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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center Alabama

CHIP REPORT | REPORT #19-00057-238 | SEPTEMBER 27, 2019

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Figure 1. *Tuscaloosa VA Medical Center, Tuscaloosa, AL (Source: https://vaww.va.gov/directory/guide/, accessed on May 22, 2019)*

Abbreviations

ADPCS	associate director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CPR	cardiopulmonary resuscitation
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 Tuscaloosa VA Medical Center (the facility). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

CHIP inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus each year.

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

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

This unannounced visit was conducted during the week of April 22, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and

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

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

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, interim 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 Council having oversight for several working groups. The director and the associate director were co-chairs of the Executive Leadership Council, which was responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes.

The facility's leadership team had been working together for eight months, although several had served in their position for years. The director, ADPCS, and associate director were permanently assigned September 20, 2015; November 17, 2013; and July 9, 2017, respectively. The chief of staff has served in an interim capacity since August 20, 2018.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders were engaged and promoted a culture of safety where employees feel safe bringing forward issues and concerns. The selected survey scores for the director and associate director were higher than the VHA average, the chief of staff was similar to or higher than VHA for three of four questions, and the ADPCS was lower than VHA for all four questions reviewed. Although only one of two selected outpatient experience survey scores was higher than the VHA average, facility leaders appeared to be actively engaged with patients.

Additionally, the OIG reviewed accreditation agency findings, sentinel events[2] and disclosures of adverse patient events, and did not identify any substantial organizational risk factors. However, the OIG has concerns regarding the root cause analysis process.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is a way to "understand the similarities

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

and differences between the top and bottom performers" within VHA.[3] Although the leadership team members were knowledgeable within their areas of responsibility about selected SAIL metrics and SAIL community living center (CLC) measures, the leaders should continue to take actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "3-star" and CLC "2-star" quality ratings.[4]

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

Quality, Safety, and Value

The OIG found there was general compliance with requirements for protected peer reviews. However, the OIG identified concerns with the interdisciplinary review of utilization management data and the patient safety program.

Medical Staff Privileging

The OIG generally complied with requirements for privileging and focused professional practice evaluations. However, the OIG identified a deficiency with the ongoing professional practice evaluation process.[5]

Environment of Care

Generally, the facility met safety and privacy measures at the parent facility. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified noncompliance at the parent facility and Selma VA Clinic with environment of care

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

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

[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."

cleanliness and maintenance, inpatient mental health unit panic alarm testing, and the emergency operations plan's hazard vulnerability analysis and inventory of assets and resources.

Mental Health

Generally, the OIG found compliance with many of the performance indicators, including the designation of a military sexual trauma (MST) coordinator, tracking of MST-related data, referral for MST-related care, and the provision of clinical care. However, the OIG noted a concern with providers' completing MST mandatory training.

Geriatric Care

The OIG found compliance with providers justifying the reason for medication initiation, patient/caregiver education and validating general patient and/or caregiver understanding after educating them about newly prescribed medications. However, the OIG identified that providers did not reconcile the patients' medications.

Women's Health

The OIG found compliance with some of the performance indicators, including requirements for a designated women veterans program manager and provision of follow-up care when indicated. The women veterans program manager tracked cervical cancer screening data but did not monitor follow-up care. Additionally, there was not an assigned women's health medical director or clinical champion, the Women Veterans Health Committee lacked required representation, and ordering providers delayed communication of abnormal results to patients.

Summary

In reviewing key healthcare processes, the OIG issued 14 recommendations for improvement directed to the facility director, associate director and chief of staff. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 64–65, 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 Tuscaloosa VA Medical Center (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.[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]

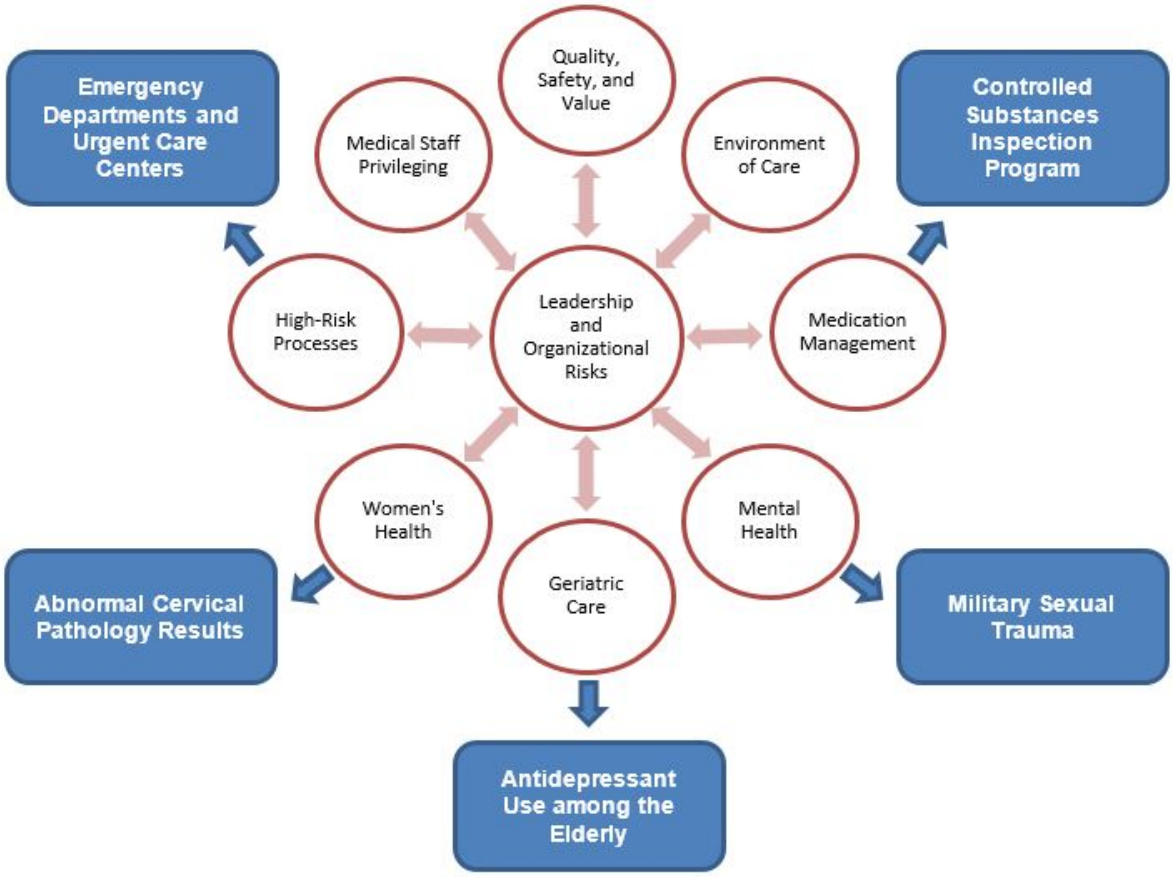

Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

[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 February 6, 2016, through April 26, 2019, the last day of the unannounced week-long 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, interim chief of staff, associate director for Patient Care Services (ADPCS), and associate director (primarily nonclinical). The interim 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.)

