DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the Captain James A. Lovell Federal Health Care Center

North Chicago, Illinois

CHIP REPORT | REPORT #18-01143-302 | SEPTEMBER 27, 2018

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Figure 1. *Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois (Source: https://vaww.va.gov/directory/guide/, accessed on August 6, 2018)*

Abbreviations

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infection
CS	controlled substances
CSC	controlled substances coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
GE	geriatric evaluation
LIP	licensed independent practitioner
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	posttraumatic stress disorder
QSV	quality, safety, and value
RCA	root cause analysis
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Captain James A. Lovell Federal Health Care Center (Facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the overall efforts of the Office of Inspector General (OIG) to ensure that our 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 on a rotating basis each year.

The OIG's current areas of focus are

1. Leadership and Organizational Risks;
2. Quality, Safety, and Value;
3. Credentialing and Privileging;
4. Environment of Care;
5. Medication Management;
6. Mental Health Care;
7. Long-term Care;
8. Women's Health; and
9. High-Risk Processes.

This review was conducted during an unannounced visit made during the week of June 18, 2018. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of Facility 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 facilities identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

The Facility is the only fully integrated VA-DoD medical facility in the United States addressing the needs and expectations of active duty military, military families, and the local veteran

population. The organizational structure at the Facility does not follow the typical VHA model. The Facility's leadership team included the Interim Director (VA), Commanding Officer/Deputy Director (DoD), Command Master Chief (DoD), Executive Officer (DoD), and 11 Associate Directors (both VA and DoD)—the Chief Medical Executive, VA Nurse Executive, Associate Director for Facility Support, and eight other associate directors.

Organizational communication and accountability are carried out through a committee reporting structure, with the Quality Council having oversight for groups such as the Infection Control, Performance Improvement, and Risk Management Committees. The leaders are members of the Quality Council, through which they track, trend, and monitor quality of care and patient outcomes.

The Interim Director was assigned on April 30, 2018, for a 90-day period. The Director position was vacated in December 2017 and had one other interim in the role. The Commanding Officer/Deputy Director was active duty military and had been in the role since July 2016. The VA Nurse Executive and the Chief Medical Executive were assigned in April 2011 and December 2016, respectively. The Associate Director for Facility Support was permanently assigned October 29, 2017.

In the review of selected employee satisfaction survey results regarding Facility leaders, the OIG noted opportunities for improvement. Facility leaders appeared actively engaged with employees and were working to improve employee satisfaction scores. In the review of selected patient experience survey results regarding Facility leaders, the OIG noted that Facility leaders seemed to be actively engaged with patients who appeared to be generally satisfied with the leadership and care provided.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[1] Although most of the leaders were knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve and maintain performance of the Quality of Care and Efficiency metrics likely contributing to the current "4-Star" rating.

[1] 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=2146. (Website accessed on April 16, 2017.)

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[2] disclosures of adverse patient events, Patient Safety Indicator data, and patient safety processes and identified the presence of organizational risk factors that may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored.

The OIG noted findings in four of the eight areas of clinical operations reviewed and issued five recommendations that are attributable to the Director, Chief Medical Executive, and Associate Director for Facility Support. These are briefly described below.

Quality, Safety, and Value

The OIG found general compliance with requirements for patient safety and performance of peer reviews. However, the OIG identified deficiencies with utilization management documentation and data review.[3]

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing, privileging, and Ongoing Professional Practice Evaluations. However, the OIG identified a deficiency in reviewing and utilizing evidence from Focused Professional Practice Evaluations to determine continuation of privileges.

Environment of Care

General safety and privacy measures were in place at the parent Facility. The representative CBOC generally met the performance indicators evaluated. The OIG did not note any issues with the availability of medical equipment and supplies. The OIG identified an EOC deficiency related to cleanliness and maintenance.

Medication Management

The OIG found general compliance with requirements for CSC reports, ordering procedures, CSC and CSIs having no conflicts of interest and completing required training, and area and pharmacy inspections. However, the OIG identified a deficiency with annual physical security survey actions.

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[2] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

[3] VHA Directive 1117, *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

Summary

In the review of key care processes, the OIG issued five recommendations that are attributable to the Director, Chief Medical Executive, and Associate Director for Facility Support. The number of recommendations should not be used 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 Interim Facility Director agreed with the Comprehensive Healthcare Inspection Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 57–58, for 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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Assistant Inspector General
for Healthcare Inspections

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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Captain James A. Lovell Federal Health Care Center (Facility) through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of healthcare services to veterans and to share findings with Facility leaders so that informed decisions can be made to improve care.

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.[4, 5] Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.[6] Figure 2 shows the direct relationship leadership and organizational risks have with the processes used to deliver health care to veterans.

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management: Controlled Substances (CS) Inspection Program; Mental Health: Posttraumatic Stress Disorder (PTSD) Care; Long-term Care: Geriatric Evaluations; Women's Health: Mammography Results and Follow-up; and High-Risk Processes: Central Line-Associated Bloodstream Infections (CLABSI) (see Figure 2).[7]

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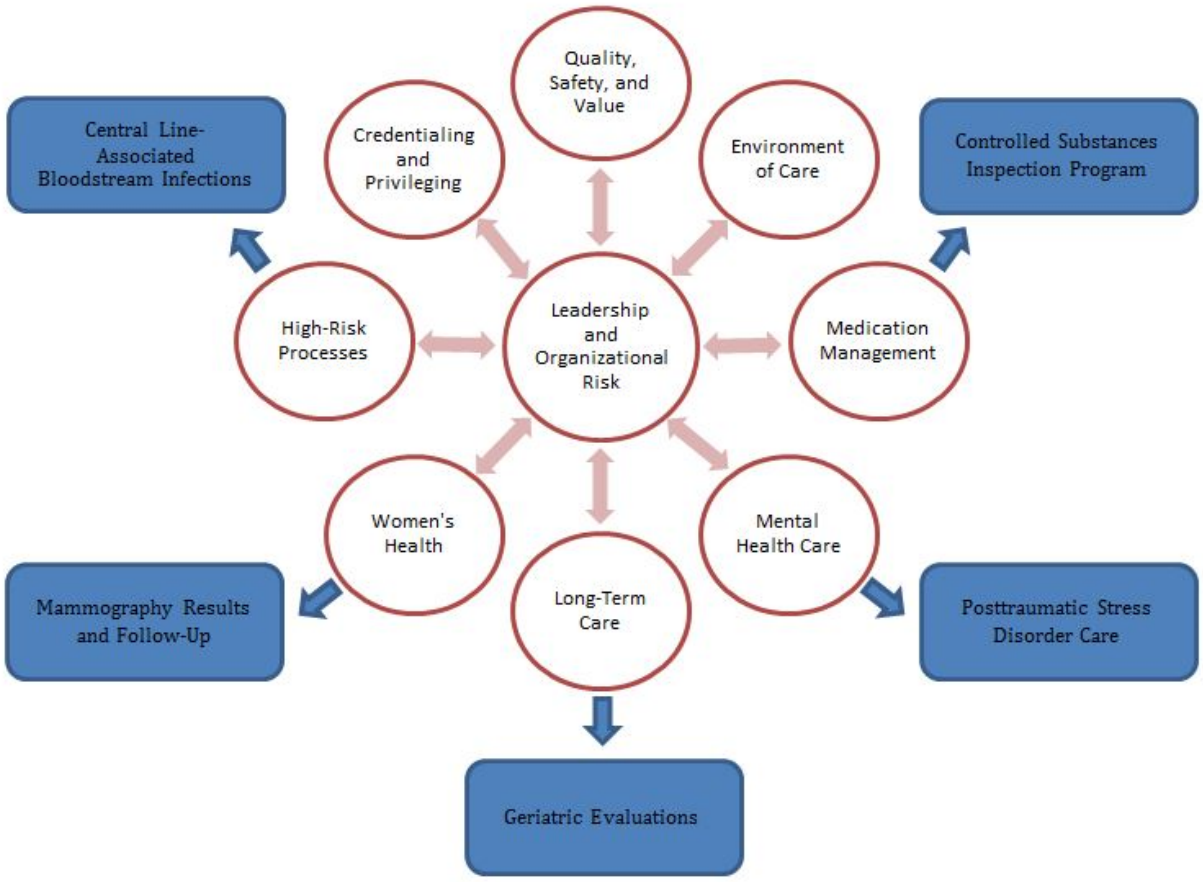
[4] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

[5] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (Website accessed on March 1, 2018.)

[6] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (Website accessed on March 1, 2018.)

[7] CHIP reviews address these processes during fiscal year (FY) 2018 (October 1, 2017, through September 30, 2018).

Figure 2. FY 2018 Comprehensive Healthcare Inspection Program Review of Healthcare Operations and Services



Source: VA OIG

Methodology

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

The review covered operations April 6, 2015,[9] through June 18, 2018, the date when an unannounced week-long site visit commenced.

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

While on site, the OIG received one complaint beyond the scope of the CHIP review and reported identified concerns to appropriate Facility and OIG staff. The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

[8] The OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect Facility accreditation status.

[9] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

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

1. Executive leadership stability and engagement,
2. Employee satisfaction and patient experience,
3. Accreditation/for-cause surveys and oversight inspections,
4. Indicators for possible lapses in care, and
5. VHA performance data.

