



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare  
Inspection of the Edward  
Hines, Jr. VA Hospital  
Hines, Illinois



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**Figure 1.** Edward Hines, Jr. VA Hospital, Hines, IL (Source: <https://vaww.va.gov/directory/guide/>, accessed on January 16, 2019)

## Abbreviations

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



## Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Edward Hines, Jr. VA Hospital (the facility). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

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

This unannounced visit was conducted during the week of November 5, 2018. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

## Results and Inspection Impact

### Leadership and Organizational Risks

The facility leadership team consists of the director, chief of staff, associate director for Patient Care Services (ADPCS), associate director (primarily nonclinical), and assistant director (primarily nonclinical). Organizational communications and accountability are managed through a committee reporting structure, with the Executive Healthcare Council having oversight for several working groups, including the Quality Board. The director is a co-chair of the Quality Board, which is responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.

At the time of the OIG's visit, the facility's leadership team had been working together since October 2017, the date of when the associate director, the newest leader, was appointed. The director, chief of staff, and assistant director were permanently assigned in 2016. The ADPCS was permanently assigned in February 2015.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders were engaged and promoted a culture of safety where employees feel safe bringing forward issues and concerns. However, opportunities exist for the ADPCS, associate director, and assistant director to provide an environment where employees feel encouraged to do the right thing. The selected outpatient experience survey scores for facility leaders were better than the VHA average, however, opportunities appear to exist for inpatient experiences. Facility leaders reported implementing processes and plans to improve patient experiences.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,<sup>1</sup> disclosures of adverse patient events, and patient safety indicator data and identified organizational risk factors with patient safety indicator data that may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored.

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.<sup>2</sup> Although the leadership

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

<sup>2</sup> VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a “star rating” system to designate a facility's performance in individual measures, domains, and overall quality.

<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 6, 2019, but is not accessible by the public.)

team members were knowledgeable within their areas of responsibility about selected SAIL metrics and SAIL community living center (CLC) measures, the leaders should continue to take actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "3-star" and CLC "1-star" quality ratings.<sup>3</sup>

The OIG noted findings in six of the eight clinical areas reviewed and issued 10 recommendations that are attributable to the director, chief of staff, and associate director. These are briefly described below.

## **Quality, Safety, and Value**

The OIG found general compliance with requirements for protected peer review and patient safety.<sup>4</sup> However, the OIG identified noncompliance with utilization management data review group representation and resuscitation episode reviews.

## **Medical Staff Privileging**

The facility generally complied with requirements for privileging and focused professional practice evaluations. However, the OIG identified noted a concern with the lack of specialty-specific criteria in the ongoing professional practice evaluation for gastroenterology providers.<sup>5</sup>

## **Environment of Care**

The facility generally complied with requirements for the representative community based outpatient clinic, emergency management program, and locked mental health inpatient unit. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified noncompliance with general safety and infection prevention.

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<sup>3</sup> Based on fiscal year 2018, quarter 3 ratings at the time of the site visit.

<sup>4</sup> The definition of utilization management can be found within VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the "forward-looking evaluation of the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria."

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

## **Mental Health**

The OIG noted general compliance with many of the mental health performance indicators, including the designation of a military sexual trauma (MST) coordinator, tracking of MST-related data, and the provision of clinical care. The OIG noted a concern, however, with providers completing the MST mandatory training requirements in a timely manner.

## **Geriatric Care**

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

## **Women's Health**

The OIG also noted the facility's compliance with the requirements for a designated women veterans program manager, clinical oversight of the women's health program, communication of abnormal results to patients within the required timeframe, and provision of follow-up care when indicated. However, the Women Veterans Health Committee membership lacked required representation, and the facility did not consistently track data related to cervical cancer screening.

## **Summary**

In reviewing key healthcare processes, the OIG issued 10 recommendations for improvement directed to the facility director, chief of staff, and associate director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

## Comments

The acting Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 69–70, and the responses within the body of the report for the full text of the directors’ comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.



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## Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to provide oversight of healthcare services to veterans. This focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Edward Hines, Jr. VA Hospital (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.<sup>6</sup> Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.<sup>7</sup> Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