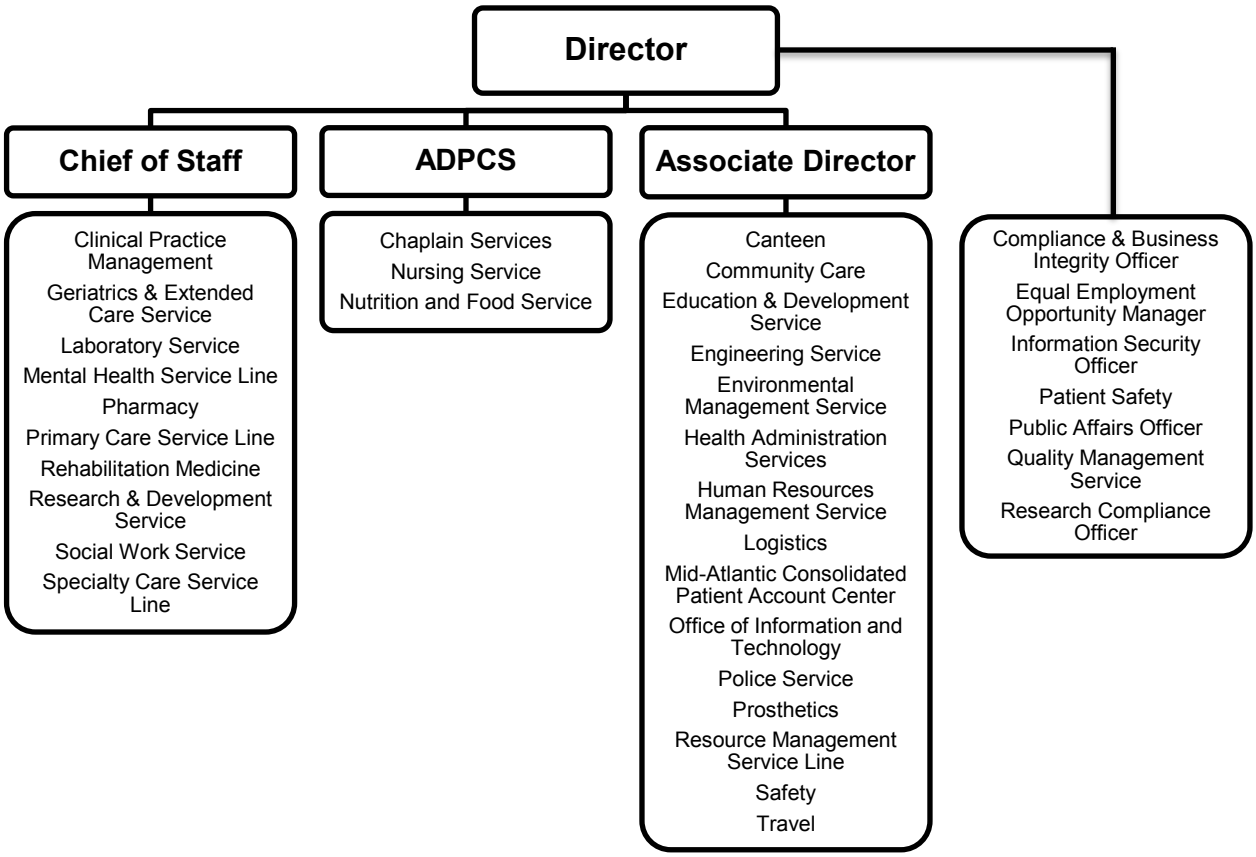

Figure 3. *Facility Organizational Chart*[12]
Source: Tuscaloosa VA Medical Center (received April 22, 2019)

At the time of the OIG site visit, the executive team had been working together for eight months, although several team members have been in their positions for at least two years (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	September 20, 2015
Chief of staff	August 20, 2018 (acting/interim)
Associate director for Patient Care Services	November 17, 2013
Associate director	July 9, 2017

Source: Tuscaloosa VA Medical Center human resources officer (received April 22, 2019)

[12] At this facility, the director is responsible for the Compliance and Business Integrity Officer, Equal Employment Opportunity Manager, Information Security Officer, Patient Safety, Public Affairs Officer, Quality Management Service, and Research Compliance Officer.

To help assess facility executive leaders' engagement, the OIG interviewed the director, interim 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 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 and community living center (CLC) measures. These are discussed in greater detail below.

These leaders are also engaged in monitoring patient safety and care through the Executive Leadership Council, which is chaired by director and co-chaired by the associate director. The Executive Leadership Council is responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Council oversees various working groups, such as the Environment of Care, Finance and Business, Clinical Executive, and Strategic Planning Boards. See Figure 4.

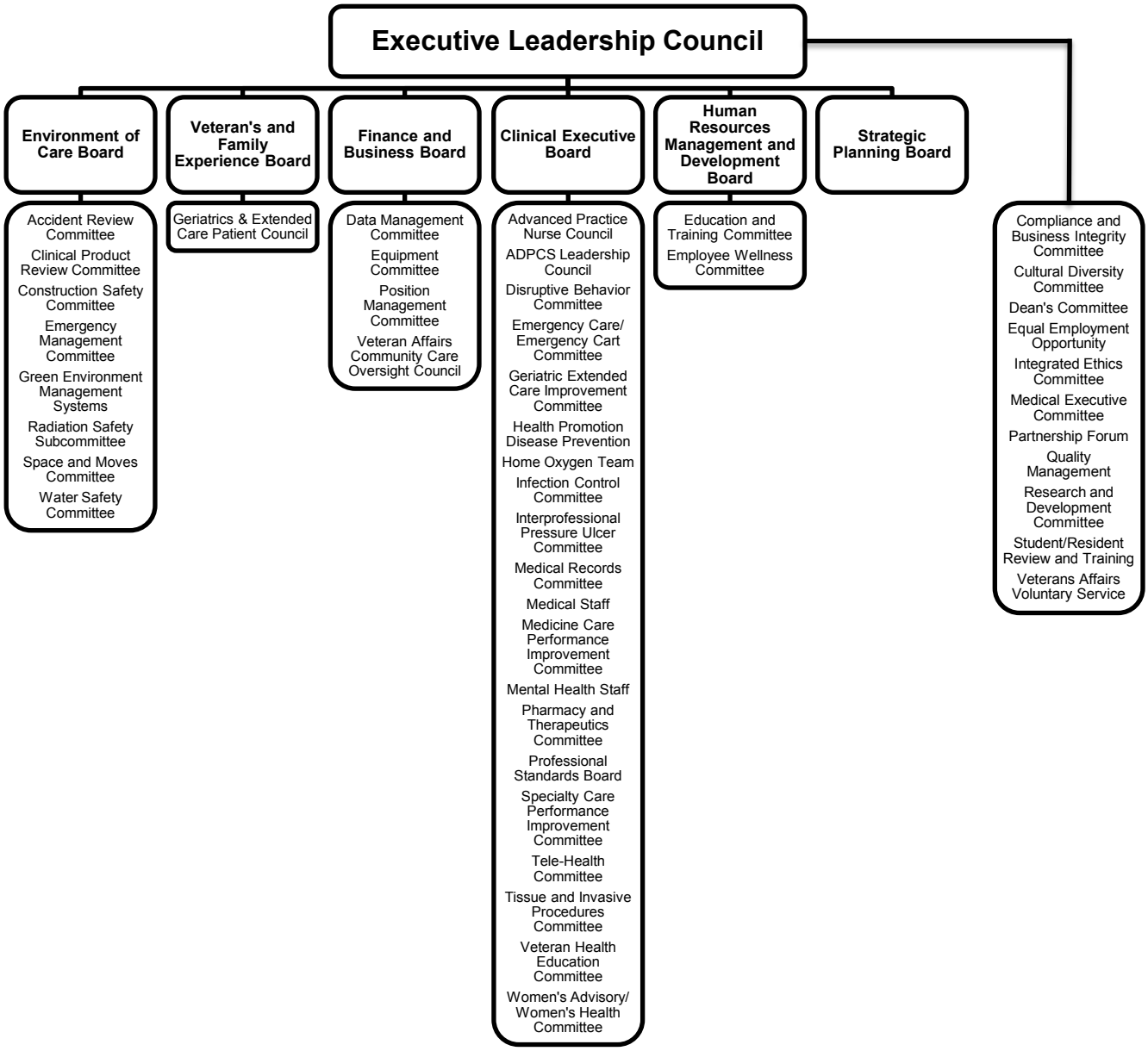

Figure 4. *Facility Committee Reporting Structure*[13]
Source: Tuscaloosa VA Medical Center (April 22, 2019)

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." Since 2001, the instrument has been refined several

[13] The Executive Leadership Council oversees the Compliance and Business Integrity Committee, Cultural Diversity Committee, Dean's Committee, Equal Employment Opportunity, Integrated Ethics Committee, Medical Executive Committee, Partnership Forum, Quality Management, Research and Development Committee, Student/Resident Review and Training, and Veterans Affairs Voluntary Service.