Executive Leadership Stability and Engagement

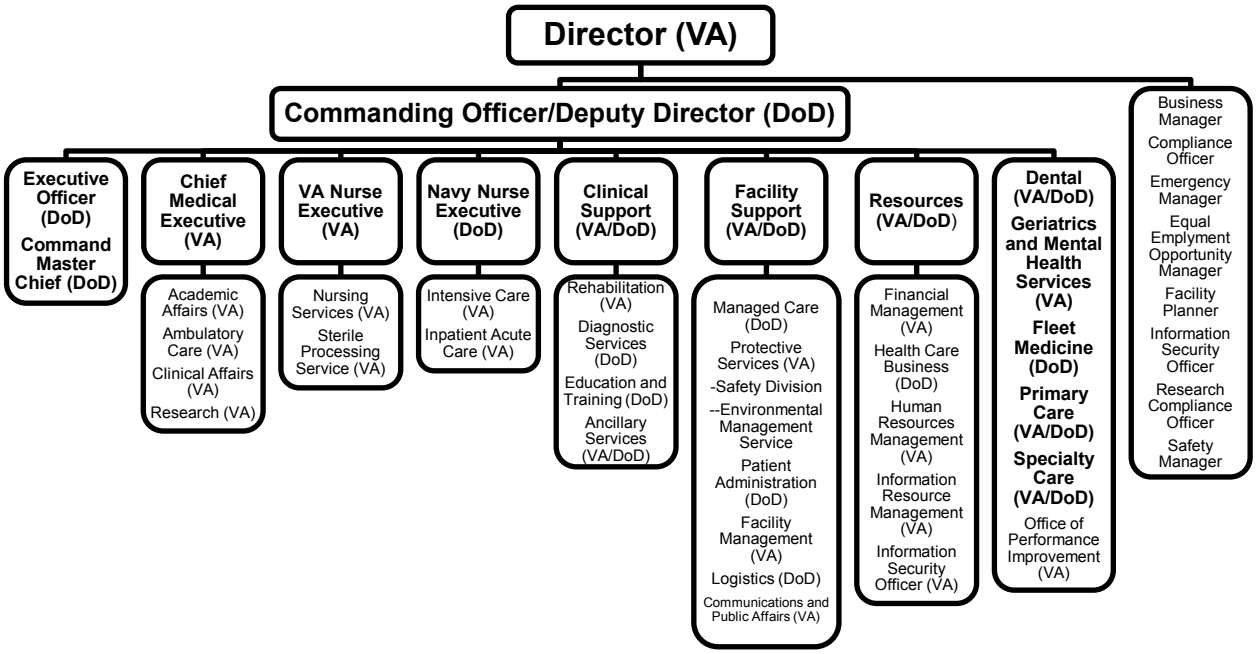
The Facility is the only fully integrated VA-DoD medical facility in the United States addressing the needs and expectations of active duty military, military families, and the local veteran population. Figure 3 illustrates the Facility's reported organizational structure, which does not follow the typical VHA model. The Facility's leadership team included the Interim Director (VA), Commanding Officer/Deputy Director (DoD), Command Master Chief (DoD), Executive Officer (DoD), and 11 Associate Directors (both VA and DoD) comprised of the Chief Medical Executive, VA Nurse Executive, Associate Director for Facility Support, and eight other associate directors. The Chief Medical Executive, VA Nurse Executive, and clinical associate directors were responsible for overseeing patient care and service directors, as well as program and practice chiefs. The Facility staff consists of both VA, Navy active duty, and VA/Navy contractors.

It is important to note that the Interim Director was assigned on April 30, 2018, for a 90-day period. The Director position was vacated in December 2017 and had one other interim in the role. The Commanding Officer/Deputy Director was active duty military, had been in the role since July 2016, and will be assigned to a new duty station starting July 2018. The VA Nurse Executive and Chief Medical Executive were assigned in April 2011 and December 2016,

[10] L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx. (Website accessed on February 2, 2017.)

respectively. The Associate Director for Facility Support was permanently assigned October 29, 2017; prior to this, the position had been filled by three different interim appointees.

Figure 3. Facility Organizational Chart



Source: Captain James A. Lovell Federal Health Care Center (June 19, 2018)
VA =VA leadership position
DoD = DoD leadership position
VA/DoD = VA and DoD leadership rotation

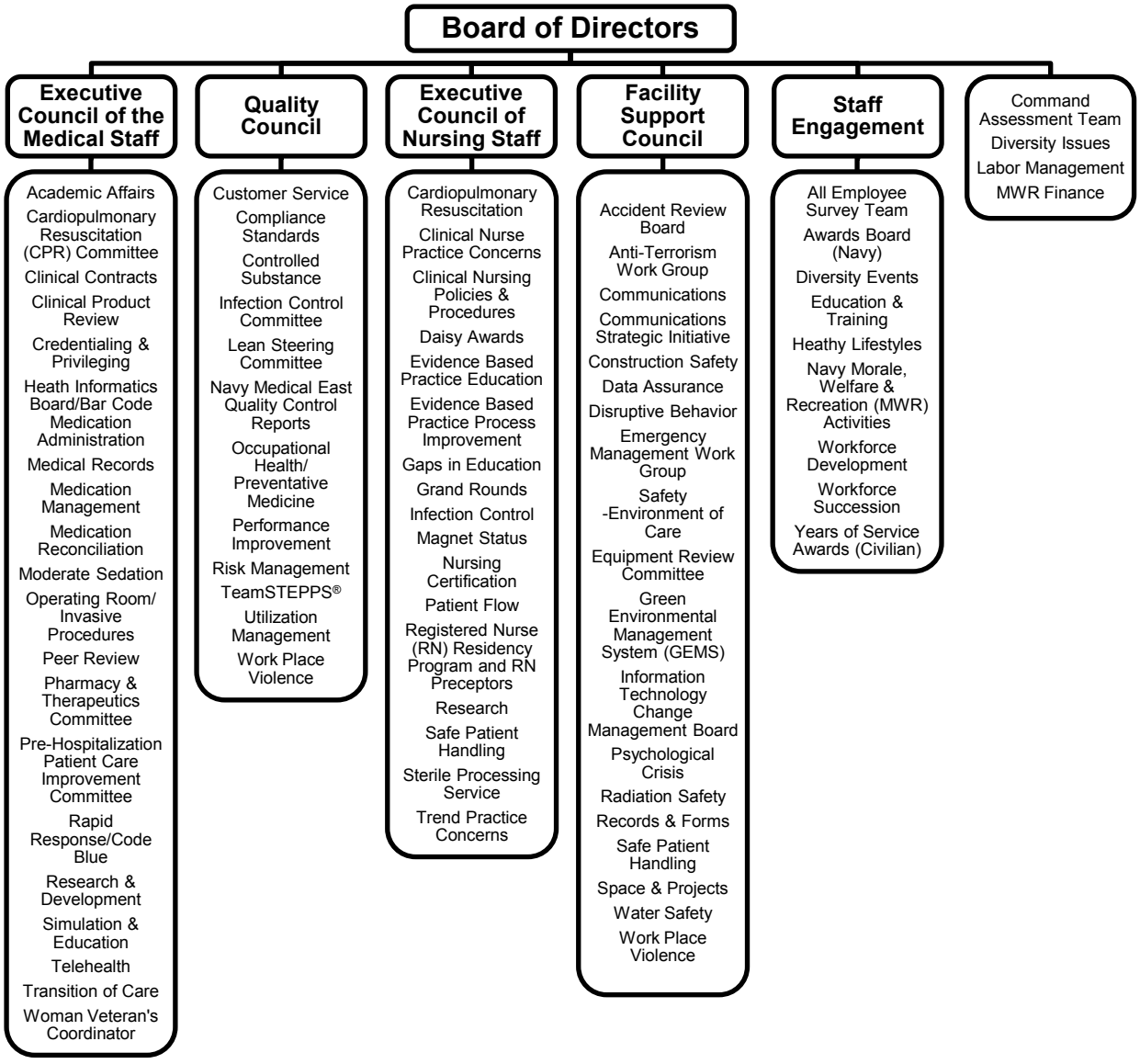
For the OIG visit, the Interim Facility Director identified which positions most closely matched the traditional VA roles of Chief of Staff, Associate Director for Patient Care Services, and Associate Director. To help assess engagement of Facility executive leadership, the OIG interviewed the Interim Director, Commanding Officer/Deputy Director, Chief Medical Executive, VA Nurse Executive, and the Associate Director for Facility Support regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, most leaders were generally able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders were also engaged in monitoring patient safety and care through formal mechanisms. They were members of the Facility's Quality Council, which tracked, trended, and monitored quality of care and patient outcomes and oversaw various working groups, such as the Infection Control, Performance Improvement, and Risk Management Committees. The Interim Director

served as the chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Board of Directors oversees the Quality Council and is comprised of the Interim Director, Commanding Officer/Deputy Director, Command Master Chief, Executive Officer, and the 11 Associate Directors. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: Captain James A. Lovell Federal Health Care Center (June 19, 2018)
TeamSTEPPS® = Team Strategies & Tools to Enhance Performance & Patient Safety

Employee Satisfaction and Patient Experience

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 at several points in response to VA leadership 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 and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017. Tables 1–3 provide relevant survey results for VHA, the Facility, and selected Facility executive leaders.[11]

Table 1 summarizes employee attitudes toward selected Facility leaders as expressed in VHA's All Employee Survey.[12] The Facility average for one of the selected survey questions was above the VHA average, while the other was equal to the VHA average.[13] The same trend was noted for the Command Suite/Office of the Director. The Chief Medical Executive and Associate Director for Facility Support had higher scores for both questions, and the VA Nurse Executive results were markedly lower than the Facility and VHA averages. With the one noted exception, the employees appear generally satisfied with Facility leaders.

[11] Rating is based on responses by employees who report to or aligned under the Command Suite/Office of the Director, Chief Medical Executive, VA Nurse Executive, and Associate Director for Facility Support.

