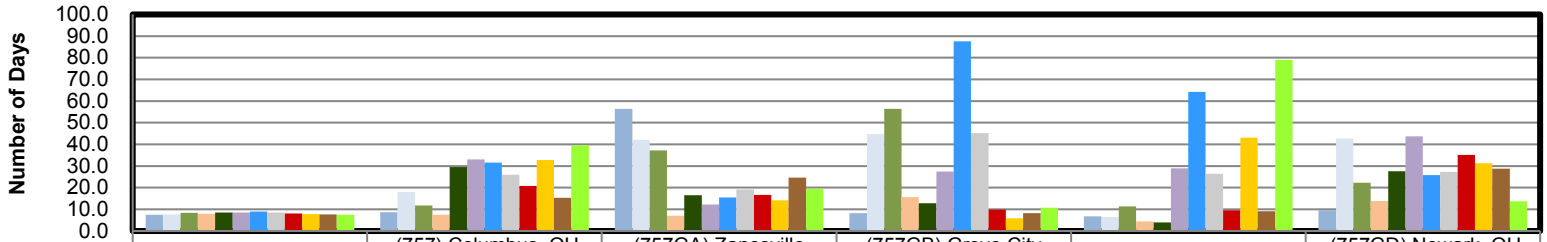
[138] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[136] Provided	Diagnostic Services[137] Provided	Ancillary Services[138] Provided
Grove City, OH	757GB	5,887	2,723	Dermatology Endocrinology	EKG	Pharmacy Prosthetics Weight management Nutrition
Marion, OH	757GC	6,470	2,259	Dermatology Endocrinology Gastroenterology Eye	EKG	Pharmacy Prosthetics Social work Weight management Nutrition
Newark, OH	757GD	8,149	2,316	Cardiology Dermatology Endocrinology Gastroenterology Infectious disease Eye General surgery	EKG	Pharmacy Prosthetics Social work Weight management Nutrition
Columbus, OH	757QC	n/a	16,384	n/a	EKG	n/a

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[139]

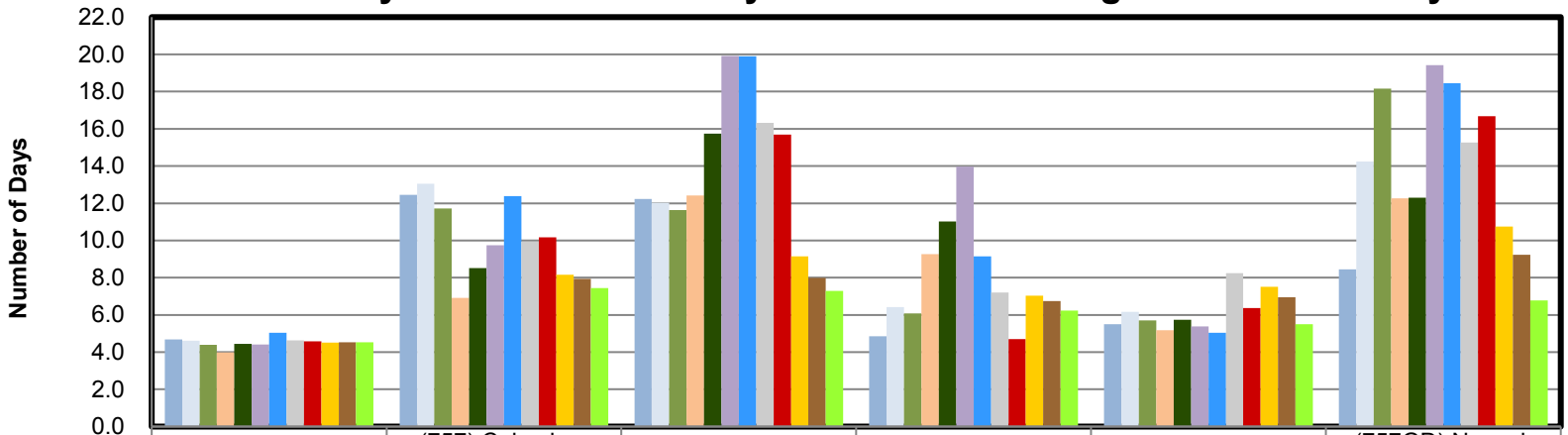
Quarterly New Primary Care Patient Average Wait Time in Days