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

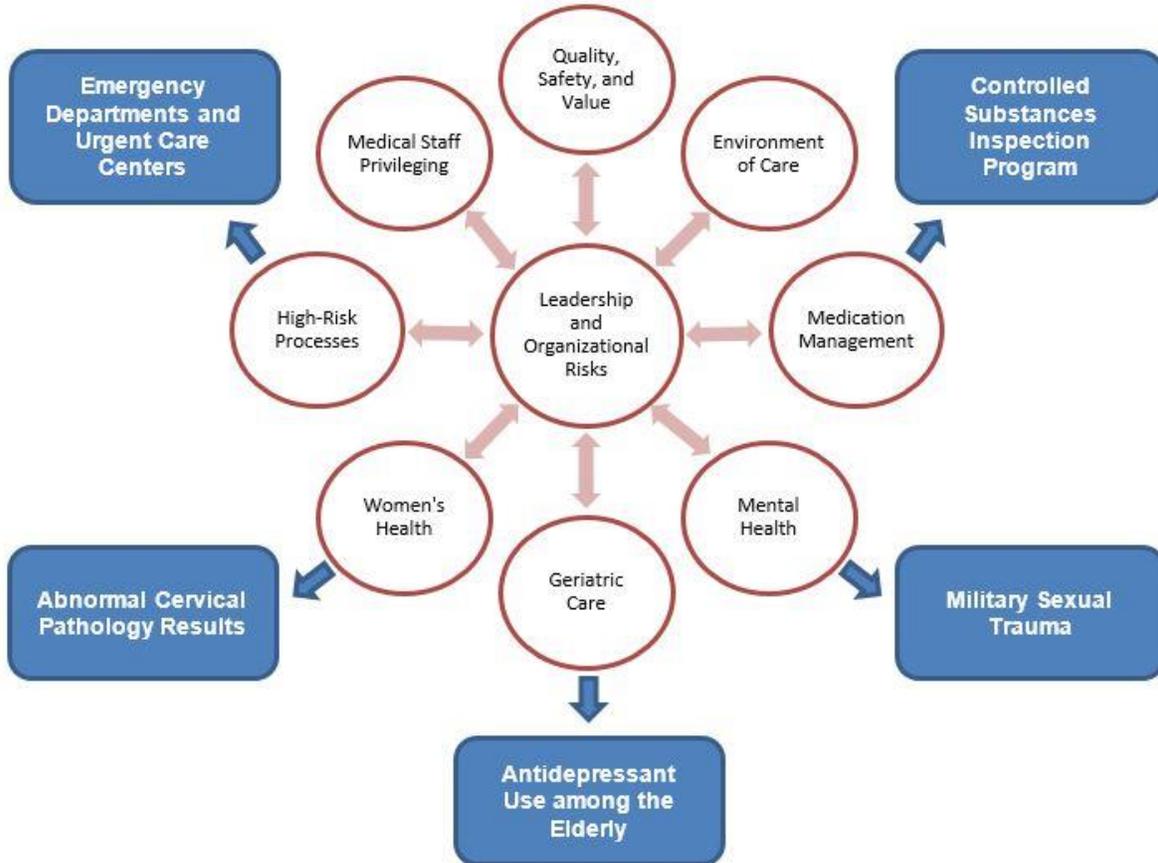
1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (specifically the controlled substances inspection program)
6. Mental health (focusing on military sexual trauma follow-up and staff training)
7. Geriatric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

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<sup>6</sup> Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/>. (The website was accessed on January 24, 2019.)

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

9. High-risk processes (specifically the emergency department and urgent care center operations and management).<sup>8</sup>



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

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

## Methodology

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

The inspection period examined operations from November 7, 2015,<sup>10</sup> through November 9, 2018, the last day of the unannounced week-long site visit.<sup>11</sup>

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

While on site, the OIG did not receive any complaints beyond the scope of the CHIP review. The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reports and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

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

<sup>10</sup> This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient Clinic reviews.

<sup>11</sup> The range represents the time period from the last Combined Assessment Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced week-long CHIP site visit.

## Results and Recommendations

### Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.<sup>12</sup> To assess the facility's risks, the OIG considered the following indicators:

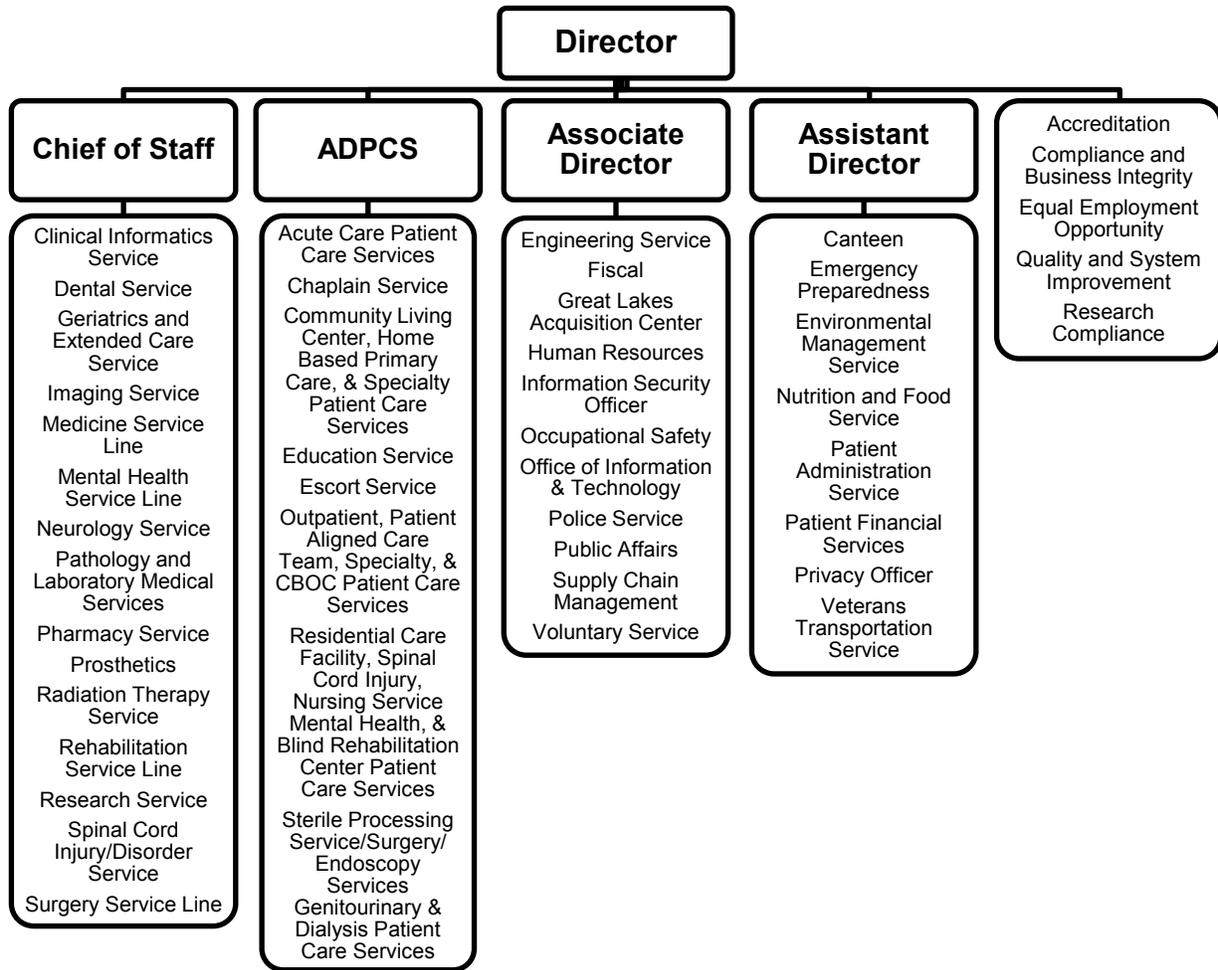
1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation and/or for-cause surveys and oversight inspections
5. Factors related to possible lapses in care
6. VHA performance data