[12] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

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

Table 1. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Command Suite – Office of the Director Average	Chief Medical Executive Average	VA Nurse Executive Average	Associate Director for Facility Support Average
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	65.5	61.3	82.0	47.4	88.0
All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?*	1 (Very Dissatisfied) –5 (Very Satisfied)	3.3	3.3	3.6	4.1	2.2	3.8

Source: VA All Employee Survey (accessed May 18, 2018, and June 11, 2018)

Table 2 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The Facility averages for the selected survey questions were generally similar to the VHA averages. The averages for the Chief Medical Executive and Associate Director for Facility Support were higher than the Facility and VHA averages. Results for the Command Suite/Office of the Director were slightly lower. The VA Nurse Executive results were markedly lower than the Facility and VHA averages. Opportunities appear to exist for the VA Nurse Executive to provide a safe workplace environment where employees feel comfortable with bringing forth issues or ethical concerns. The leaders verbalized ongoing efforts to improve the culture of the organization.

Table 2. Survey Results on Employee Attitudes toward Workplace (October 1, 2016, through September 30, 2017)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Command Suite – Office of the Director Average	Chief Medical Executive Average	VA Nurse Executive Average	Associate Director for Facility Support Average
All Employee Survey Q43. *My supervisor encourages people to speak up when they disagree with a decision.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.6	3.6	4.4	2.5	4.6
All Employee Survey Q44. *I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.8	3.6	4.4	2.8	4.8
All Employee Survey Q75. *I can talk with my direct supervisor about ethical concerns without fear of having my comments held against me.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.8	3.6	4.4	2.8	5.0

Source: VA All Employee Survey (accessed May 18, 2018, and June 11, 2018)

VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA utilizes industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences of their health care and to support the goal of benchmarking its performance against the private sector.

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes towards Facility leaders (see Table 3). For this Facility, three of four patient survey results reflected higher care ratings than the VHA average. Patients appear generally satisfied with the leadership and care provided, and Facility leaders appeared to be actively engaged with patients.

Table 3. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.7	63.4
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.	83.4	85.3
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	74.9	79.5
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.	75.2	79.2

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 22, 2017)

Accreditation/For-Cause Surveys[14] and Oversight Inspections

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 4 summarizes the relevant Facility inspections most recently performed by the OIG and The Joint Commission (TJC).[15] One recommendation remains open from an OIG review published in September 2017.

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

[15] TJC is 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.

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[16] and College of American Pathologists,[17] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long-Term Care Institute conducted an inspection of the Facility's Community Living Center.[18]

Table 4. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the Captain James A. Lovell Federal Health Care Center North Chicago, Illinois, July 2, 2015*)	April 2015	10	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Captain James A. Lovell Federal Health Care Center, July 27, 2015*)	April 2015	7	0
OIG (*Veterans Choice Program Dermatology Delays, Captain James A. Lovell Federal Health Care Center, August 7, 2017*)	Not applicable	2	0
OIG (*Quality of Care and Other Concerns, Captain James A. Lovell Federal Health Care Center, September 20, 2017*)	September 2015	3	1
TJC	December 2017		
• Hospital Accreditation		40	0
• Behavioral Health Care Accreditation		6	0
• Home Care Accreditation		1	0

Sources: OIG and TJC (Inspection/survey results verified with the Accreditation Specialist on June 20, 2018)

[16] 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.

[17] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

[18] Since 1999, the Long Term Care Institute has been to over 3,500 healthcare facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 5 summarizes key indicators of risk since the OIG's previous April 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of June 18, 2018.[19]

Table 5. Summary of Selected Organizational Risk Factors (April 2015 to June 18, 2018)

Factor	Number of Occurrences
Sentinel Events[20]	2
Institutional Disclosures[21]	2
Large-Scale Disclosures[22]	0

Source: Captain James A. Lovell Federal Health Care Center Chief of Organizational Performance Improvement (received June 18, 2018)

Through discussions with staff, the OIG found that the Facility did not have consistent risk management, quality management, or patient safety processes in place, including those associated with institutional disclosures, root cause analyses (RCAs),[23] and peer review

[19] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events 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 Captain James A. Lovell Federal Health Care Center is a mid-high complexity (1c) affiliated Facility as described in Appendix B.)

[20] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

[21] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or his or her personal representative that an adverse event has occurred during 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.

[22] Large-scale disclosure of adverse events (sometimes referred to as "notification") is 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.

[23] According to VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011, VHA has implemented approaches to improve patient safety, including the reporting of patient safety incidents to the VHA National Center for Patient Safety, in order for VHA to learn about system vulnerabilities and how to address them as well as the requirement to implement RCA (a widely-used methodology for dealing with safety-related issues) to allow for more accurate and rapid communication throughout an organization of potential and actual causes of harm to patients.

activities. For example, the OIG found a lack of processes to assist with identification of patient care concerns that may warrant institutional disclosures or the tracking to completion of disclosures. The OIG also found that recommended actions were not fully implemented for two of three RCAs. Finally, the OIG found that the Chief Medical Executive was not the designated chair of the Peer Review Committee, as required by VHA. In December 2012, the Facility Director requested, and was granted, a waiver from the VISN 12 Network Director that allowed a physician other than the Chief Medical Executive to chair the committee but required that "the physician must hold a directorate level position[24] or higher in the organization." In 2014, the Facility Director granted a change to the VISN 12 approved waiver to allow for physicians at lower than a directorate level to chair the Peer Review Committee. The OIG found no evidence that a VHA national program office was aware of or approved this waiver.

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[25] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 6 summarizes Patient Safety Indicator data from October 1, 2015, through December 31, 2017.

[24] Directorate level position refers to a position that is at the Facility's Associate Director level and reports directly to the Commanding Officer.

[25] Agency for Healthcare Research and Quality. https://www.qualityindicators.ahrq.gov/. (Website accessed on March 8, 2017.)

Table 6. Patient Safety Indicator Data
(October 1, 2015, through December 31, 2017)

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 12	Facility
Pressure ulcers	0.88	1.02	0.00
Death among surgical inpatients with serious treatable conditions	118.96	106.87	0.00
Iatrogenic pneumothorax	0.19	0.20	0.00
Central venous catheter-related bloodstream infection	0.14	0.06	0.00
In-hospital fall with hip fracture	0.09	0.04	0.00
Perioperative hemorrhage or hematoma	2.58	3.57	0.00
Postoperative acute kidney injury requiring dialysis	0.80	1.74	0.00
Postoperative respiratory failure	5.34	4.05	3.09
Perioperative pulmonary embolism or deep vein thrombosis	3.26	3.70	0.00
Postoperative sepsis	3.96	2.88	0.00
Postoperative wound dehiscence	1.04	1.51	6.06
Unrecognized abdominopelvic accidental puncture/laceration	1.21	1.31	1.93

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

The Patient Safety Indicator measures for postoperative wound dehiscence and unrecognized abdominopelvic accidental puncture/laceration showed a higher observed rate than Veterans Integrated Service Network (VISN) 12 and VHA.

One patient developed a post-operative wound dehiscence that was reviewed by the Patient Safety Manager, who determined there was no indication for additional review.

One patient had an unrecognized abdominopelvic accidental puncture/laceration during a laparoscopic procedure. The case was reviewed through peer review and Surgical Morbidity and Mortality conference, and a protocol change was developed for procedures to be used in complex cases.

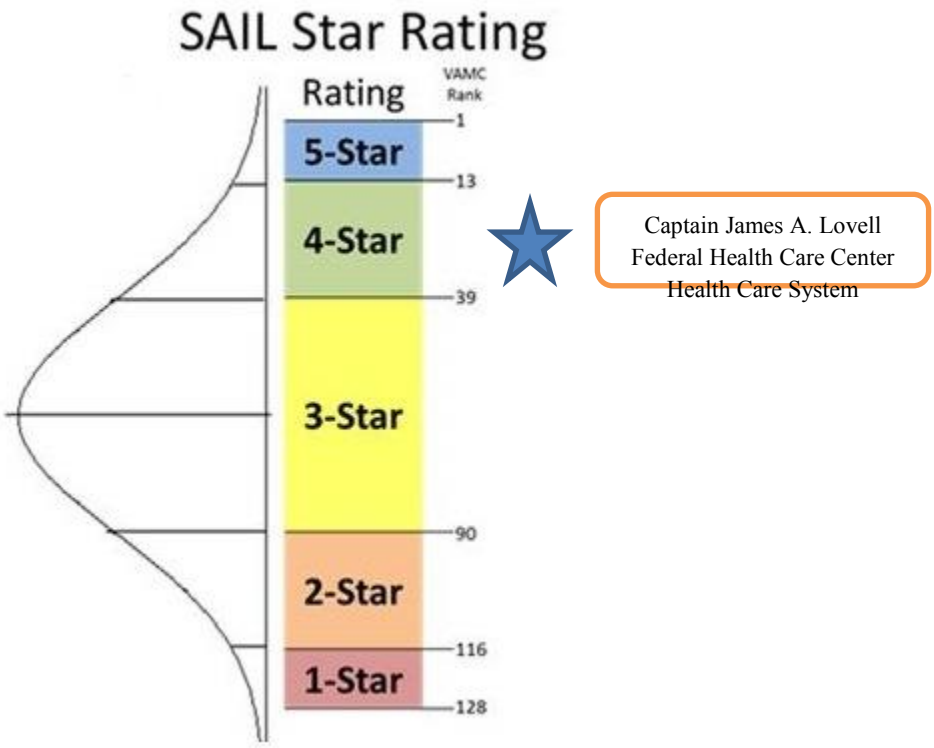
Veterans Health Administration Performance Data

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 but has 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.[26]

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.[27] As of June 30, 2017, the Facility was rated "4-Star" for overall quality.

Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2017)



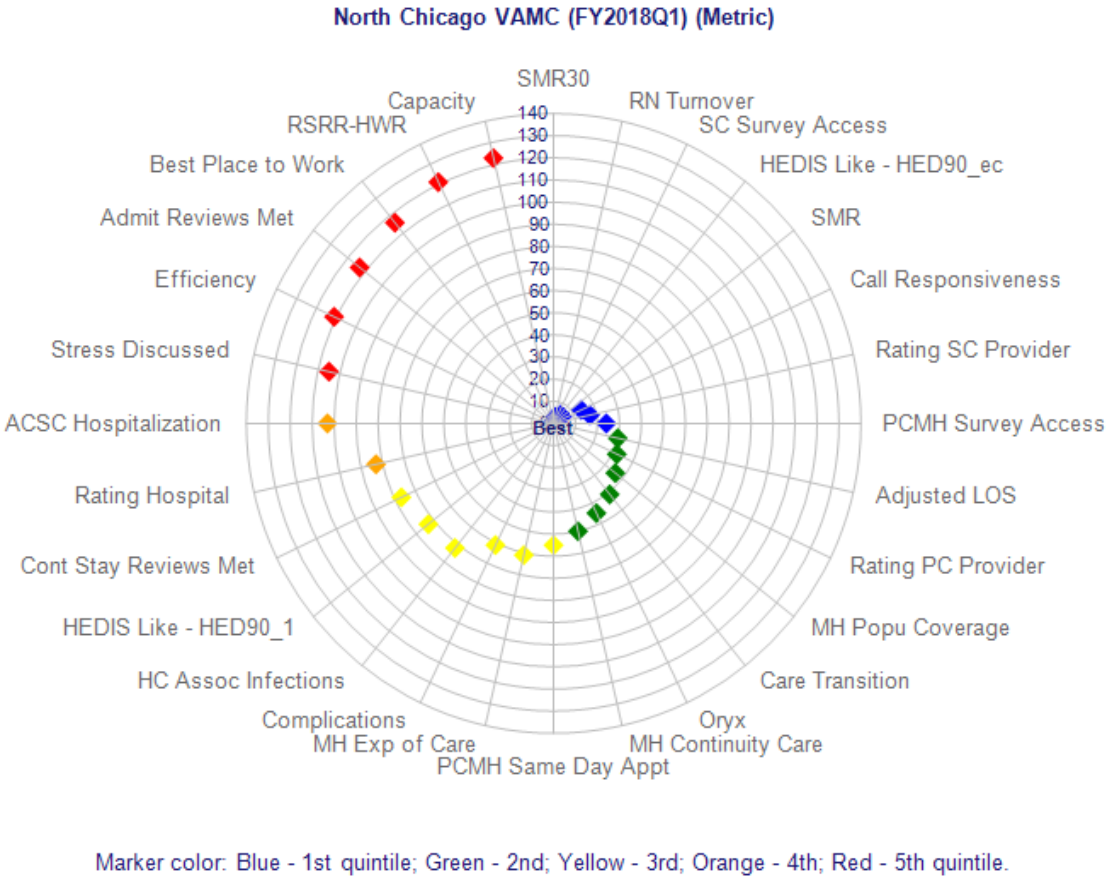
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed May 18, 2018)

[26] 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=2146. (Website accessed on April 16, 2017.)

[27] Based on normal distribution ranking quality domain of 128 VA Medical Centers.

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of June 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example, in the areas of Acute Care 30-day Standardized Mortality Ratio (SMR 30), Call Responsiveness, Rating (of) Specialty Care (SC) Provider, and MH Population (Popu) Coverage).[28] Metrics that need improvement are denoted in orange and red (for example, Ambulatory Care Sensitive Conditions (ACSC) Hospitalizations, Best Place to Work, and Risk Standardized Readmission Rate-Hospital Wide Readmission (RSRR-HWR).

Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2017)



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). For data definitions, see Appendix D.

[28] For data definitions of acronyms in the SAIL metrics, please see Appendix D.

Conclusion

The Facility is the only fully integrated VA-DoD medical facility in the United States addressing the needs and expectations of active duty military, military families, and the local veteran population. Because of this unique structure, Facility leadership is shared between VHA and DoD. The Facility's leadership team included the Interim Director (VA), Commanding Officer/Deputy Director (DoD), Command Master Chief (DoD), Executive Officer (DoD), and 11 Associate Directors (both VA and DoD).

The OIG noted that most Facility leaders were actively engaged with employees and patients and were working to improve employee satisfaction scores. However, the OIG identified organizational risks related to a lack of consistent risk management, quality management, and/or patient safety processes, including those associated with institutional disclosures, RCAs, and peer review activities that may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented. Although the leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take and maintain actions to improve care and performance of selected Quality of Care and Efficiency metrics that are likely contributing to the "4-Star" rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.[29] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[30]

VHA requires that its facilities operate a Quality, Safety, and Value (QSV) program to monitor the quality of patient care and performance improvement activities. The purpose of the OIG review was to determine whether the Facility implemented and incorporated selected key functions of VHA's Enterprise Framework for QSV into local activities. To assess this area of focus, the OIG evaluated the following: protected peer reviews of clinical care,[31] utilization management (UM) reviews,[32] and patient safety incident reporting with related root cause analyses (RCAs).[33]

VHA has implemented approaches to improving patient safety, including the reporting of patient safety incidents to its National Center of Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required RCAs help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the organization.[34]

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[35]

- Protected peer reviews

[29] VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

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

[31] According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff. (Due for recertification June 30, 2015, but has not been updated.)

[32] According to VHA Directive 1117, *Utilization Management Program*, July 9, 2014 (amended January 18, 2018), UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

[33] VHA Handbook 1050.01.

[34] VHA Handbook 1050.01.

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

  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Entry of all reported patient incidents into VHA's patient safety reporting system[36]
  - Annual completion of a minimum of eight RCAs[37]
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

Conclusion

The OIG found general compliance with requirements for patient safety and performance of peer reviews. However, the OIG identified deficiencies with UM documentation and data review, which warranted recommendations for improvement.

Utilization Management: Documentation of Decisions

VHA requires that Physician UM Advisors document their decisions in the National UM Integration database regarding appropriateness of patient admissions and continued stays.[38] This allows for national level UM data to be available for review by an interdisciplinary group to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor

[36] WebSPOT has been the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database. However, it is expected that by April 1, 2018, all facilities will have implemented the new Joint Patient Safety Reporting System (JPSR); and it is anticipated that all previous patient safety event reporting systems will be discontinued by July 1, 2018.

[37] According to VHA Handbook 1050.01, March 4, 2011, the requirement for a total of eight RCAs and aggregated reviews is a minimum number, as the total number of RCAs is driven by the events that occur and the Safety Assessment Code (SAC) score assigned to them. At least four analyses per fiscal year must be individual RCAs, with the balance being aggregated reviews or additional individual RCAs.

[38] VHA Directive 1117.

outcomes. The OIG found that the Physician UM Advisors completed 78 of 151 (51.7 percent) of the reviews during the timeframe of April 2, 2018, through June 4, 2018. This resulted in a lack of data available for review. Reasons for noncompliance provided by the Chief Hospitalist included high physician turnover, use of physician contractors, and lack of good processes. Reasons provided by a MH physician were increases in workload and staffing shortages when providers are on leave.

Recommendation 1

1. The Chief Medical Executive ensures Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and monitors compliance.

Facility concurred.

Target date for completion: January 31, 2019

Facility response: Facility implemented a new organized and standardized process to ensure Physician Utilization Management Advisor's (PUMA) consistently document their decisions in the National Utilization Management Integration database and monitor compliance.

Facility identified a designated PUMA lead who ensures the PUMA referrals are completed. PUMA referrals completion rate data is reviewed and reported to the Patient Flow Committee and Quality Council. PUMA referral completion will be tracked for six consecutive months to ensure that 75% target is consistently met or exceeded.

Utilization Management: Data Review

VHA requires that an interdisciplinary facility group review UM data. This group should include representatives from UM, medicine, nursing, social work, case management, MH, and Chief Business Office Revenue Utilization Review.[39] An interdisciplinary review ensures that a comprehensive, systematic approach is taken when reviewing UM data to identify areas for improvement throughout the facility. From September 13, 2017, through June 11, 2018, the UM Committee met quarterly; however, MH staff attended no meetings, and the Chief Business Office Revenue Utilization Review attended one meeting. This resulted in a lack of interdisciplinary expertise in the review and analysis of UM data. The reason provided by the Chief Hospitalist and MH physician was that MH staff had not been invited to attend the meetings. The OIG was unable to obtain a reason for lack of attendance by Chief Business Officer Revenue Utilization Review despite multiple attempts to speak to the UM Committee representative.

[39] VHA Directive 1117.

Recommendation 2

2. The Facility Director ensures all required members consistently participate in the interdisciplinary group that reviews utilization management data and monitors compliance.

Facility concurred.

Target date for completion: February 28, 2019

Facility response: Facility reviewed and updated the current Patient Flow Committee charter to ensure UM data are reviewed on an ongoing basis by an interdisciplinary group. Current charter includes representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and Chief Business Office Revenue Utilization Review (CBO R-UR). Required attendance will be monitored and reported to Executive Council of Medical Staff (ECOMS) for six consecutive months to ensure members or their designees attend 90% of meetings.

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIP).[40]

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This systematic process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.[41]

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges need to be specific, based on the individual's clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, 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 the expiration of the held privileges.[42]

The purpose of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of 10 LIPs who were hired within 18 months prior to the on-site visit,[43] and 20 LIPs who were re-privileged within 12 months prior to the visit.[44] The OIG evaluated the following performance indicators:

- Credentialing
  - Current licensure
  - Primary source verification
- Privileging
  - Verification of clinical privileges
  - Requested privileges

[40] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)

[41] VHA Handbook 1100.19.

[42] VHA Handbook 1100.19.

[43] The 18-month period was from December 18, 2016, through June 18, 2018.

[44] The 12-month review period was from June 18, 2017, through June 18, 2018.