	VHA Total	(757) Columbus, OH (Chalmers P. Wylie)	(757GA) Zanesville, OH	(757GB) Grove City, OH	(757GC) Marion, OH	(757GD) Newark, OH (Daniel L. Kinnard)
JUL-FY18	7.5	8.8	56.4	8.3	6.8	9.6
AUG-FY18	7.7	18.0	42.2	44.7	6.5	42.6
SEP-FY18	8.5	11.8	37.2	56.4	11.4	22.2
OCT-FY19	8.0	7.6	7.0	15.6	4.3	13.9
NOV-FY19	8.5	29.5	16.5	12.9	3.9	27.6
DEC-FY19	8.6	33.0	12.3	27.5	28.9	43.8
JAN-FY19	9.0	31.6	15.4	87.6	64.3	25.9
FEB-FY19	8.5	25.9	19.2	45.3	26.4	27.3
MAR-FY19	8.1	20.8	16.7	9.8	9.6	35.2
APR-FY19	7.8	32.7	14.2	6.0	43.1	31.4
MAY-FY19	7.6	15.4	24.6	8.2	9.1	28.7
JUN-FY19	7.6	39.6	19.4	10.8	79.1	13.7

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the facility's explanation for the increased wait times for the Community-Based Outpatient Clinic name.
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.

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



	VHA Total	(757) Columbus, OH (Chalmers P. Wylie)	(757GA) Zanesville, OH	(757GB) Grove City, OH	(757GC) Marion, OH	(757GD) Newark, OH (Daniel L. Kinnard)
JUL-FY18	4.7	12.5	12.2	4.9	5.5	8.4
AUG-FY18	4.6	13.0	12.0	6.4	6.2	14.2
SEP-FY18	4.4	11.7	11.6	6.1	5.7	18.2
OCT-FY19	4.0	6.9	12.4	9.3	5.2	12.3
NOV-FY19	4.4	8.5	15.7	11.0	5.7	12.3
DEC-FY19	4.4	9.7	19.9	14.0	5.4	19.4
JAN-FY19	5.0	12.4	19.9	9.1	5.0	18.5
FEB-FY19	4.6	9.9	16.3	7.2	8.2	15.3
MAR-FY19	4.6	10.2	15.7	4.7	6.4	16.7
APR-FY19	4.5	8.1	9.1	7.0	7.5	10.7
MAY-FY19	4.5	7.9	8.0	6.7	6.9	9.2
JUN-FY19	4.5	7.4	7.3	6.2	5.5	6.8

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

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[140]

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

[140] 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: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 15, 2019

From: Network Director, VISN 10 (10N10)

Subj: Comprehensive Healthcare Inspection of the Chalmers P. Wylie Ambulatory Care Center, Columbus, OH

To: Director, Bay Pines Office of Healthcare Inspections (54CH03)

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

1. I have reviewed the draft report of the Comprehensive Healthcare Inspection of the Chalmers P. Wylie Ambulatory Care Center, Columbus, OH.

2. I concur with the responses and action plans submitted by the Chalmers P. Wylie Ambulatory Care Center Director.

3. Thank you for the opportunity to respond to this report.

(Original signed by:)

Ronald E. Stertzbach for

RimaAnn O. Nelson

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

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 22, 2019

From: Director, Chalmers P. Wylie Ambulator Care Center (757/00)

Subj: Comprehensive Healthcare Inspection of the Chalmers P. Wylie Ambulatory Care Center, Columbus, OH

To: Director, VA Healthcare System (10N10)

1. Thank you for conducting the Comprehensive Healthcare Inspection Program (CHIP) Review during the week of July 15, 2019.
2. I have reviewed the recommendations provided and concur with all the recommendations.
3. We appreciate the opportunity to undergo this review as part of our ongoing continuous improvement processes to promote optimal care delivery to our Veterans.
4. Action plans for the recommendations are attached. All thirteen plans of action have been carefully analyzed and implemented and will be closely monitored through satisfactory completion.

(Original signed by:)

Vivian T. Hutson, FACHE

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

OIG Contact and Staff Acknowledgments

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