### Executive Leadership Position Stability and Engagement

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

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<sup>12</sup> L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. [www.IHI.org](http://www.IHI.org) (The website was accessed on February 2, 2017.)



**Figure 3. Facility Organizational Chart**  
Source: Edward Hines, Jr. VA Hospital (received November 6, 2018)

At the time of the OIG site visit, the executive team had been working together for over one year (see Table 1). The ADPCS was the most tenured team member, and all positions were permanently assigned.

**Table 1. Executive Leader Assignments**

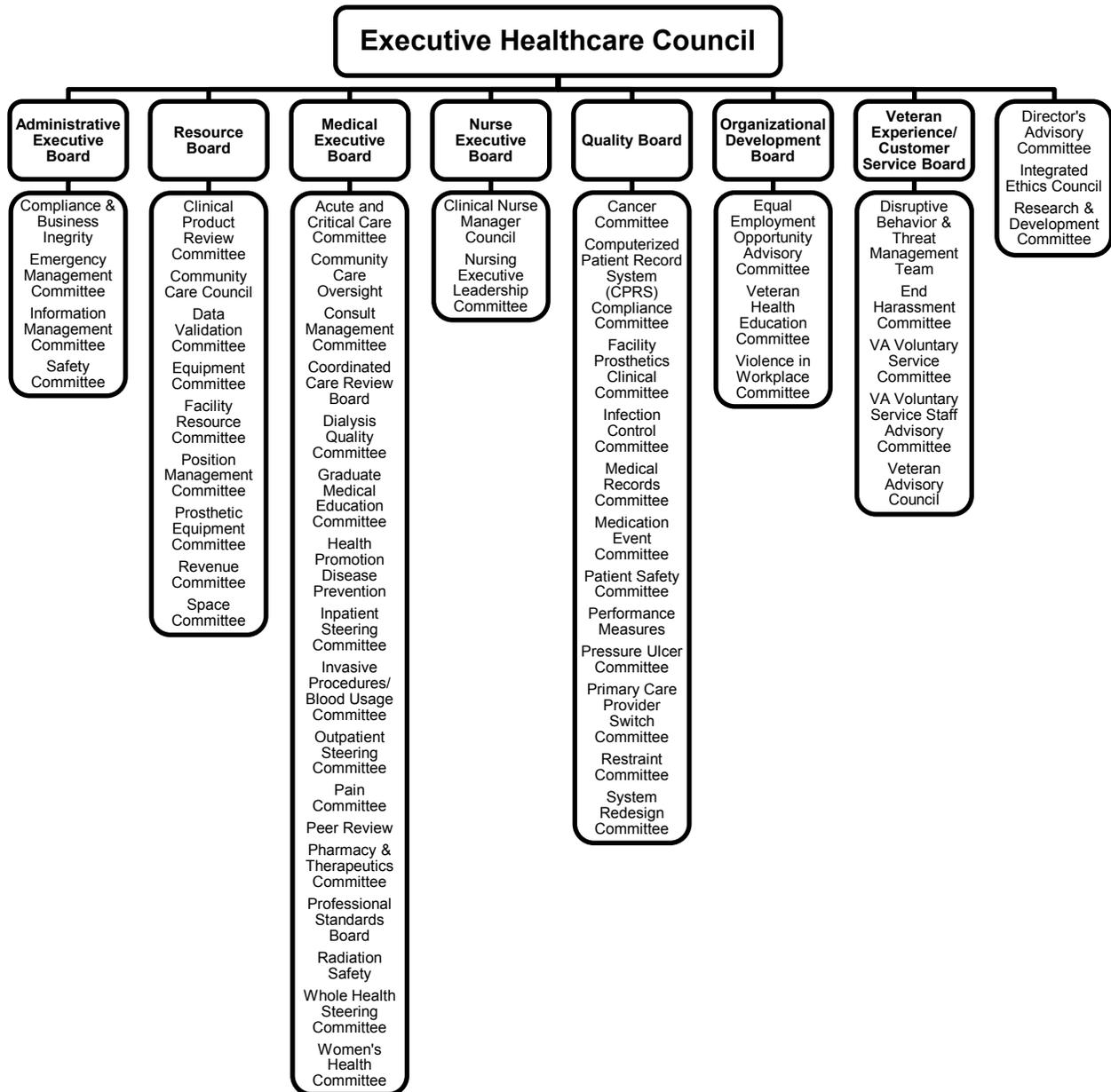
Leadership Position	Assignment Date
Facility director	September 18, 2016
Chief of staff	October 16, 2016
Associate director for Patient Care Services	February 22, 2015
Associate director	October 29, 2017
Assistant director	September 18, 2016

Source: Edward Hines, Jr. VA Hospital human resources officer (received November 6, 2018)

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

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable, within their scope of responsibilities, about selected Strategic Analytics for Improvement and Learning (SAIL) metrics and community living center (CLC) measures. These are discussed in greater detail below.