    - Facility-specific
    - Service-specific
    - Provider-specific
  - Service chief recommendation of approval for requested privileges
  - Medical Staff Executive Committee decision to recommend requested privileges
  - Approval of privileges for a period of less than, or equal to, two years
- Focused Professional Practice Evaluation (FPPE)
  - Evaluation initiated
    - Timeframe clearly documented
    - Criteria developed
    - Evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee decision to recommend continuing initially granted privileges
- Ongoing Professional Practice Evaluation (OPPE)
  - Determination to continue privileges
    - Criteria specific to the service or section
    - Evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee decision to recommend continuing privileges

Conclusion

The OIG found general compliance with requirements for credentialing, privileging, and OPPEs. However, the OIG identified a deficiency in using evidence from FPPEs to determine continuation of privileges that warranted a recommendation for improvement.

FPPE Processes

VHA requires that all LIPs new to the facility have FPPEs completed and documented in the practitioner's profile and reported to an appropriate Medical Staff Committee.[45] The process involves the evaluation of privilege-specific competence of the practitioner who has no previously documented evidence of competently performing the requested privileges. FPPEs

[45] VHA Handbook 1100.19.

may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.[46]

For 3 of 10 applicable LIPs, there was no evidence that their FPPEs were presented to the Facility's Credentialing and Privileging Subcommittee so that these results could be used in the consideration of continued privileges. The Credentialing and Privileging Subcommittee approved their continued privileges without sufficient information to support the LIP's provision of safe medical care. The Chief Medical Executive reported to the OIG that a process was not in place to track and require submission of FPPEs before decisions were made to grant continued privileges.

Recommendation 3

3. The Chief Medical Executive ensures that the Credentialing and Privileging Subcommittee consistently review Focus Professional Practice Evaluations in the granting of continued privileges and monitors compliance.

Facility concurred.

Target date for completion: January 31, 2019

Facility response: Credentialing and Privileging (C&P) Subcommittee consistently reviews Focus Professional Practice Evaluations in the granting of continued privileges and monitors compliance. C&P Office has revised the current credentialing monitoring and will track to ensure that FPPE information is consistently utilized a in granting privileges. The C&P Office will track Executive Council of Medical Staff minutes for evidence of compliance until at least 90% of new LIPs' privileges were continued with consideration of FPPE results for six consecutive months.

[46] VHA Handbook 1100.19.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC 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.[47]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG also determined whether the Facility met requirements in selected areas that are often associated with higher risks of harm to patients in the locked MH Unit and with Emergency Management processes.[48]

VHA requires managers to ensure capacity for MH 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 to ensure safety and to provide the type and intensity of clinical intervention necessary to treat the patient. Such care needs to be well integrated with the full continuum of care to support safety and effective management during periods of such severe difficulty. Inpatient MH settings must also provide a healing, recovery-oriented environment.[49]

VHA requires managers to establish a comprehensive Emergency Management program to ensure continuity of patient care and hospital operations in the event of a disaster or emergency, which includes conducting a Hazard Vulnerability Analysis (HVA) and developing an Emergency Operations Plan (EOP).[50] These requirements allow the identification and minimization of impacts from potential hazards, threats, incidents, and events on health care and other essential services provided by facilities. VHA also requires managers to develop Utility Management Plans to ensure reliability and reduce failures of electrical power distribution systems in accordance with TJC,[51] Occupational Safety and Health Administration,[52] and

[47] VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

[48] Applicable requirements include 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).

[49] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

[50] VHA Directive 0320.01, *Comprehensive Emergency Management Program Procedures*, April 6, 2017.

[51] TJC. EOC standard EC.02.05.07.

[52] Occupational Safety and Health (OSHA) is part of the US Department of Labor. OSHA assures safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education, and assistance.

National Fire Protection Association standards.[53] The provision of sustained electrical power during disasters or emergencies is critical to continued operations of a healthcare facility.

In all, the OIG team inspected five inpatient units (intensive care – 133-2D, Community Living Center – 134-1B (Courage), medical/surgical – 133-4A, inpatient MH – 131-4C, and post-anesthesia care) in addition to the Emergency Department and the Women's Health Outpatient Clinic. The team also inspected the Kenosha CBOC. The OIG reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent Facility
  - EOC rounds
  - EOC deficiency tracking
  - Infection prevention
  - General safety
  - Environmental cleanliness
  - General privacy
  - Women veterans' exam room privacy
  - Availability of medical equipment and supplies
- Community Based Outpatient Clinic
  - General safety
  - Medication safety and security
  - Infection prevention
  - Environmental cleanliness
  - General privacy
  - Exam room privacy
  - Availability of medical equipment and supplies
- Locked MH Unit
  - Bi-annual MH EOC Rounds
  - Nursing station security

[53] National Fire Protection Association (NFPA) is a global nonprofit organization devoted to eliminating death, injury, and property and economic loss due to fire, electrical, and related hazards.

- 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

Conclusion

General safety and privacy measures were in place at the parent Facility. The representative CBOC generally met the performance indicators evaluated. The OIG did not note any issues with the availability of medical equipment and supplies. The OIG identified a cleanliness deficiency that warranted a recommendation for improvement.

Facility Cleanliness and Maintenance

TJC requires hospitals to identify environment deficiencies, hazards, and unsafe practices; and to keep furnishings and equipment safe and in good repair.[54, 55] This ensures a clean and safe healthcare environment. The OIG inspected seven patient care areas and found that five had dirty, dusty, and/or rusty ventilation grills;[56] four had stained, dusty, cracked, and/or broken ceiling tiles;[57] two had privacy curtains needing repair or replacement;[58] and three had dusty fire sprinkler heads and damaged walls.[59] Facility managers stated the reasons for the lack of general cleanliness and repairs in the patient care areas were that Environmental Managements Service (EMS) supervisors were "looking" but not "seeing" deficiencies and also not following established oversight procedures. In addition, EMS did not check the cleanliness of ventilation grills during EOC rounds.

[54] TJC. EOC standard EC.02.06.01, EP01 and EP20.

[55] TJC. EOC standard EC.04.01.01, EP14.

[56] Community Living Center – 134-1B (Courage), medical/surgical – 133-4A; inpatient MH – 131-4C, and post-anesthesia care units and the Emergency Department.

[57] Community Living Center – 134-1B (Courage) and medical/surgical – 133-4A units, Women's Health Outpatient Clinic, and the Emergency Department.

[58] Post-anesthesia care unit and the Emergency Department.

[59] Community Living Center – 134-1B (Courage) and medical/surgical – 133-4A units and the Emergency Department.

Recommendation 4

4. The Associate Director for Facility Support ensures that a safe and clean environment is maintained throughout the Facility and monitors compliance.

Facility concurred.

Target date for completion: February 28, 2019

Facility response: The Facility Management Service has current processes in place to ensure a clean and safe environment. Environmental Management Service (EMS) has a Standard Operating Practice in place that addresses routine cleaning. Compliance will be ensured through EMS inspections and Environment of Care rounds monitored by the Safety Committee. Identified concerns will have 85% of actions closed or have a plan for improvement within 14 business days as monitored through facility tracking database and inspections for six consecutive months.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.[60] Diversion by healthcare workers—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—remains a serious problem that can increase serious patient safety issues, causes harm to the diverter, and elevates the liability risk to healthcare organizations.[61]

VHA requires that facility managers implement and maintain a CS inspection program to minimize the risk for loss and diversion and to enhance patient safety.[62] Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSI), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.

The OIG review of these issues was conducted to determine whether the Facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.[63] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[64] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[65] CS inspection quarterly trend reports for the prior four quarters;[66] and other relevant documents. The OIG evaluated the following performance indicators:

- CSC reports
  - Monthly summary of findings to the Director
  - Quarterly trend report to the Director
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Annual physical security survey of the pharmacy/pharmacies by VA Police

[60] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (Website accessed on August 21, 2017.)

[61] 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.

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

[63] VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

[64] The review period was October 1, 2017, through March 31, 2018.

[65] The review period was June 1, 2017, through May 31, 2018.

[66] The four quarters were from April 1, 2017, through March 31, 2018.

  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transition
  - Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from 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 CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSIs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated
  - Security and documentation of drugs held for destruction[67]

[67] The "Destructions File Holding Report" lists all drugs awaiting local destruction or turn-over to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

- Accountability for all prescription pads in pharmacy
- Verification of hard copy outpatient pharmacy CS prescriptions
- Verification of 72-hour inventories of the main vault
- Quarterly inspections of emergency drugs
- Monthly CSI checks of locks and verification of lock numbers

Conclusion

The OIG found general compliance with requirements for CSC reports, ordering procedures, CSC and CSIs having no conflicts of interest and completing required training, and area and pharmacy inspections. However, the OIG identified a deficiency with annual physical security survey actions that warranted a recommendation for improvement.

Annual Physical Security Survey Actions

VHA requires the Chief, Police and Security Unit, to follow up with the pharmacy to ensure that identified deficiencies from the annual physical security survey have been corrected.[68] This ensures the security of medications stored in the pharmacy. The VA Police conducted the Facility's 2017 annual physical security survey and recommended that the pharmacy dispensing window be modified to comply with VA standards for bullet resistant glass.[69] Facility leadership explained to the OIG that while the VA requires bullet resistant protection in the pharmacy dispensing area, the DoD mandates that the pharmacy have unobstructed direct patient counseling. The Facility produced an unsigned VA/DoD draft Executive Council Decision Memorandum, dated 2008, outlining the VA and DoD's opposing requirements. However, the Facility could not produce an action plan or waiver from VHA Central Office.

Recommendation 5

5. The Facility Director ensures that deficiencies identified on the annual physical security survey are addressed and monitors compliance.

Facility concurred.