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 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 the selected survey leadership questions was similar to or higher than the VHA average. The response average for the director and associate director were higher than the facility and VHA averages, while those for the chief of staff were similar to or higher than the VHA and facility scores for three of four questions. The ADPCS results were lower than the VHA and facility averages for all four questions reviewed.[15] Of note, the interim chief of staff started in August 2018, and the ADPCS was detailed to another facility from February 2018 through November 2018. The director discussed initiatives to improve employee satisfaction, including "We Care" rounding, an open-door policy, and enhanced communication initiatives. Employees appear satisfied with the director and associate director.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[16]	0–100 where HIGHER scores are more favorable	71.7	73.7	92.2	67.3	68.6	93.6

[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.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.5	4.6	3.7	2.9	3.9
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.5	4.8	3.8	3.3	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	3.6	4.7	3.6	3.1	4.0

Source: VA All Employee Survey (accessed March 22, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility and executive leadership team averages for the selected survey questions were 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	3.8	4.9	4.0	3.9	4.8

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.7	4.3	3.8	3.9	4.4
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	1.4	0.9	1.6	1.1	0.9

Source: VA All Employee Survey (accessed March 22, 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.[17]

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to relevant survey questions that reflect patients'

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

attitudes toward facility leaders (see Table 4). For this facility, one of 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 leaders have established a Veteran Experience Committee which reports to Executive Leadership Council.

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?*[18]	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
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	80.7
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.5	72.6

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

[18] The facility does not have inpatient beds.

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.[19] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[20] Indicative of effective leadership, the facility has closed all recommendations for improvement.[21] The facility had a TJC review in February 2019; however, at the time of OIG site visit, the facility had not received the final report.

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and College of American Pathologists.[22] Additional results included the Long Term Care Institute's inspections of the facility's CLC.[23]

[19] 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.

[20] 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."

[21] 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.

[22] According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs; According to the College of American Pathologists, for 70 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." College of American Pathologists. https://www.cap.org/about-the-cap. (The website was accessed on August 8, 2018.); 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.

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

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the Tuscaloosa VA Medical Center, Tuscaloosa, Alabama, Report No. 16-00108-274, April 28, 2016*)	February 2016	9	0
OIG (*Review of Community Based Outpatient Clinic and Other Outpatient Clinics of Tuscaloosa VA Medical Center, Tuscaloosa, Alabama, Report No. 16-00017-245, April 20, 2016*)	February 2016	4	0
TJC Hospital Accreditation	March 2016	6	0
TJC Nursing care Center Accreditation		3	0
TJC Behavioral Health Care Accreditation		4	0
TJC Home Care Accreditation		1	0

Sources: OIG and TJC (Inspection/survey results verified with the chief of Quality Management on April 22, 2019)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from February 6, 2016 (the prior comprehensive OIG inspection), through April 26, 2019.[24]

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

Table 6. Summary of Selected Organizational Risk Factors (February 6, 2016, through April 26, 2019)

Factor	Number of Occurrences
Sentinel Events[25]	0
Institutional Disclosures[26]	6
Large-Scale Disclosures[27]	0

Source: Tuscaloosa VA Medical Center's risk manager and patient safety manager (received April 22−24, 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.[28] However, this data is not applicable since inpatient medical/surgical care is not provided at the facility.

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[29]

[25] 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."

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

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

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

VA also uses a star-rating system where facilities with a "5-star" rating are performing within the top 10 percent of facilities and "1-star" facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.[30] As of June 30, 2018, the facility was rated as "3-star" for overall quality.

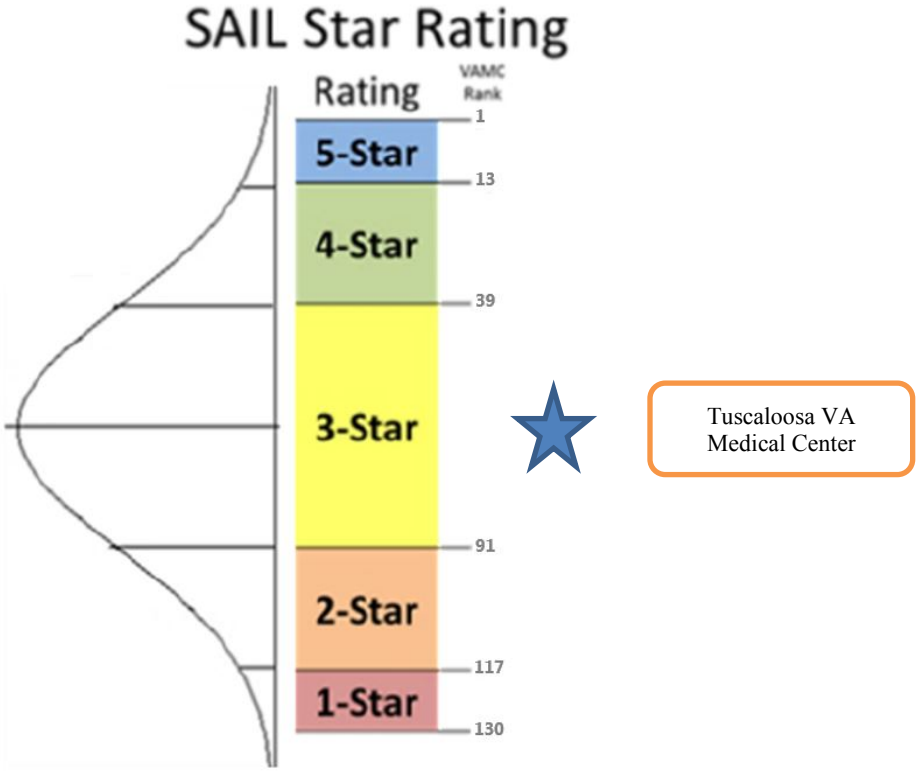

Figure 5. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed March 22, 2019)