These leaders are also engaged in monitoring patient safety and care through the Quality Board, for which the director is a co-chair and the chief of staff and ADPCS are members. The Quality Board is responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes and reports to the Executive Healthcare Council. The director also serves as the chairperson of the Executive Healthcare Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Healthcare Council oversees various working groups, such as the Administrative Executive Board, Medical Executive Board, Nurse Executive Board, and Organizational Development Board. See Figure 4.



**Figure 4. Facility Committee Reporting Structure**  
Source: Edward Hines, Jr. VA Hospital (November 7, 2018)

## Employee Satisfaction

The All Employee Survey is an “annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential.” Since 2001, the instrument has been refined several times in response to VA leaders’ inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point

for discussions, indicate areas for further inquiry, and be considered along with other information on facility leadership.

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2017, through September 30, 2018.<sup>13</sup> Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for several selected survey leadership questions was similar to or higher than the VHA average.<sup>14</sup> The same trend was noted for the members of the executive leadership team. In all, employees appear generally satisfied with facility leaders.

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<sup>13</sup> Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, and associate director.

<sup>14</sup> The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: <i>Servant Leader Index Composite</i> <sup>15</sup>	0–100 where HIGHER scores are more favorable	71.7	72.7	84.0	87.5	80.0	79.6	— <sup>16</sup>
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.4	4.0	3.9	4.1	4.0	3.0
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.6	4.1	4.1	4.1	4.0	—
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.7	4.2	4.1	4.1	4.2	3.8

*Source: VA All Employee Survey (accessed October 10, 2018)*

Table 3 summarizes employee attitudes toward the workplace, also as expressed in VHA’s All Employee Survey. Note that the facility and available executive leadership team averages for the selected survey questions were similar to or better than the VHA average, with the exception of

<sup>15</sup> According to the 2018 VA All Employee Survey (AES) Questions by Organizational Health Framework, Servant Leader Index, “is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others’ contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others’ needs before their own.”

<sup>16</sup> Response averages are only provided for groups of five or more respondents.

the survey question on moral distress, where opportunities appear to exist for the ADPCS, associate director, and assistant director to provide an environment where employees feel they are encouraged to do the right thing.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.8	4.4	4.6	3.7	4.3	4.0
All Employee Survey: <i>Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.6	3.7	4.5	3.8	3.6	—
All Employee Survey: <i>In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?</i>	0 (Never) – 6 (Every Day)	1.5	1.5	0.7	0.9	2.3	1.9	2.0

Source: VA All Employee Survey (accessed October 10, 2018)

## Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through June 30, 2018. VHA’s Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients’ experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.<sup>17</sup>

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients’ attitudes toward facility leaders (see Table 4). For this facility, the outpatient survey results reflected higher care ratings than the VHA average, while opportunities appear to exist to improve veteran experiences in the inpatient setting. The leadership team reported taking actions to improve the patient experience, which included conducting and addressing veterans’ concerns during townhall meetings, and ensuring continuity of care for patients discharged from the hospital.

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

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	66.8	65.9
Survey of Healthcare Experiences of Patients (inpatient): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	84.3	82.5
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.2	81.1

<sup>17</sup> Ratings are based on responses by patients who received care at this facility.

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.3	84.1

*Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 10, 2018)*

## Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.<sup>18</sup> Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).<sup>19</sup> Indicative of effective leadership, the facility has closed all recommendations for improvement (see Table 5).<sup>20</sup>

At the time of the site visit, the OIG also noted the facility’s current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and College of American Pathologists.<sup>21</sup> Additional results included the Long Term Care Institute’s inspection of the

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<sup>18</sup> The Joint Commission (TJC) conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.

<sup>19</sup> According to VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017, TJC provides an “internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care.” TJC “has been accrediting VA medical facilities for over 35 years.” Compliance with TJC standards “facilitates risk reduction and performance improvement.”

<sup>20</sup> A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

<sup>21</sup> According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs*, May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities “provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies.” VHA’s commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs; According to the College of American Pathologists, for 70 years it has “fostered excellence in laboratories and advanced the practice of pathology and laboratory science.” College of American Pathologists. <https://www.cap.org/about-the-cap>. (The website was accessed on August 8, 2018.); In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

facility's CLC<sup>22</sup> and the Paralyzed Veterans of America's inspection of the facility's spinal cord injury/disorder unit and spinal cord injury/disorder related services.<sup>23</sup>

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG ( <i>Combined Assessment Program Review of the Edward Hines, Jr. VA Hospital, Hines, Illinois, Report No. 15-04700-119, February 24, 2016</i> )	November 2015	11	0
OIG ( <i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Edward Hines, Jr. VA Hospital, Hines, Illinois, Report No. 15-05158-74, January 12, 2016</i> )	November 2015	3	0
OIG ( <i>Healthcare Inspection – Nutrition and Food Service Environment of Care Concerns, Edward Hines, Jr. VA Hospital, Hines, Illinois, Report No. 16-03302-252, May 23, 2017</i> )	May 2016	2 <sup>24</sup>	0
OIG ( <i>Healthcare Inspection – Echocardiography Scheduling and Quality of Care Concerns, Edward Hines, Jr. VA Hospital, Report No. 15-01900-142, Hines, Illinois, February 2, 2017</i> )	April–May 2015	4	0
OIG ( <i>Healthcare Inspection – Environment of Care and Safety Concerns in Operating Room Areas, Edward Hines Jr. VA Hospital, Hines, Illinois, Report No. 14-05173-92, January 19, 2016</i> )	October 2014 December 2014	4	0

<sup>22</sup> The Long Term Care Institute states that it has been to over 4,000 healthcare facilities conducting quality reviews and external regulatory surveys since 1999. The Long Term Care Institute is “focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings.” Long Term Care Institute. <http://www.ltcior.org/about-us/>. (The website was accessed on March 6, 2019.)