Target date for completion: January 31, 2019

Facility response: The FHCC is a unique facility which serves both DoD and VA populations and there are policy differences between DoD and VA regarding physical security for outpatient pharmacy dispensing areas. The VA requires placement of bullet resistant glass protection and

[68] VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
[69] VA Handbook 0730/4, *Security and Law Enforcement,* March 29, 2013.

the DoD requires the pharmacy to provide an unobstructed direct patient counseling area. The facility pharmacy dispensing window is in a DoD owned building. Due to this factor and the uniqueness of our facility, leadership will be initiating a waiver proposal to VA Central Office to request an exemption from the VA requirement.

Mental Health Care: Posttraumatic Stress Disorder Care

Posttraumatic Stress Disorder (PTSD) may occur "following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury, or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."[70] For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. Non-war zone military experiences, such as the crash of a military aircraft, may also contribute to the development of PTSD.[71]

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed.[72] VHA requires that

1. PTSD screening is performed for every new patient and then is repeated every year for the first five years post-separation and every five years thereafter, unless there is a clinical need to re-screen earlier;
2. If the patient's PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.[73]

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG team reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 33 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Completion of suicide risk assessment by acceptable provider within required timeframe
- Offer to patient of further diagnostic evaluation

[70] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (rescinded November 16, 2017).

[71] VHA Handbook 1160.03.

[72] A PTSD screen is not required if the patient received a PTSD diagnosis in outpatient setting in the past year; has a life expectancy of 6 months or less; has severe cognitive impairment, including dementia; is enrolled in a VHA or community-based hospice program; or has a diagnosis of cancer of the liver, pancreas, or esophagus.

[73] Department of Veterans Affairs, Information Bulletin, *Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 6, 2015.

- Referral for diagnostic evaluation
- Completion of diagnostic evaluation within required timeframe

Conclusion

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

Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.[74] As a group, veterans experience more chronic disease and disability than their non-veteran peers. VA must plan for the growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.[75] Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.[76]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[77] This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. The healthcare team would then manage the patient with treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.[78] Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.[79]

In determining whether the Facility provided an effective geriatric evaluation, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of 44 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Provision of or access to GE
- Program oversight and evaluation
  - Evidence of GE program evaluation
  - Evidence of performance improvement activities through leadership board
- Provision of clinical care
  - Medical evaluation by GE provider

[74] VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

[75] VHA Directive 1140.04.

[76] Chad Boult, Lisa B. Boult, Lynne Morishita, Bryan Dowd, Robert L. Kane, and Cristina F. Urdangarin, "A randomized clinical trial of outpatient geriatric evaluation and management," *Journal of the American Geriatrics Society* 49, no. 4 (April 2001): 351–359.

[77] Public Law 106-117.

[78] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

[79] VHA Directive 1140.04.

  - Assessment by GE nurse
  - Comprehensive psychosocial assessment by GE social worker
  - Patient or family education
  - Plan of care based on GE
- Geriatric management
  - Implementation of interventions noted in plan of care

Conclusion

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

Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.[80] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veteran's Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.[81] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services including mammography services to eligible women veterans.[82]

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Communication with patients must be documented.[83]

The OIG team examined whether the Facility complied with selected VHA requirements for the reporting of mammography results by reviewing relevant documents and interviewing selected employees and managers. The team also reviewed the EHRs of 50 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Electronic linking of mammogram results to radiology order
- Scanning of hard copy mammography reports, if outsourced
- Inclusion of required components in mammography reports
- Communication of results and any recommended course of action to ordering provider
- Communication of results and any recommended course of action to patient

[80] U.S. Breast Cancer Statistics. http://www.BreastCancer.org. (Website accessed on May 18, 2017.)

[81] VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011 (Handbook rescinded and replaced with VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018).

[82] Veterans Health Care Act of 1992, Title I, Publ L. 102-585 (1992).

[83] VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017, and further amended July 24, 2018).

- Performance of follow-up mammogram if indicated
- Performance of follow-up study

Conclusion

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

High-Risk Processes: Central Line-Associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[84] Central lines "refer to a broad category of intravascular (within blood vessels) devices used to administer fluids, medications, blood and blood products, and parenteral nutrition. Unlike the short, temporary catheters inserted into the peripheral vasculature,"[85] central lines are threaded through a vein in the arm, chest, neck, or groin and advanced so that the furthest tip terminates at or close to the heart or in one of the great vessels.[86]

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a central line-associated bloodstream infection (CLABSI) as a "primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site."[87]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[88] The patient's age, underlying conditions, and gender are basic risk factors, but external risk factors such as prolonged hospitalization, multi-lumen central lines, and central line duration far outnumber the basic ones. External factors are associated with a 2.27-fold increased risk for mortality and increased healthcare costs.[89]

The OIG's review of these issues examined whether the Facility established and maintained programs to reduce the incidence of healthcare-associated bloodstream infections in intensive care unit patients with indwelling central lines. In addition to conducting manager and staff interviews, the OIG team reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents. The team also reviewed the training records of 12 clinical employees involved in inserting and/or managing central lines. The OIG evaluated the following performance indicators:

- Presence of Facility policy on the use and care of central lines

[84] TJC. Infection Prevention and Control: IC.01.03.01.

[85] Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

[86] These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.

[87] The Centers for Disease Control and Prevention, *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011.

[88] The Centers for Disease Control and Prevention National Healthcare Safety Network, *Bloodstream Infection Event: Central Line-Associated Bloodstream Infection and non-central line-associated Bloodstream Infection*, January 2017.

[89] Association for Professionals in Infection Control and Epidemiology, 2015.

- Performance of annual infection prevention risk assessment
- Evidence of routine discussion of CLABSI data and prevention outcome measures in committee minutes
- Provision of infection incidence data on CLABSI
- Education on reducing the risk of CLABSI for staff involved in inserting and/or managing central lines
- Educational materials about CLABSI prevention for patients and families
- Use of a checklist for central line insertion and maintenance

Conclusion

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

Appendix A: Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Five OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Director, Chief Medical Executive, and Associate Director for Facility Support. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs	• None	• Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database. • All required members consistently participate in the interdisciplinary group that reviews utilization management data.
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• The Credentialing and Privileging Subcommittee consistently reviews FPPEs in the granting of continued privileges.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent Facility
	  ○ EOC rounds and deficiency tracking
	  ○ Infection prevention
	  ○ General safety
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• CBOC
	  ○ General safety
	  ○ Medication safety and security
	  ○ Infection prevention
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• Locked MH Unit
	  ○ Bi-annual MH EOC rounds
	  ○ Nursing station security
	  ○ Public area and general unit safety
	  ○ Patient room safety
	  ○ Infection prevention
	  ○ Availability of medical equipment and supplies
	• Emergency Management
	  ○ Hazard Vulnerability Analysis (HVA)
	  ○ Emergency Operations Plan (EOP)
	  ○ Emergency power testing and availability
		• None	• Facility managers maintain a safe and clean environment throughout the Facility.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	• CSC reports • Pharmacy operations • Annual physical security survey • CS ordering processes • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections	• None	• Deficiencies on the annual pharmacy physical security survey are addressed.
Mental Health Care: Posttraumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• None	• None
Long-term Care: Geriatric Evaluations	• Provision of or access to geriatric evaluation • Program oversight and evaluation requirements • Geriatric evaluation requirements • Geriatric management requirements	• None	• None
Women's Health: Mammography Results and Follow-Up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• None	• None
High-Risk Processes: Central Line-Associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• Education and educational materials • Policy, procedure, and checklist for insertion and maintenance of central venous catheters		

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this mid-high complexity (1c)[90] affiliated[91] Facility reporting to VISN 12.

Table 7. Facility Profile for North Chicago (556) (October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[92]	Facility Data FY 2016[93]	Facility Data FY 2017[94]
Total Medical Care Budget in Millions	$406.2	$398.9	$423.1
Number of:			
• Unique Patients	55,876	73,454	76,244
• Outpatient Visits	400,020	435,118	419,340
• Unique Employees[95]	1341	1332	1355
Type and Number of Operating Beds:			
• Community Living Center	134	134	134
• Domiciliary	125	125	125
• Medicine	32	32	32
• Mental Health	52	52	52
• Residential Rehabilitation	18	18	18
• Surgery	4	4	4
Average Daily Census:			
• Community Living Center	122	113	125
• Domiciliary	91	75	82

[90] The VHA medical centers are classified according to a facility complexity model; 1c designation indicates a Facility with medium-high volume, medium-risk patients, some complex clinical programs, and medium-sized research and teaching programs.

[91] Associated with a medical residency program.

[92] October 1, 2014, through September 30, 2015.

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

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

[95] Unique employees involved in direct medical care (cost center 7000).

Profile Element	Facility Data FY 2015[92]	Facility Data FY 2016[93]	Facility Data FY 2017[94]
• Medicine	18	22	23
• Mental Health	21	15	17
• Residential Rehabilitation	15	13	16
• Surgery	2	2	2

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

VA Outpatient Clinic Profiles[96]

The VA outpatient clinics in communities within the catchment area of the Facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 8 provides information relative to each of the clinics.

Table 8. VA Outpatient Clinic Workload/Encounters[97] and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[98] Provided	Diagnostic Services[99] Provided	Ancillary Services[100] Provided
Evanston, IL	556GA	2,643	1,665	Gastroenterology Nephrology	EKG Laboratory & Pathology	Nutrition Pharmacy Weight Management
McHenry, IL	556GC	8,599	3,777	Gastroenterology Nephrology Podiatry	EKG Laboratory & Pathology	Nutrition Pharmacy Weight Management

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

[97] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

[98] Specialty care services refer to non-PC and non-MH services provided by a physician.