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

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

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

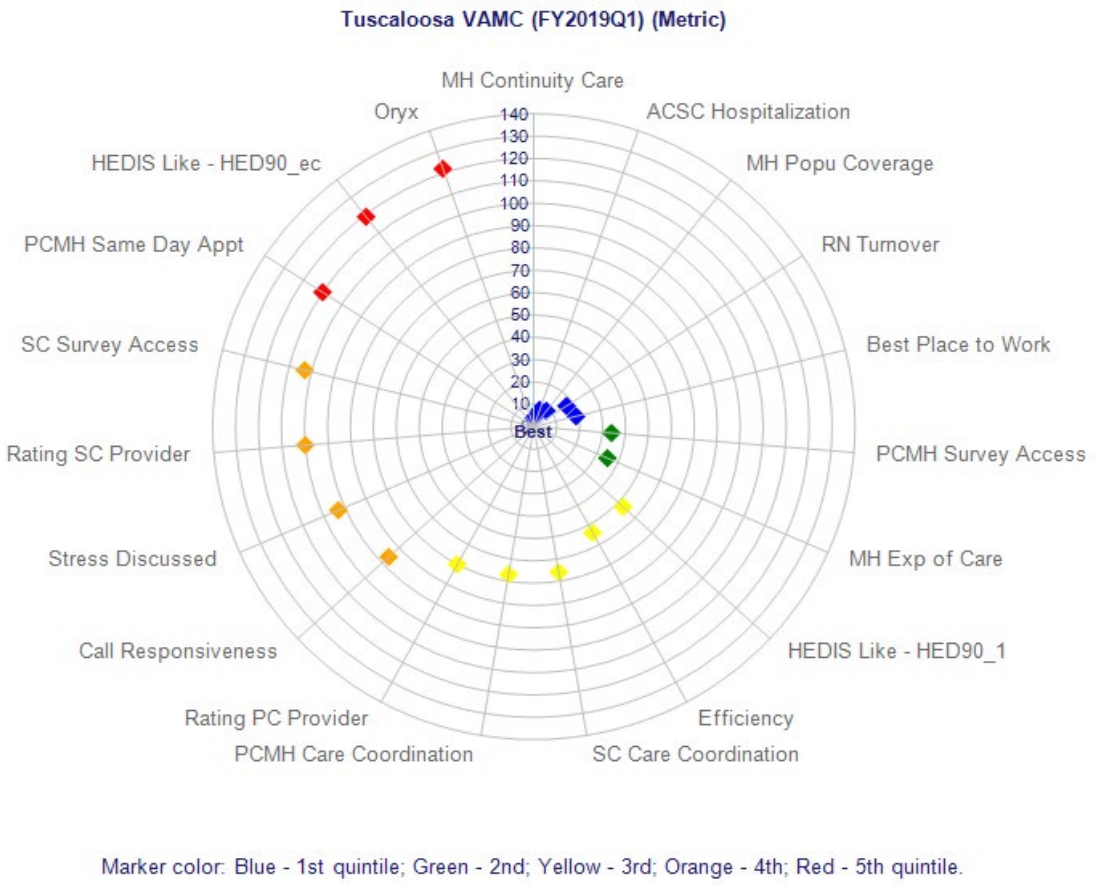

Figure 6. *Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

The SAIL Value Model also includes "SAIL CLC," which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in The Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare*.[32] The SAIL CLC provides a single resource to review quality measures and health inspection results. It

[32] According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, May 21, 2019, "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

includes star ratings for an unannounced survey, staffing, quality, and overall results.[33] Table 7 summarizes the rating results for the facility's CLC as of December 31, 2018. The facility has an overall "2-star" rating; its rating for quality is also "2-star."

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

Domain	Star Rating
Unannounced Survey	1
Staffing	5
Quality	2
Overall	2

Source: VHA Support Service Center

In exploring the reasons for the "2-star" quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 7 illustrates the facility's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of physical restraints long stay (LS), catheter in bladder (LS), and improvement in function short stay (SS)). Metrics that need improvement and were likely the reasons why the facility had a "2-star" for quality are denoted in orange and red (for example, new or worse pressure ulcers (SS), urinary tract infections (UTI) (LS), and falls with major injury (LS)).[34]

[33] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated May 21, 2019). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on July 18, 2019, but is not accessible by the public.)

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

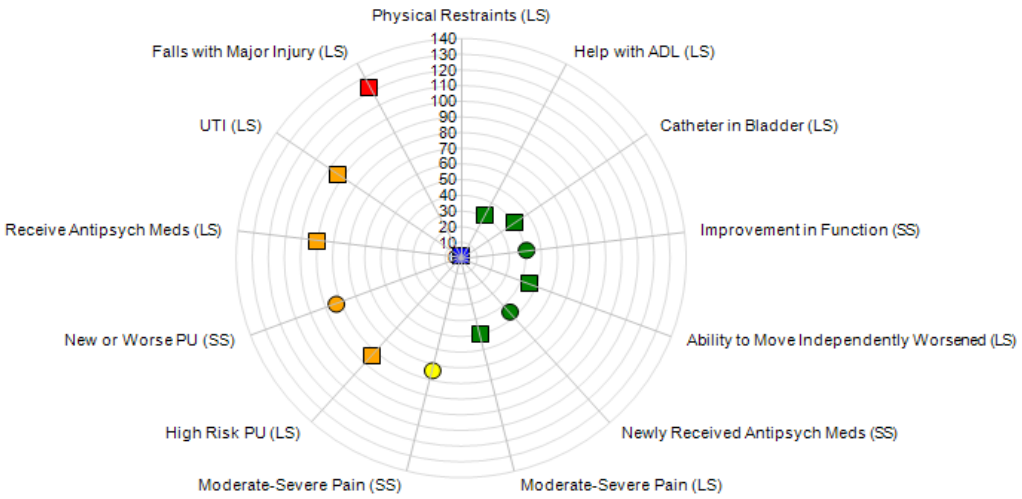

Figure 7. *Facility CLC Quality Measure Rankings (as of December 31, 2018)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team appeared relatively stable, with two of the four leaders carrying out their responsibilities for at least two years. Selected survey scores related to employees' satisfaction with the facility executive leaders were generally higher than VHA averages for the director and associate director, while the ADPCS appeared to have opportunities to improve employee satisfaction. The facility leaders seemed actively engaged with employees and patients and were working to sustain and further improve employee and patient engagement and satisfaction. The leadership appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to maintain positive perceptions of the facility through active stakeholder engagement). The OIG's review of the facility's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors; however, the OIG had concerns regarding the root cause analysis process—the root cause analysis corrective actions were not implemented or, if implemented, not measured, allowing existing system vulnerabilities that were not eliminated or controlled to expose veterans to potential and preventable adverse events (see Recommendations 2–5 on pages 23–25). The leadership team was knowledgeable within their scope of responsibility about selected SAIL and CLC metrics and should continue to take actions to improve performance of measures contributing to the SAIL "3-star" and CLC "2-star" quality ratings.

Quality, Safety, and Value

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

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

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[42]

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[35] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 and has not been recertified.)

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

[37] VHA Directive 1026.

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

[39] According to VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." This directive was in effect at the time of the review but was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019). This directive expired on July 31, 2019.

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

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

[42] 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.[43]

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.[44]

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

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

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

[43] VHA Directive 1117(1).

[44] VHA Handbook 1050.01.

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

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

  - Peer review of all applicable deaths within 24 hours of admission to the hospital
  - Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[47]
- UM[48]
  - 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[49]
  - 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[50]
  - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
  - Evidence of basic or advanced cardiac life support certification for code team responders
  - Evaluation of each resuscitation episode by the CPR Committee or equivalent

[47] VHA Directive 1190.

[48] The facility's inpatient care includes only mental health.

[49] 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 analysis per fiscal year must be individual [root cause analyses], with the balance being aggregated reviews or additional individual [root cause analyses]."

[50] The facility does not have inpatient medical beds and the response to medical emergencies is basic life support and use of the 911 system. They do have a committee that reviews medical emergencies.

Quality, Safety, Value Conclusion

The OIG found general compliance with requirements for protected peer reviews. The facility does not have inpatient medical beds, and for basic life support and other medical emergencies, the staff use the 911 system. The OIG noted that a committee reviewed medical emergencies; however, the committee was not fully evaluating each CPR event. The OIG also identified concerns with the interdisciplinary review of UM data and the patient safety program that warranted recommendations for improvement.

Specifically, VHA requires that an interdisciplinary facility group review UM data. This group must include, but not be limited to, representatives from utilization management, medicine, nursing, social work, case management, mental health, and chief Business Office revenue utilization review (CBO R-UR).[51] From March 2018 through March 2019, the Executive Leadership Council was responsible for the review of utilization management data, however, social work was not represented. This resulted in a lack of expertise in the review and analysis of utilization management data. The chief of Quality Management stated that utilization management data was reported to both the Clinical Executive Board and Executive Leadership Council, and there was a social worker on the Clinical Executive Board. However, neither the Clinical Executive Board nor Executive Leadership Council included all required members. The chief of staff confirmed that it was an oversight that a representative from Social Work Service did not attend the Executive Leadership Council meetings.

Recommendation 1

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

Facility concurred.

Target date for completion: December 31, 2019

Facility response: Tuscaloosa VA Medical Center's Executive Leadership Council added the Chief of Social Work/designee as a voting member on May 13, 2019 to ensure all required representatives consistently participate in interdisciplinary reviews of utilization management data. Monthly attendance for Chief of Social Work/ designee will be monitored by Quality Management until compliance is 90% or greater for six months. Results of the review will be reported to the Executive Leadership Council.

[51] VHA Directive 1117(1).

For root cause analyses, VHA requires facilities to complete a minimum of eight root cause analyses during each fiscal year to help identify and mitigate vulnerabilities in their systems of care and to also avoid future occurrences.[52] For FY 2018, the facility completed six of the eight required root cause analyses, limiting opportunities for the facility to identify and improve system vulnerabilities. The patient safety manager and chief of Quality Management were aware of the requirement to conduct a minimum of eight root cause analyses. The patient safety manager did not have a tracking process in place and stated that completion "fell through the cracks." The patient safety manager reports to the chief of Quality Management, who was not aware of the deficiency until this OIG review.