<sup>23</sup> The Paralyzed Veterans of America inspection took place May 8–9, 2018. This veteran service organization review does not result in accreditation status.

<sup>24</sup> Although three recommendations were made, Recommendation 1 was directed to the Veterans Integrated Service Network director.

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
TJC			
<ul style="list-style-type: none"> <li>• Regular                             <ul style="list-style-type: none"> <li>○ Hospital Accreditation</li> <li>○ Behavioral Health Accreditation</li> <li>○ Home Care Accreditation</li> </ul> </li> <li>• For Cause</li> <li>• Opioid Treatment Program</li> </ul>	<p style="text-align: center;">January 2018</p>   <p style="text-align: center;">May 2017</p> <p style="text-align: center;">May 2018</p>	<p>48</p> <p>0</p> <p>5</p> <p>3</p> <p>3</p>	<p>0</p> <p>0</p> <p>0</p> <p>0</p> <p>0</p>

*Sources: OIG and TJC (Inspection/survey results verified with the assistant chief of Quality and System Improvement on November 6, 2018)*

### Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from November 7, 2015 (the prior comprehensive OIG inspection), through November 9, 2018.<sup>25</sup>

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<sup>25</sup> It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Edward Hines, Jr. VA Hospital is a high complexity (1a) affiliated facility as described in Appendix B.)

**Table 6. Summary of Selected Organizational Risk Factors  
(November 7, 2015, through November 9, 2018)**

Factor	Number of Occurrences
Sentinel Events <sup>26</sup>	5
Institutional Disclosures <sup>27</sup>	3
Large-Scale Disclosures <sup>28</sup>	0

*Source: Edward Hines, Jr. VA Hospital’s patient safety and risk managers (received November 7, 2018)*

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.<sup>29</sup> The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 7 summarizes patient safety indicator data from July 1, 2016, through June 30, 2018.

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<sup>26</sup> The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient “death, permanent harm, or severe temporary harm and intervention required to sustain life.”

<sup>27</sup> According to VHA Directive 1004.08, *Disclosure of Adverse Events To Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an “administrative disclosure”) as “a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or [his or her] personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.”

<sup>28</sup> According to VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines large-scale disclosures of adverse events (sometimes referred to as “notifications”) as “a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue.”

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

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

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 12	Facility
Pressure ulcer	0.76	0.92	0.53
Death among surgical inpatients with serious treatable conditions	114.89	100.00	169.81
Iatrogenic pneumothorax <sup>30</sup>	0.15	0.16	0.34
Central venous catheter-related bloodstream infection	0.16	0.07	0.00
In-hospital fall with hip fracture	0.09	0.02	0.10
Perioperative hemorrhage or hematoma	2.59	3.64	1.91
Postoperative acute kidney injury requiring dialysis	0.96	1.88	2.42
Postoperative respiratory failure	4.88	5.44	8.18
Perioperative pulmonary embolism or deep vein thrombosis	3.05	3.60	4.56
Postoperative sepsis	3.70	2.47	5.87
Postoperative wound dehiscence (rupture along incision)	0.93	1.39	1.52
Unrecognized abdominopelvic accidental puncture or laceration	1.07	0.96	1.05

*Source: VHA Support Service Center*

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

Of the 12 patient safety indicator measures, the facility had eight measures—death among surgical inpatients with serious treatable conditions, iatrogenic pneumothorax, in-hospital fall with hip fracture, postoperative acute kidney injury requiring dialysis, postoperative respiratory failure, perioperative pulmonary embolism or deep vein thrombosis, postoperative sepsis, and postoperative wound dehiscence—that show higher reported rate of occurrence than VHA and VISN 12. The patient safety indicator measure for unrecognized abdominopelvic accidental puncture/laceration shows a higher observed rate than VISN 12.

Nine surgical inpatients with serious treatable conditions died. The facility conducted internal reviews of the patients' care individually and in aggregate, determined that appropriate services were consulted, and did not identify improvement opportunities.

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<sup>30</sup> According to Northwestern Memorial Hospital, "A Pneumothorax is a type of lung injury that allows air to leak into the area between the lungs and the chest wall, which causes mild to severe chest pain and shortness of breath. An Iatrogenic Pneumothorax is one which was caused by medical treatment, often as an incidental event during a procedure such as a pacemaker insertion." Northwestern Medicine. <http://www.nmh.org/nm/quality-lung-injury-due-to-medical-care>. (The website was accessed on March 6, 2019.)

Four patients experienced an iatrogenic pneumothorax postoperatively. Facility reviews of the patients' care determined that the care provided was appropriate for three of the patients and that the pneumothorax was an expected complication after lung surgery for the fourth patient.

One patient sustained an in-hospital fall with a hip fracture while trying to get out of bed. A review was conducted, and the facility reinforced fall precautions with nursing staff to prevent reoccurrence.