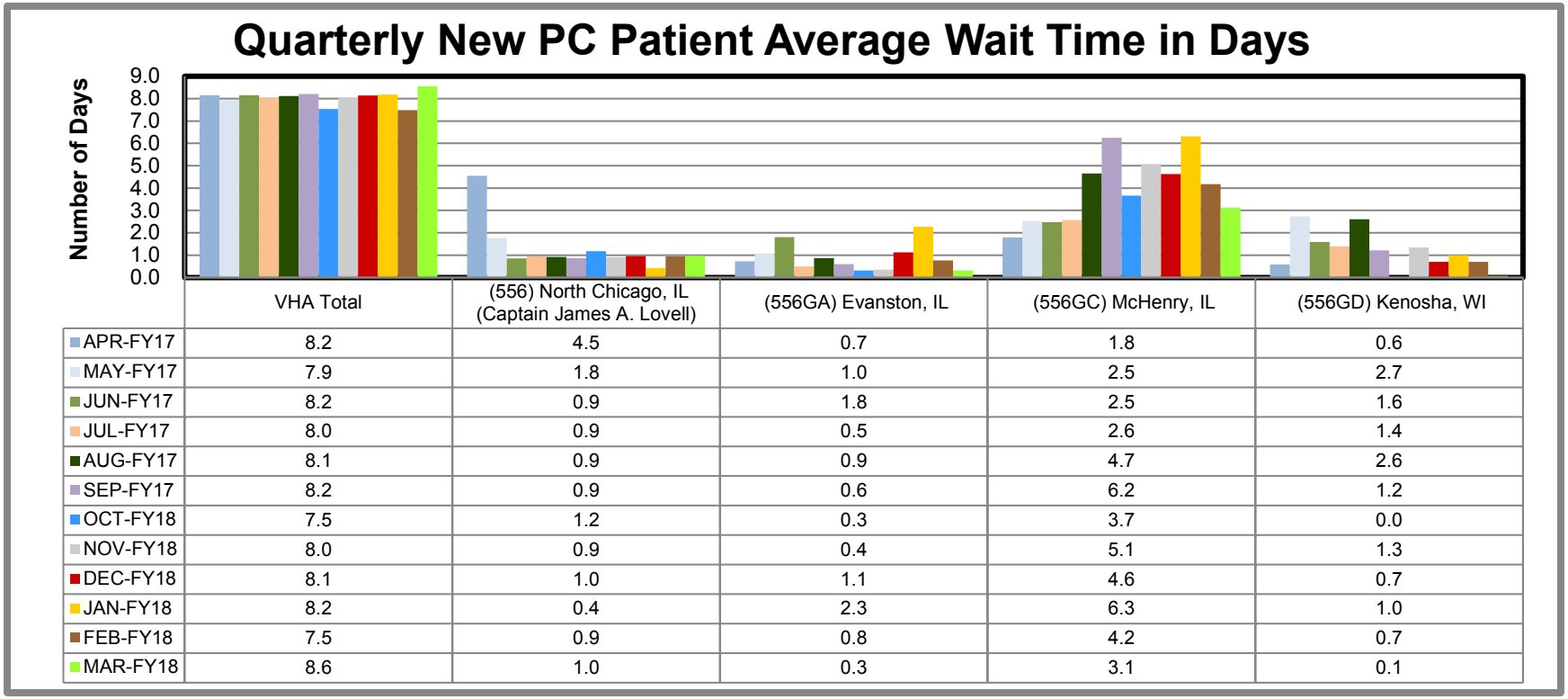
[99] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

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

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[98] Provided	Diagnostic Services[99] Provided	Ancillary Services[100] Provided
Kenosha, WI	556GD	4,023	3,169	Gastroenterology Infectious Disease Nephrology	EKG Laboratory & Pathology	Nutrition Pharmacy Weight Management

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

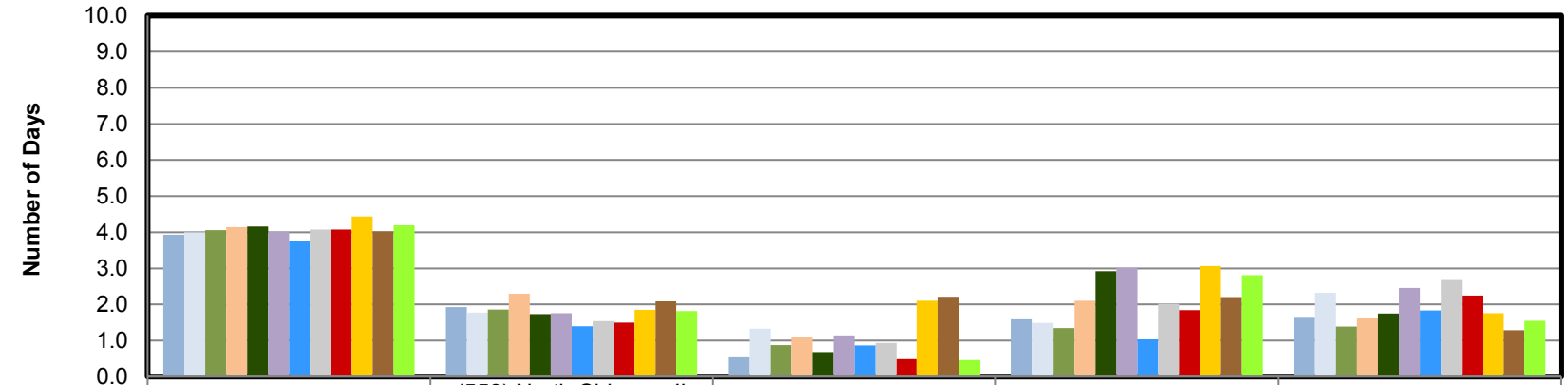
Appendix C: Patient Aligned Care Team Compass Metrics[101]



	VHA Total	(556) North Chicago, IL (Captain James A. Lovell)	(556GA) Evanston, IL	(556GC) McHenry, IL	(556GD) Kenosha, WI
APR-FY17	8.2	4.5	0.7	1.8	0.6
MAY-FY17	7.9	1.8	1.0	2.5	2.7
JUN-FY17	8.2	0.9	1.8	2.5	1.6
JUL-FY17	8.0	0.9	0.5	2.6	1.4
AUG-FY17	8.1	0.9	0.9	4.7	2.6
SEP-FY17	8.2	0.9	0.6	6.2	1.2
OCT-FY18	7.5	1.2	0.3	3.7	0.0
NOV-FY18	8.0	0.9	0.4	5.1	1.3
DEC-FY18	8.1	1.0	1.1	4.6	0.7
JAN-FY18	8.2	0.4	2.3	6.3	1.0
FEB-FY18	7.5	0.9	0.8	4.2	0.7
MAR-FY18	8.6	1.0	0.3	3.1	0.1

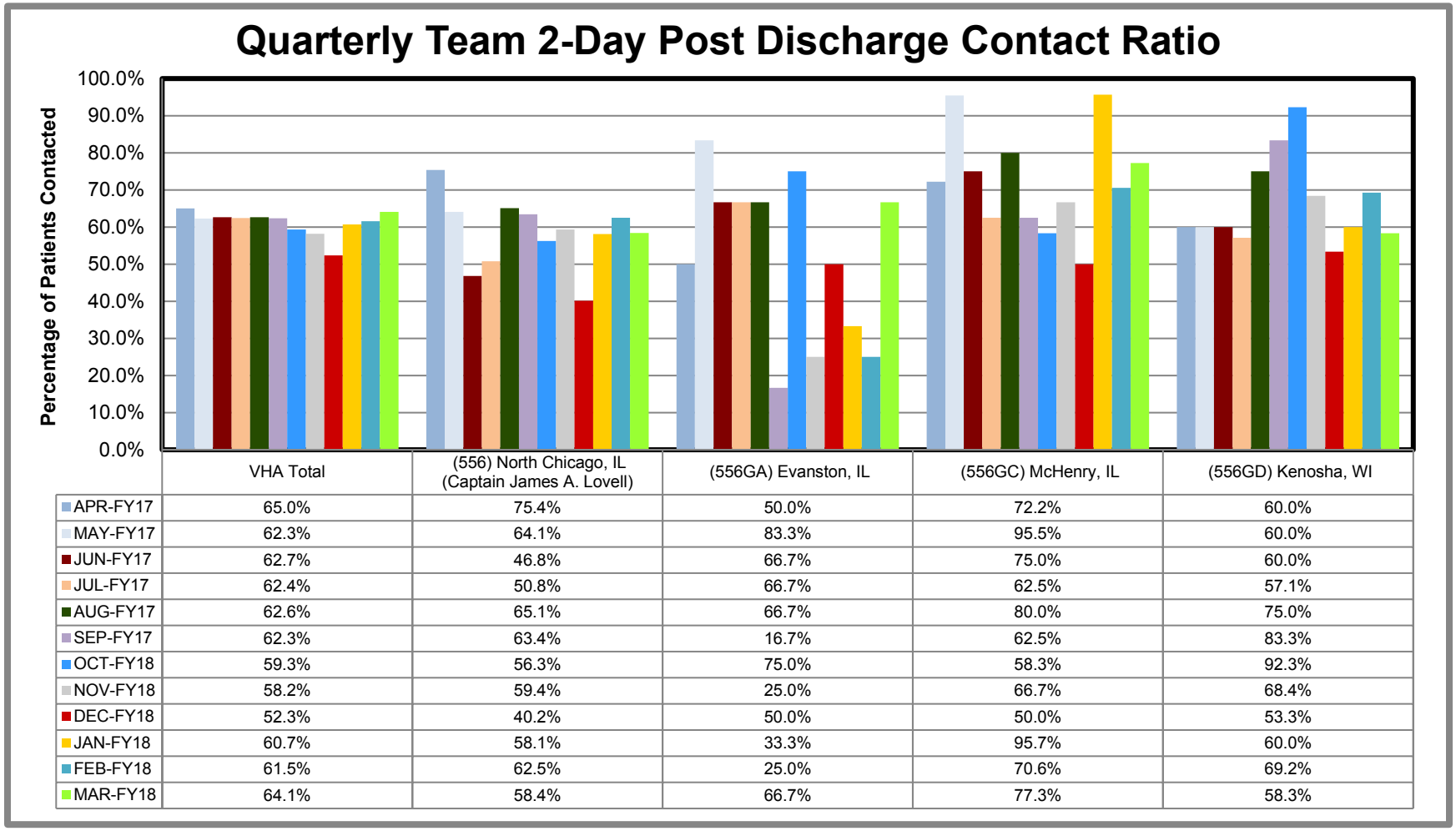
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
***Data Definition**: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the 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 FY 2015, this metric was calculated using the earliest possible create date.*

[101] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.