Recommendation 2

2. The facility director requires the patient safety manager to ensure completion of the required minimum of eight root cause analyses each fiscal year and monitors patient safety manager's compliance.

Facility concurred.

Target date for completion: February 20, 2020

Facility response: The Patient Safety Manager will submit a status report of completed Root Cause Analyses (RCAs) in the quarterly/ annual Patient Safety report to the Executive Leadership Council. Quality Management will monitor compliance (met/not met) for a total of eight RCAs being completed in 2019 and reported in the annual Patient Safety report to the Executive Leadership Council by January 31, 2020.

To ensure thoroughness and credibility, VHA requires root cause analysis to include several elements, such as determination of human and other factors and the processes and systems related to the occurrence, analysis of the underlying systems, consideration of relevant literature, and exclusion of individuals directly involved in the event.[53] None of the five root cause analyses reviewed included all required elements. This resulted in insufficient evaluation of patient safety events and limited the analysis of system vulnerabilities that may lead to patient harm.

According to the patient safety manager, there was not always a trained patient safety specialist involved in the root cause analysis meetings. The patient safety manager stated that the review teams were provided a 90-minute just-in-time training prior to initiating the root cause analysis and the team would identify someone with experience to facilitate the meetings. The teams received guidance for performing the analysis but did not document the steps to show completion of the root cause analysis. The patient safety manager had reported being unavailable to support and assist with root cause analyses due to competing priorities such as being the chair of the

[52] VHA Handbook 1050.01.

[53] VHA Handbook 1050.01.

Institutional Review Board, recall coordinator, and ethics chairperson. The chief of Quality Management supervises the patient safety manager and reported to the OIG the lack of awareness that assistance was needed to support the patient safety program.

Recommendation 3

3. The facility director makes certain that the patient safety manager or designee includes all the required elements in root cause analyses and monitors patient safety manager's compliance.

Facility concurred.

Target date for completion: March 1, 2020

Facility response: The Patient Safety Manager will ensure just in time training for Root Cause Analysis (RCA) team members prior to the initiation of the review. RCA just in time training will encompass VHA Handbook 1050.01 requirements for RCA process and documentation to include but not limited to elements, such as determination of human and other factors and the processes and systems related to the occurrence; analysis of the underlying systems; identification of system vulnerabilities or risks and their potential contributions to the adverse event or close call; consideration of relevant literature; exclusion of individuals directly involved in the event; and identify at least one root cause with corresponding action and outcome measure. In addition, all Senior leadership and the Quality Manager will receive training on all required elements of RCAs no later than October 2019. Quality Management will monitor compliance for 90% or greater for six months as evidence by the RCA team documenting required elements for each individual or aggregate RCA and report to the Executive Leadership Council by March 1, 2020.

VHA requires QSV reviews to be completed, evaluated, and monitored for effectiveness.[54] Additionally, VHA requires that corrective actions identified through root cause analysis processes are implemented to prevent occurrences of similar events.[55] For two of five root cause analyses reviewed, the OIG did not find evidence of action items implementation. For the three root cause analyses where action plans were implemented, none had outcomes measured to assess if the action created improvement. This resulted in the potential for future occurrences of similar events.

The patient safety manager stated the facility had no formal tracking for actions or outcome measures. The patient safety manager determined future requirements, sent reminders to those responsible for completing the identified corrective actions, and submitted a patient safety report to the Executive Leadership Council which did not include overdue action items or outcome

[54] VHA Directive 1026.

[55] VHA Handbook 1050.01.

measures. The chief of Quality Management admitted that the report did not consistently include robust content.

Recommendation 4

4. The facility director ensures that managers consistently implement improvement actions arising from root cause analysis activities and evaluate actions taken for sustained improvement and monitors compliance.

Facility concurred.

Target date for completion: March 15, 2020

Facility response: The RCA report with action plan and outcome measures will be submitted to the Director for concurrence through the Patient Safety Manager. A tracking spreadsheet will be used to monitor completion of action plan and outcome measures by the Patient Safety Manager with status report provided to the Executive Leadership Council monthly including any overdue action items or outcome measures. Numerator: number of outcome measures completed on time and Denominator: total number of outcome measures. Compliance will be monitored by Quality Management monthly for six months until 90% compliant with completion of action items for individual/ aggregate RCAs and reported to Executive Leadership Council.

In addition, VHA requires that the patient safety manager or designee provides feedback about root cause analysis actions to the individuals or departments who reported the incidents.[56] For the four applicable root cause analyses, the OIG did not find evidence that the individual or department reporting the incident received feedback about actions taken. This resulted in missed opportunities to establish employee trust in the system and to positively reinforce a culture of safety. Due to lack of attention to detail, the patient safety manager did not follow up with reporting individuals or departments.

Recommendation 5

5. The facility director ensures the patient safety manager or designee provides feedback to individuals or departments who submit patient safety incidents that result in root cause analysis and monitors patient safety manager compliance.

[56] VHA Handbook 1050.01.

Facility concurred.

Target date for completion: February 20, 2020

Facility response: The Patient Safety Manager/ designee will verify on the RCA tracking sheet whether the individual(s) or departments who submitted patient safety incidents that resulted in root cause analysis was provided feedback and report in quarterly Patient Safety Reports to the Executive Leadership Council. Compliance monitoring will be conducted for six months with a compliance rate of 90% or greater.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging "of all health care 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).[57]

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.[58]

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[s] (OPPE), [are] essential to confirm the quality of care delivered."[59]

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.[60] 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.[61]

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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[57] 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.)

[58] VHA Handbook 1100.19.

[59] VHA Handbook 1100.19.

[60] 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).

[61] 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.)

- Two 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.[62]
- Four 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[63]
  - 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

[62] The 18-month period was from October 22, 2017, through April 22, 2019. The 12-month review period covered April 22, 2018, through April 22, 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.

[63] 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[64]
  - 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 and FPPEs. However, the OIG identified a deficiency with the OPPE process that warranted a recommendation.

Specifically, VHA requires the competency of licensed independent providers be evaluated by another provider with similar training and privileges.[65] Of the two solo providers evaluated, one provider was not evaluated by a similarly trained and privileged provider. As a result, the provider continued to deliver care without a thorough evaluation of their practice. The chief of dental reported that the provider, who has periodontal privileges, primarily works in general dentistry and does minimal periodontal-specific work. In addition, the provider who evaluated the periodontist was trained in the specialty but was not similarly privileged. The interim chief of staff was unaware that the provider should be treated as a solo provider.

Recommendation 6

6. The chief of staff ensures ongoing professional practice evaluations utilize assessments by providers with similar training and privileges and monitors compliance.

[64] The facility did not have providers who underwent FPPE for cause.

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

Facility concurred.

Target date for completion: February 1, 2020

Facility response: The Chief of Staff's office conducted a review to ensure that ongoing professional practice evaluation (OPPE) utilizes assessments by providers with similar training and privileges and monitors compliance. Only Dental service required an amendment to a provider's clinical care review metrics. Compliance with OPPE will be monitored with a compliance of greater than 90% for sustainment for six months with a provider of similar training and privileges completing the clinical care review metrics. The Chief of Staff's office will conduct the monitoring and provide supporting data for compliance to the Medical Executive Committee quarterly.

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.[66]

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.[67]

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.[68]

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.[69] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[70]

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

[67] 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).

[68] 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.)

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

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

Occupational Safety and Health Administration,[71] and National Fire Protection Association standards.[72] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[73]

In all, the OIG team inspected thee areas—the community living center (Eagles Cove), inpatient mental health unit (3-west), and primary care clinic (teams 1 and 2). The team also inspected the Selma 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
  - Mental health environment of care rounds
  - Nursing station security
  - Public area and general unit safety

[71] 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.)

[72] 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.)

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

  - 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 safety and privacy measures at the parent facility with the above performance measures. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified noncompliance with environment of care cleanliness and maintenance, inpatient mental health unit panic alarm testing, and the emergency operations plan's hazard vulnerability analysis and inventory of assets and resources.