Three patients experienced a postoperative acute kidney injury. Nephrology providers reviewed the care of each patient. One patient developed complications after surgery, and providers determined dialysis was not indicated due to the patient's condition. One patient was receiving medical treatment, and providers determined dialysis was not indicated. The facility determined hemodialysis was indicated for the remaining one patient who tolerated the procedure and was discharged home. The facility did not identify any trends.

Seven patients reportedly developed postoperative respiratory failure; however, subsequent electronic health record reviews by respiratory specialists determined that three patients did not have respiratory failure. Clinicians reviewed the remaining cases at several levels, including the VA Surgical Quality Improvement Program and other internal reviews, and determined that the patients received appropriate care.

Ten patients experienced perioperative pulmonary embolism or deep vein thrombosis. Clinical staff reviewed the care received by seven of the patients individually and in aggregate. Facility managers reported that these seven patients had multiple medical problems and were considered high risk for complications. Program managers did not identify trends and considered care to be appropriate. The facility was not able to provide evidence of internal reviews for the remaining three cases.

Postoperative sepsis occurred in seven patients. Clinical managers reported reviewing all cases and planned on implementing a sepsis protocol<sup>31</sup> as an improvement action.

One patient developed a wound dehiscence, which was repaired, and the patient fully recovered and was discharged home.

Two patients experienced accidental puncture/lacerations. Surgeons repaired the tear for one patient, the facility reviewed both cases, individually and in aggregate, and no improvement actions were recommended.

The above organizational risk factors may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and closely monitored.

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<sup>31</sup> Robert L. Gauer, "Early Recognition and Management of Sepsis in Adult: The First Six Hours," *American Family Physician*, <https://www.aafp.org/afp/2013/0701/p44.html> (The website was accessed on February 5, 2019.)

## Veterans Health Administration Performance Data

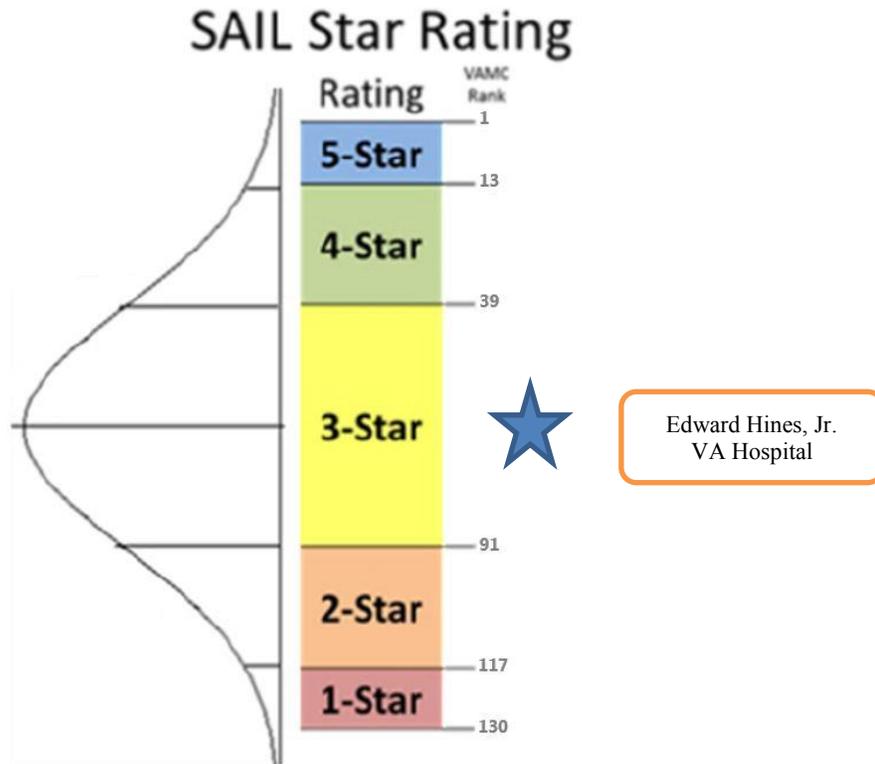
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes “measures on healthcare quality, employee satisfaction, access to care, and efficiency.” It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to “understand the similarities and differences between the top and bottom performers” within VHA.<sup>32</sup>

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.<sup>33</sup> As of June 30, 2018, the facility was rated as “3-star” for overall quality.

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<sup>32</sup> VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