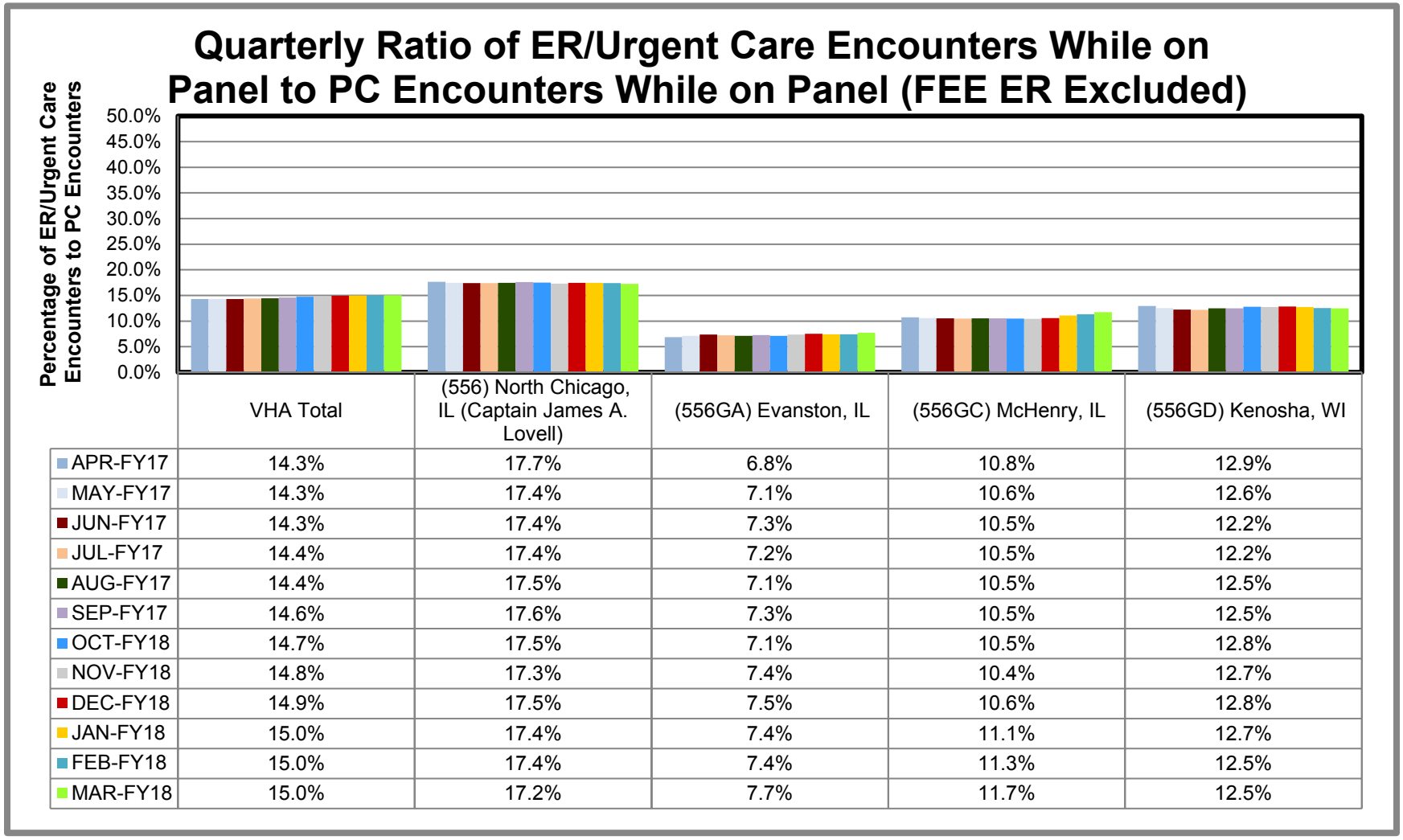
	VHA Total	(556) North Chicago, IL (Captain James A. Lovell)	(556GA) Evanston, IL	(556GC) McHenry, IL	(556GD) Kenosha, WI
APR-FY17	3.9	1.9	0.5	1.6	1.7
MAY-FY17	4.0	1.8	1.3	1.5	2.3
JUN-FY17	4.1	1.9	0.9	1.3	1.4
JUL-FY17	4.1	2.3	1.1	2.1	1.6
AUG-FY17	4.2	1.7	0.7	2.9	1.7
SEP-FY17	4.0	1.8	1.1	3.0	2.5
OCT-FY18	3.7	1.4	0.9	1.0	1.8
NOV-FY18	4.1	1.5	0.9	2.0	2.7
DEC-FY18	4.1	1.5	0.5	1.8	2.2
JAN-FY18	4.4	1.9	2.1	3.1	1.8
FEB-FY18	4.0	2.1	2.2	2.2	1.3
MAR-FY18	4.2	1.8	0.5	2.8	1.5

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 PC 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.*



	VHA Total	(556) North Chicago, IL (Captain James A. Lovell)	(556GA) Evanston, IL	(556GC) McHenry, IL	(556GD) Kenosha, WI
APR-FY17	65.0%	75.4%	50.0%	72.2%	60.0%
MAY-FY17	62.3%	64.1%	83.3%	95.5%	60.0%
JUN-FY17	62.7%	46.8%	66.7%	75.0%	60.0%
JUL-FY17	62.4%	50.8%	66.7%	62.5%	57.1%
AUG-FY17	62.6%	65.1%	66.7%	80.0%	75.0%
SEP-FY17	62.3%	63.4%	16.7%	62.5%	83.3%
OCT-FY18	59.3%	56.3%	75.0%	58.3%	92.3%
NOV-FY18	58.2%	59.4%	25.0%	66.7%	68.4%
DEC-FY18	52.3%	40.2%	50.0%	50.0%	53.3%
JAN-FY18	60.7%	58.1%	33.3%	95.7%	60.0%
FEB-FY18	61.5%	62.5%	25.0%	70.6%	69.2%
MAR-FY18	64.1%	58.4%	66.7%	77.3%	58.3%

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
Data Definition: *The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within two business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within two business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17."*



	VHA Total	(556) North Chicago, IL (Captain James A. Lovell)	(556GA) Evanston, IL	(556GC) McHenry, IL	(556GD) Kenosha, WI
APR-FY17	14.3%	17.7%	6.8%	10.8%	12.9%
MAY-FY17	14.3%	17.4%	7.1%	10.6%	12.6%
JUN-FY17	14.3%	17.4%	7.3%	10.5%	12.2%
JUL-FY17	14.4%	17.4%	7.2%	10.5%	12.2%
AUG-FY17	14.4%	17.5%	7.1%	10.5%	12.5%
SEP-FY17	14.6%	17.6%	7.3%	10.5%	12.5%
OCT-FY18	14.7%	17.5%	7.1%	10.5%	12.8%
NOV-FY18	14.8%	17.3%	7.4%	10.4%	12.7%
DEC-FY18	14.9%	17.5%	7.5%	10.6%	12.8%
JAN-FY18	15.0%	17.4%	7.4%	11.1%	12.7%
FEB-FY18	15.0%	17.4%	7.4%	11.3%	12.5%
MAR-FY18	15.0%	17.2%	7.7%	11.7%	12.5%

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
Data Definition: *This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a LIP divided by the number of PC Team Encounters WOT with an LIP* ***plus*** *the total number of VHA ER/Urgent Care Encounters WOT with an LIP.*

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[102]

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	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	All Employee Survey Best Places to Work score	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Capacity	Physician Capacity	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	% 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

[102] VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: February 14, 2018.

Measure	Definition	Desired Direction
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Healthcare 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	MH 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	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (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 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
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
Rating Hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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
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

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 4, 2018

From: Director, VA Great Lakes Health Care System (10N12)

Subj: CHIP Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, IL

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

Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed the document and I concur with the recommendations and corrective actions Captain James A. Lovell Federal Health Care Center has implemented in response to the identified recommendations. If additional information is needed please contact the Survey Accreditation Facilitator, Performance Improvement at the Captain James A. Lovell Federal Health Care Center, North Chicago.

(Original signed by:)

Renee Oshinski
Network Director, VISN 12

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

Appendix F: Interim Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 31, 2018

From: Interim Director, Captain James A. Lovell Federal Health Care Center (556/00)

Subj: CHIP Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, IL

To: Director, VA Great Lakes Health Care System (10N12)

1. Thank you for the opportunity to view the draft CHIP Review report of the Captain James A. Lovell Federal Health Care Center, North Chicago, IL Inspection. I have reviewed the document and concur with the recommendations.

2. Corrective action plans have been implemented as detailed in the attached report. If additional information is needed please contact the Survey Accreditation Facilitator, Performance Improvement at the Captain James A. Lovell Federal Health Care Center, North Chicago.

(Original signed by:)

Daniel S. Zomchek, Ph.D., FACHE
Interim Director

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

OIG Contact and Staff Acknowledgments

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