Specifically, VHA[74] and TJC[75] require hospitals to identify environmental deficiencies, hazards, and unsafe practices and to keep furnishings and equipment safe and in good repair. At the locked inpatient mental health unit (3 West), community living center (Eagles Cove), and the Selma VA Clinic, the OIG observed dirty/dusty/rusty heating, ventilation, and air conditioning (HVAC) grills; dirty floors; dirty light fixtures or dead insects inside light lenses; and damaged walls and doors. The community living center and the Selma VA Clinic also had stained ceiling tiles. These findings may potentially affect the safety and physical well-being of patients, staff, and visitors. The chief of engineering stated that the dirty/dusty HVAC grills were identified, and a contract was in development for cleaning of the patient rooms. Wall damage was believed to be caused by the moving of oversized equipment used to serve the bariatric population. The environmental management service foreman stated that three housekeeping supervisors and the service chief retired within three months, resulting in staffing challenges.

Recommendation 7

7. The associate director ensures that a safe and clean environment is maintained throughout the facility and Selma VA Clinic and monitors compliance.

[74] VHA Directive 1608.

[75] TJC. Environment of Care standard EC.02.06.01.

Facility concurred.

Target date for completion: January 15, 2020

Facility response: Main Campus: The Engineering Chief ensured that all identified ceiling tiles were replaced, wall repair, and other maintenance issues were addressed immediately. Installation of wall protection and stainless-steel corner guards will be initiated. In addition, we will also replace existing laminate doors with vinyl high-impact doors. Products are on order with a 6-8-week lead time with targeted installation completion by September 13, 2019. The Tuscaloosa VA Medical Center contracts with a vendor for cleaning of heating, ventilation, and cooling system grills which is being contracted to begin August 5, 2019 and completed December 5, 2019.

The Environmental Management Service Chief also ensured that Environmental Management Service workers cleaned areas in the community living center and mental health service areas at the time of the inspection. The facility currently conducts Environment of Care rounds in which deficiencies are tracked until closed within fourteen days or an action plan is initiated and tracked until closure if unable to correct deficiency within the time frame. In addition to the facility Environment of Care Rounds conducted, weekly inspection check sheets were developed to ensure Environmental Management Service supervisors monitor for compliance and initiate corrective actions for deficiencies. Weekly checklists will be submitted to the Environmental Management Service foreman for review. Compliance will be monitored by the Environmental Management Service foreman for six months to ensure identified deficiencies are corrected at 90%.

Selma Community Based Outpatient Clinic is a lease space and is under contract for environmental care services for cleaning. The heating, ventilation, and cooling system issues were corrected by contracted service during the week of the inspection and continues to be cleaned weekly by the contracted service. The Selma CBOC will be checked for cleanliness including the heating, ventilation, and cooling system at least bi-annually during the Environment of Care rounds. Compliance (met/not met) will be monitored by the Safety Specialist for six months. The contracted service will be notified for corrective actions. Identified issues and corrective actions will be tracked until closure within fourteen days or an action plan will be implemented and tracked until resolution. Compliance monitoring will be reported to the Environment of Care Board.

VHA requires that VA police periodically test and document response time to panic alarm testing in the locked mental health units.[76] The OIG found no documented evidence of VA police response times when the facility's locked mental health unit panic alarms were tested. This may

[76] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017; Department of Veterans Affairs, VHA Center for Patient Safety*, Mental Health Environment of Care Checklist (MHEOCC)*, November 15, 2018.

result in an unsafe environment for patients, visitors, and staff since timely police responses greatly impact the overall success of police intervention and reduces organizational risks. Since December 2017, the vacant chief of police position had three interim staff detailed to the position.

Recommendation 8

8. The associate director ensures the VA police respond to panic alarm testing in the locked mental health unit and document response time and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: The Tuscaloosa VA Medical Center police department maintains a spreadsheet to monitor compliance with panic alarm testing with documented evidence of response times for the locked mental health units. A total of seven different panic alarm testing was conducted during May, June, and July 2019 in different locations on the mental health locked units. The response time for panic alarm testing ranged from 1-4 minutes and was documented with 100% compliance. Panic alarm testing with response times will be included in the security report submitted to Environment of Care Board at least quarterly. Numerator: number of panic alarms responded to by police and documented Denominator: total number of panic alarms alarm tests. Monitoring for sustained compliance will be conducted for six months with a target of 90% or greater compliance of documented response times for panic alarm tests conducted.

Also, VHA requires facilities to have a comprehensive emergency management plan that includes an annual review of the hazard vulnerability analysis and inventory of resources and assets that may be needed during emergencies.[77] This review is to be documented, evaluated by the Emergency Management Committee, and approved by the executive leadership team. The OIG found no evidence the Emergency Management Committee reviewed the hazard vulnerability analysis or the inventory of resources and assets during the previous 12 months. This resulted in a lack of assurance that the facility is prepared for contingency operations during emergencies.

The safety manager, in the position for only three months, reported the facility's missing annual review for the hazard vulnerability analysis was an accidental omission. Additionally, the safety manager had only records for inventory directly under emergency management and engineering and acknowledged a lack of full understanding of the required inventory process, review, and validation. According to the chief of engineering, the safety manager did not have the benefit of

[77] VHA Directive 0320.01.

a transition with the predecessor because the prior manager left in September 2016, and the position was covered by acting staff.

Recommendation 9

9. The associate director ensures that the comprehensive emergency management plan is reviewed annually by the Emergency Management Committee and approved by executive leadership and monitors compliance.

Facility concurred.

Target date for completion: February 15, 2020

Facility response: The annual 2018 Emergency Management Plan was completed January 2019 and reviewed by the Emergency Management Committee during August 2019. Continued compliance will be monitored with the annual 2019 Emergency Management Plan by February 15, 2020 with a goal of met/ not met. The annual plan is to be completed and reviewed by the Emergency Management Committee and approved by executive leadership.

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.[78] 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.[79]

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.[80]

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;[81] 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[82]
- Requirements for controlled substances inspectors

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

[79] 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.

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

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

[82] 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[83]
  - Accountability for all prescription pads in pharmacy
  - Verification of hard copy controlled substances prescriptions
  - Verification of 72-hour inventories of the main vault
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[84]

[83] 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."

[84] 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

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

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

The Department of Veterans Affairs uses the term "military sexual trauma" (MST) to refer to a "psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training."[85] "MST is an experience, not a diagnosis or a mental health condition." Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.[86]

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.[87] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[88]

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system.[89] Those who screen positive must have access to appropriate MST-related care.[90] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.[91]

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.[92] All mental health and primary care providers must complete MST mandatory

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

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

[87] VHA Directive 1115.

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

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

[90]VHA Directive 1115.

[91] VHA Handbook 1160.01.

[92] VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[93]

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 39 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, referral for MST-related care, and the provision of clinical care. However, the OIG identified noncompliance with providers' completion of MST mandatory training.

Specifically, VHA requires that all primary care and mental health providers complete the MST mandatory training; for those hired after July 1, 2012, this training must be completed no later than 90 days after entering their position.[94] The OIG found that 2 of 10 providers hired after July

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

[94] VHA Directive 1115.01; Acting Deputy Under Secretary for Health for Operations and Management, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*

1, 2012, did not complete the required training within 90 days. This could potentially result in clinicians providing counseling, care, and service without the required MST training. The chief of psychology reported that one provider was not assigned the training in a timely manner due to lack of attention to detail. The associate chief nurse, mental health service stated the second provider completed the training five days late due to competing priorities that arose as a result of inadequate staffing.

Recommendation 10

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

Facility concurred.