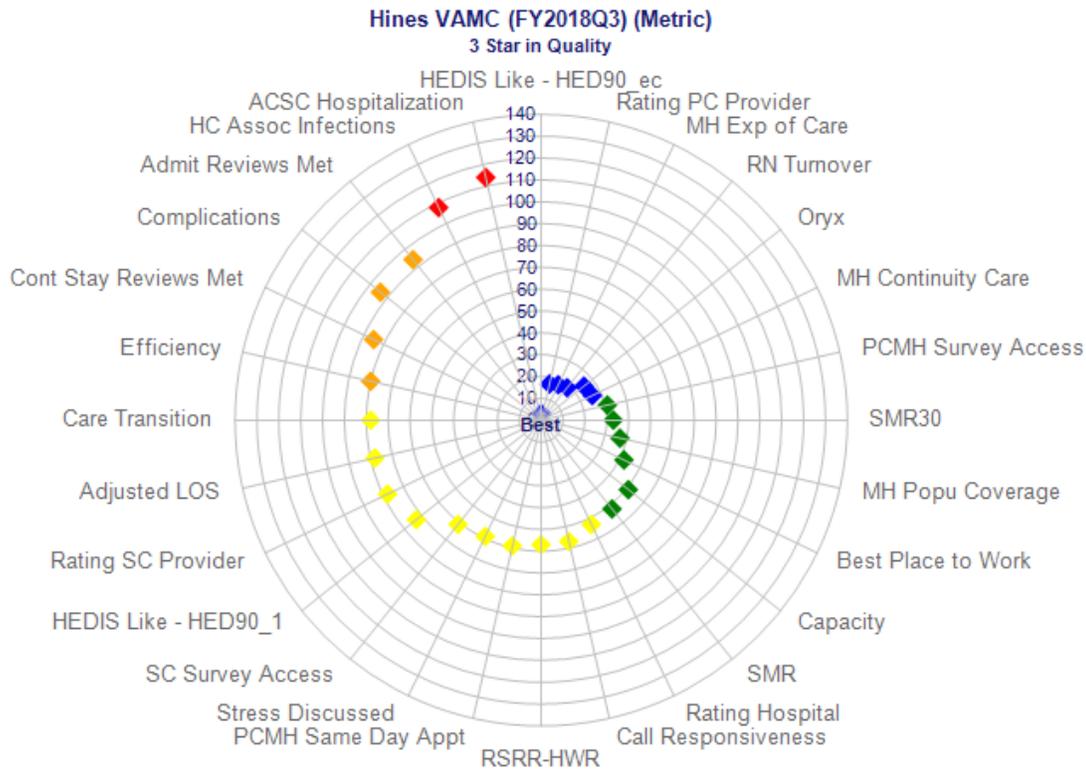
<sup>33</sup> According to the methods established by the SAIL Model, this is based on normal distribution ranking of the quality domain for 130 VA Medical Centers.



**Figure 5.** Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)  
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed October 10, 2018)

Figure 6 illustrates the facility’s quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2018. Of note, Figure 6 uses blue and green data points to indicate high performance (for example, in the areas of rating (of) primary care (PC) provider, mental health (MH) experience (Exp) of care, and registered nurse (RN) turnover). Metrics that need improvement are denoted in orange and red (for example, continued (Cont) stay reviews met, complications, and healthcare (HC) associated (Assoc) infections).<sup>34</sup>

<sup>34</sup> For information on the acronyms in the SAIL metrics, please see Appendix D.



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

**Figure 6.** Facility Quality of Care and Efficiency Metric Rankings (as of June 30, 2018)

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

The SAIL Value Model also includes “SAIL CLC,” which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in The Centers for Medicare & Medicaid Services’ (CMS) *Nursing Home Compare*.<sup>35</sup> The SAIL CLC provides a single resource to review quality measures and health inspection results. It

<sup>35</sup> According to Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, November 19, 2018, “In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several “star” ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes.”

includes star ratings for an unannounced survey, staffing, quality, and overall results.<sup>36</sup> Table 8 summarizes the rating results for the facility’s CLC as of June 30, 2018. Although the facility has an overall “2-star” rating, its rating for quality is only a “1-star,” which is determined by the performance indicators detailed in Table 8.

**Table 8. Facility CLC Star Ratings  
(as of June 30, 2018)**

Domain	Star Rating
Unannounced Survey	★★
Staffing	★★★★★
Quality	★
<b>Overall</b>	★★

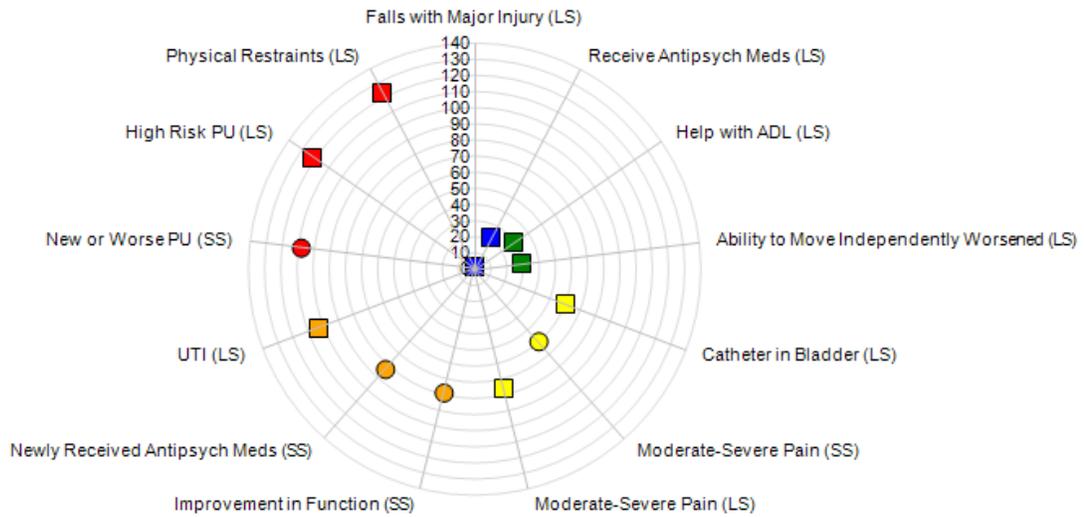
*Source: VHA Support Service Center*

In exploring the reasons for the “1-star” quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 7 illustrates the facility’s CLC quality rankings and performance compared with other VA CLCs as of June 30, 2018. Figure 7 uses blue and green data points to indicate high performance (for example, in the areas of falls with major injury–long stay (LS) and ability to move independently worsened (LS)). Metrics that need improvement and were likely the reasons why the facility had a “1-star” for quality are denoted in orange and red (for example, improvement in function–short stay (SS), urinary tract infection (UTI) (LS), high risk pressure ulcer (PU) (LS), and physical restraints (LS)).<sup>37</sup>

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<sup>36</sup> *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018).  
<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>.  
(The website was accessed on March 6, 2019, but is not accessible by the public.)