Target date for completion: February 20, 2020

Facility response: The Tuscaloosa VA Medical Center provides and monitors Military Sexual Trauma (MST). Training is assigned to employees upon hire; however, it was identified that employees who were outliers did not complete training prior to the 90 days post hire. Reminders are sent by Talent Management System (TMS) with notification to the employee and supervisor. The sample size used by OIG consisted of 10 employees since July 1, 2012 with two outliers. Tuscaloosa VA Medical Center conducted an audit of employees who required MST training within 90 days of hire from April – August 2019 with a 100% compliance rate noted. Tuscaloosa VA Medical Center will reevaluate in three months to ensure sustainment of compliance of 90% or greater and report through Executive Leadership Council.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."[95] The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.[96]

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepression drugs, psychotherapy, or a combination of both."[97]

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.[98] The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."[99] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[100] Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.[101] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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

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

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

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

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

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

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

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.[102]

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 29 patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[103] The OIG evaluated the following performance indicators:

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

Geriatric Care Conclusion

The OIG found compliance with providers justifying the reason for medication initiation, patient/caregiver education, and validating general patient and/or caregiver understanding after educating them about newly prescribed medications. However, the OIG identified that providers did not reconcile the patients' medications which warranted in a recommendation for improvement.

According to TJC, for medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolve any discrepancies.[104] TJC also requires patients' "medical record contains information that reflects the patient's care, treatment, and services."[105] Furthermore, VHA requires that clinicians review and reconcile medications relevant to the episode of care.[106] The OIG determined that medication reconciliation was performed in 72 percent of the electronic health records reviewed.[107] Failure to maintain and communicate accurate patient medication

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

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

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

[105] TJC. Record of Care, Treatment, and Services standard RC.02.01.01.

[106] VHA Directive 1164.

[107] The confidence intervals are not included because the data represents every patient in the study population.

information and reconcile medications increase the risk that there may be duplications, omissions, and interactions in the patient's actual drug regimen.[108]

The chief of Pharmacy reported that for the five weeks patients were in the residential rehabilitation treatment program, medication reconciliation was ongoing throughout the stay. The patients had frequent medication adjustments, and medication reconciliations were not always documented for each change.

For outpatient prescriptions, the chief of Pharmacy believed medication reconciliation requirements were met because the electronic health record documentation contained an active list of medications. However, the newly ordered medications were documented in a different section of the record, and the providers would have to initiate a new progress note to capture the updated medication in the active medication list. A clinical reminder for medication reconciliation was available, however, not all providers were utilizing it.

Recommendation 11

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

Facility concurred.

Target date for completion: February 20, 2020

Facility response: Tuscaloosa VA Medical Center has a clinical reminder to assist providers with medication reconciliation requirements for medications. An audit was conducted of elderly Veterans 65 years of age or greater on antidepressants for appropriate medication reconciliation with a 61% compliance from May 1, 2019-July 31, 2019. Staff education was provided in Medical Staff Committee by the Pharmacy Chief during the July and August 2019 meetings to discuss the importance of monitoring antidepressants in the elderly and conducting medication reconciliation. Audits will be conducted monthly for six months until 90% or greater compliance is sustained for medication reconciliation conducted for Veterans 65 years of age or greater on antidepressants.

[108] TJC. National Patient Safety Goal standard Rationale for NPSG.03.06.01.

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.[109] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[110] 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.[111] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[112]

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.[113]

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 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.[114]

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

[109] 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.)

[110] Center 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] 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.)

[112] Center for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

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

[114] 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.[115]

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 eight 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

The OIG found compliance with some of the performance indicators, including requirements for a designated women veterans program manager and provision of follow-up care when indicated. The women veterans program manager tracked cervical cancer screening data but did not monitor follow-up care. Additionally, there was no assigned women's health medical director or clinical champion, the Women Veterans Health Committee (noted on Figure 4 as the Women's Advisory/Women's Health Committee) lacked required representation, and ordering providers

[115] VHA Directive 1330.01(2).

delayed communication of abnormal results to patients which warranted recommendations for improvement.

Specifically, VHA requires that each "(Health Care System) must have a WHMD or Women's Health Clinical Champion responsible for clinical oversight of the women's health program."[116] The OIG found that the facility had been without a women's health medical director or clinical champion since July 2018. This resulted in a lack of clinical oversight for the women's veteran program. The interim chief of staff was aware of the requirement and stated that, due to staffing constraints, an interim was not assigned, but active recruitment was in progress.

Recommendation 12

12. The director makes certain that the chief of staff assigns a women's health medical director or clinical champion and monitors chief of staff's compliance.

Facility concurred.

Target date for completion: August 15, 2019

Facility response: A Certified Registered Nurse Practitioner was appointed as the Women's Health Clinical Champion by the chief of staff and approved by the director on August 5, 2019.

In addition, 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, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership."[117] The OIG found that, in addition to a lack of a women's health medical director or clinical champion, the committee also lacked representation from pharmacy, radiology, and laboratory services. 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 awareness of the requirements but assumed there had been prior approval for the current membership as the representation was lacking on previous committee attendance.

Recommendation 13

13. The chief of staff confirms that the Women Veterans Health Committee includes required core members and monitors committee's compliance.

[116] VHA Directive 1330.01(2).

[117] VHA Directive 1330.01(2).

Facility concurred.

Target date for completion: January 15, 2020

Facility response: The Women Veterans' Health Committee's charter was revised to include required core members (Women's Health Clinical Champion, radiology, pharmacy, and laboratory representatives) in April 2019. Monthly attendance at the Women Veterans' Health Committee by the Women's Health Clinical Champion, radiology, pharmacy, and laboratory representatives will be monitored by the Chief of Staff's office until 90% or greater compliance for six months. Compliance will be reported to the Clinical Executive Board every other month.

VHA requires the ordering provider to notify the patient of abnormal cervical pathology results within seven calendar days.[118] The OIG determined that ordering providers notified patients of abnormal results within seven calendar days in 75 percent of the electronic health records reviewed.[119] Timely communication of abnormal results minimizes potential risks to patients. For one patient, the women's health provider was reported as being out of the office without assignment of a backup provider when the pathology results became available; this caused delayed results notification to the patient. The second case involved an inpatient, and the women's health provider communicated results to the inpatient provider; however, communication to the patient was not performed and documented until 189 days later by a registered nurse care manager.

Recommendation 14

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

Facility concurred.

Target date for completion: February 20, 2020

Facility response: Patient notification of abnormal pap smears within seven days was noted at 26% in March 85% in April, and 100% in May 2019 which reflects progressive improvement. Education was provided regarding the seven-day notification for abnormal results to the interim and current Women's Clinic staff in August 2019. Quality Management will conduct audits to monitor sustainment of compliance at 90% or greater for six months for patient notification of abnormal pap smear results by providers within seven days. Compliance reports will be reported to the Clinical Executive Board every other month.

[118] VHA Directive 1330.01(2).

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

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• The patient safety manager ensures completion of the required minimum of eight root cause analyses each fiscal year. • The patient safety manager includes all the required elements in root cause analyses. • The patient safety manager provides feedback to individuals or departments who submit patient safety incidents that result in root cause analysis.	• All required representatives consistently participate in interdisciplinary reviews of UM data. • Managers implement improvement actions arising from root cause analysis activities and evaluate actions taken to ascertain sustained improvement.
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• OPPEs utilize assessments by providers with similar training and 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
		• The VA police respond to panic alarm testing in the locked mental health unit and document response time.	• A safe and clean environment is maintained throughout the facility and Selma VA Clinic.
			• The comprehensive emergency management plan is reviewed annually by the Emergency Management Committee and approved by executive leadership.

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	• None
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	• Primary care and mental health providers complete MST mandatory training within the required time frame.	• None
Geriatric Care: Antidepressant Use among the Elderly	• Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation	• Clinicians review and reconcile patients' medications and maintain and communicate accurate patient medication information in patients' electronic health record.	• None
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data	• A women's health medical director or clinical champion is assigned at the facility. • Providers notify patients of abnormal cervical pathology results within the required time frame.	• The Women Veterans Health Committee includes required core members.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated		

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) affiliated[120] facility reporting to VISN 7.[121]

Table B.1. Facility Profile for Tuscaloosa VA Medical Center (679) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[122]	Facility Data FY 2017[123]	Facility Data FY 2018[124]
Total medical care budget dollars	$135,706,248	$157,800,275	$152,427,351
Number of:			
• Unique patients	16,862	16,416	16,472
• Outpatient visits	220,010	197,994	203,835
• Unique employees[125]	813	826	898
Type and number of operating beds:			
• Community living center	104	114	134
• Domiciliary	136	136	128
• Mental health	43	43	43
• Residential psychology	12	12	12
Average daily census:			
• Community living center	100	104	118
• Domiciliary	75	101	110
• Mental health	51	34	41
• Residential psychology	9	10	11

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

[120] Associated with a medical residency program.

[121] The VHA medical centers are classified according to a facility complexity model; a designation of "3" indicates a facility with "low volume, low-risk patients, few or no complex clinical programs, and small or no research and teaching programs."

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

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

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

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

VA Outpatient Clinic Profiles[126]

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)[127]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[128] Provided	Diagnostic Services[129] Provided	Ancillary Services[130] Provided
Selma, AL	679GA	1,602	131	n/a	n/a	Pharmacy Social work Nutrition

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

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

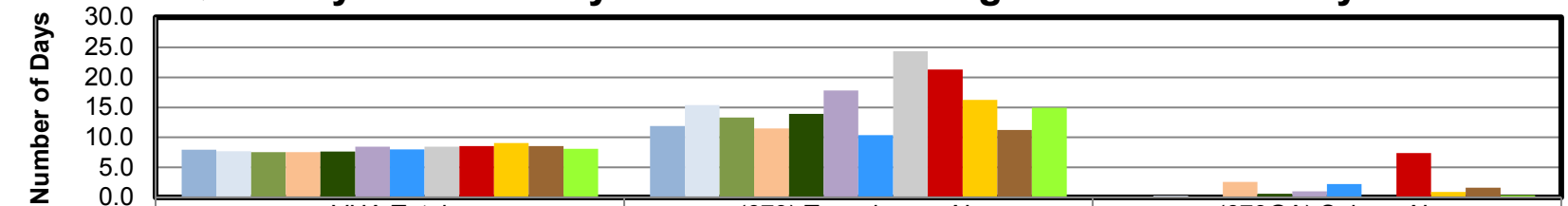
[127] The definition of an "encounter" can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015, and has not been updated.) An encounter is a "professional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

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

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

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

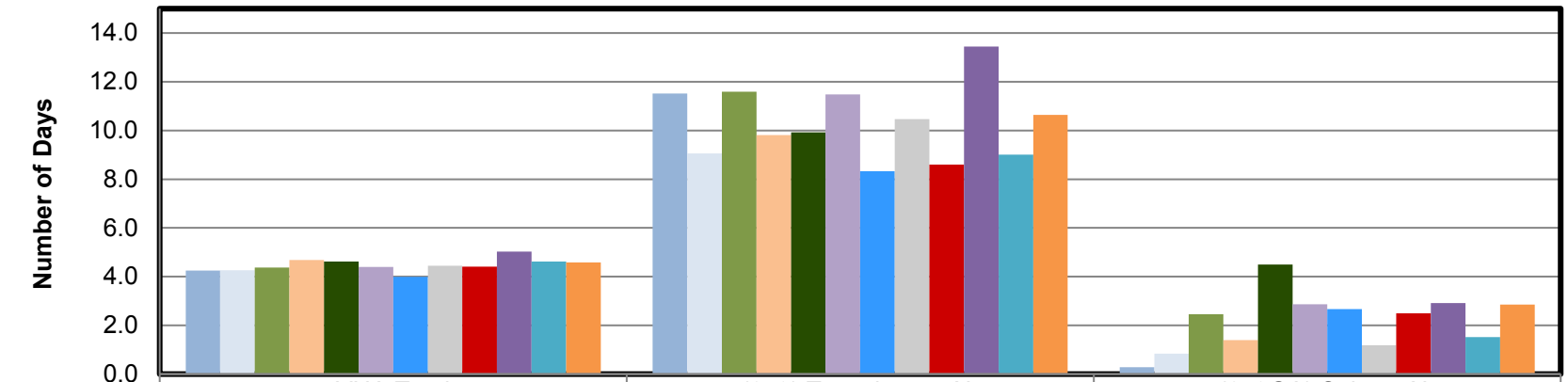
Appendix C: Patient Aligned Care Team Compass Metrics[131]



	VHA Total	(679) Tuscaloosa, AL	(679GA) Selma, AL
APR-FY18	7.9	11.9	0.1
MAY-FY18	7.7	15.4	0.3
JUN-FY18	7.6	13.3	0.0
JUL-FY18	7.5	11.5	2.6
AUG-FY18	7.7	13.9	0.6
SEP-FY18	8.5	17.8	1.0
OCT-FY19	8.0	10.4	2.3
NOV-FY19	8.5	24.3	0.0
DEC-FY19	8.6	21.3	7.4
JAN-FY19	9.0	16.3	0.9
FEB-FY19	8.5	11.2	1.6
MAR-FY19	8.1	14.9	0.3

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
Data Definition: "The average number of calendar days between a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. Note that prior to FY15, this metric was calculated using the earliest possible create date."

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



	VHA Total	(679) Tuscaloosa, AL	(679GA) Selma, AL
APR-FY18	4.3	11.5	0.3
MAY-FY18	4.3	9.1	0.8
JUN-FY18	4.4	11.6	2.5
JUL-FY18	4.7	9.8	1.4
AUG-FY18	4.6	9.9	4.5
SEP-FY18	4.4	11.5	2.9
OCT-FY19	4.0	8.3	2.7
NOV-FY19	4.4	10.5	1.2
DEC-FY19	4.4	8.6	2.5
JAN-FY19	5.0	13.4	2.9
FEB-FY19	4.6	9.0	1.5
MAR-FY19	4.6	10.6	2.9

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
Data Definition: "The average number of calendar days between 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[132]

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

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

Measure	Definition	Desired Direction
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS like – HED90_1	HEDIS-EPRP based PRV TOB BHS	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS-eOM based DM IHD	A higher value is better than a lower value
MH wait time	Mental health care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	ORYX	A higher value is better than a lower value
PC routine care appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC urgent care appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
Physician capacity	Physician capacity	A lower value is better than a higher value
PC wait time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value

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

Measure	Definition	Desired Direction
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC routine care appt	Timeliness in getting a SC routine care appointment (specialty care)	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SC urgent care appt	Timeliness in getting a SC urgent care appointment (specialty care)	A higher value is better than a lower value
Seconds pick up calls	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty care wait time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value
Telephone abandonment rate	Telephone abandonment rate	A lower value is better than a higher value

Source: VHA Support Service Center

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions[133]

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

[133] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated May 21, 2019). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on July 18 , 2019, but is not accessible by the public.)

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 13, 2019

From: Interim Deputy Network Director, VA Southeast Network (10N7)

Subj: Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center, Tuscaloosa, AL

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

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

1. I have had the opportunity to review the Draft Report: Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center, Tuscaloosa, AL.

2. Tuscaloosa VA Medical Center submits the attached draft report concurring with recommendations 1-14. I concur with the submission from the Tuscaloosa VA Medical Center.

3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer at (678) 924-5700.

(Original signed by:)

Benita Miller, LMSW, FACHE, VHA-CM
For Leslie Wiggins, Network Director

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

Appendix G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 30, 2019

From: Director, Tuscaloosa VA Medical Center (679/00)

Subj: Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center, Tuscaloosa, AL

To: Director, VA Southeast Network (10N7)

1. Thank you for the opportunity to review the draft of Tuscaloosa VA Medical Center Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report.

2. I concur with the report and recommendations. Attached is the facility's corrective action plan for the recommendations.

3. Tuscaloosa VA Medical Center continues in its ongoing efforts to provide safe, efficient, and quality services to our Veterans. Tuscaloosa VA Medical Center was rated as a 3 Star facility in 3rd quarter 2018 on the strategic analysis for improvement and learning (SAIL) and has progressed to an interim 5 Star facility since 1st quarter 2019.

(Original signed by:)

John F. Merkle, FACHE, VHA-CM

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

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