<sup>37</sup> For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.



**Figure 7.** Facility CLC Quality Measure Rankings (as of June 30, 2018)

LS = Long-Stay Measure      SS = Short-Stay Measure

Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness. For data definitions, see Appendix E.

## Leadership and Organizational Risks Conclusion

The facility’s executive leadership team appeared relatively stable, with all the leadership positions permanently filled for over one year prior to the OIG’s on-site visit. In review of selected survey scores related to employee satisfaction with the facility’s executive leaders, the OIG noted that employees appeared generally satisfied but opportunities seemed to exist for the ADPCS, associate director, and assistant director to provide an environment where employees feel encouraged to do the right thing. In review of patient experience survey data, outpatient satisfaction scores were above VHA averages, while inpatient satisfaction with care provided could be improved. The leaders appeared to support efforts to enhance patient safety, quality care, and other positive outcomes. However, the organizational risk factors detailed in this report, if uncorrected, can perpetuate noncompliance with requirements and/or lapses in patient safety measures. Corrective processes must be fully implemented and continuously monitored. The leadership team was generally knowledgeable, within their scope of responsibility, about selected SAIL and SAIL CLC metrics but should continue to take actions to improve care and performance of metrics that are likely contributing to the current SAIL “3-star” and CLC “1-star” quality ratings.

## Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.<sup>38</sup> VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.<sup>39</sup> VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.<sup>40</sup>

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,<sup>41</sup> utilization management (UM) reviews,<sup>42</sup> patient safety incident reporting with related root cause analyses,<sup>43</sup> and cardiopulmonary resuscitation (CPR) episode reviews.<sup>44</sup>

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.<sup>45</sup>

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<sup>38</sup> VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 and has not been recertified.)

<sup>39</sup> Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

<sup>40</sup> VHA Directive 1026.

<sup>41</sup> The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a critical review of care, performed by a peer, to evaluate care provided by a clinician for a specific episode of care, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements.

<sup>42</sup> According to VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria."

<sup>43</sup> The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

<sup>44</sup> VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

<sup>45</sup> VHA Directive 1190.

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.<sup>46</sup>

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.<sup>47</sup>

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.<sup>48</sup>

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:<sup>49</sup>

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

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<sup>46</sup> VHA Directive 1117(1).

<sup>47</sup> VHA Handbook 1050.01.

<sup>48</sup> VHA Directive 1177, VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, January 11, 2017.

<sup>49</sup> For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

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

## Quality, Safety, Value Conclusion

The OIG found general compliance with requirements for protected peer reviews, UM, and patient safety. However, the OIG identified concerns with the lack of representation in

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<sup>50</sup> VHA Directive 1190.

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

interdisciplinary reviews of UM data and incomplete analysis and trending of resuscitation episodes that warranted recommendations for improvement.

Specifically, VHA requires that an interdisciplinary facility group review UM data. This group must include, but not be limited to, representatives from UM, medicine, nursing, social work, case management, mental health, and chief Business Office revenue-utilization review.<sup>52</sup> From October 2017 through September 2018, the physician UM advisors and UM team, the facility group that reviews UM data, lacked representation from the chief Business Office revenue-utilization review. As a result, the team performed reviews and analyses of UM data without the perspective of a key utilization review colleague. The UM leader was unaware of the requirement.

VHA also requires that the facility establish a committee for reviewing each resuscitative episode under the facility's responsibility and that each review include elements, such as identification of errors or deficiencies in technique or procedures, lack of availability or malfunction of equipment, clinical or patient care issues, and delays in initiating CPR or resuscitation.<sup>53</sup> The OIG found evidence of the reviews by the Acute and Critical Care Committee, however, the reviews lacked the required elements. This resulted in an incomplete analysis of resuscitation episodes and trends, which may impact patient safety. The Associate Chief of Medicine stated staff were unaware of the requirements and believed current practice met standards.

## **Recommendation 1**

1. The facility director ensures the interdisciplinary group or committee that reviews utilization management data includes a representative from the chief Business Office revenue-utilization review and monitors the committee's compliance.

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<sup>52</sup> VHA Directive 1117(1).

<sup>53</sup> VHA Directive 1177.

Facility concurred.

Target date for completion: May 30, 2019

Facility response: The Utilization Management Subcommittee meets weekly as an interdisciplinary group and reports monthly to the Inpatient Steering Committee. It was discussed at both the UM Subcommittee and Inpatient Steering Committee that UR as a voting representative would be the most effective at the Inpatient Steering Committee. The Charter for the Inpatient Steering Committee was changed to include a representative from the chief Business Office revenue utilization as a voting member in December 16, 2018. The new representative has attended monthly Inpatient Steering Meeting since December 19, 2018. The Committee Chair of Inpatient Steering monitors attendance compliance of 90% for the new representative. Negative attendance trends are reported by the Committee Chair of Inpatient Steering to MEB [Medical Executive Board] for action and follow through. A 90% compliance rate has been achieved since the OIG survey.

## Recommendation 2

2. The facility director ensures the Acute and Critical Care Committee conducts a complete analysis of resuscitation episodes by reviewing required elements and monitors the committee's compliance.

Facility concurred.

Target date for completion: November 29, 2019

Facility response: All code resuscitations are reviewed monthly by the Code Review Subcommittee. The review team is notified of the code via a CPRS alert when the code note is complete to assure critical issues are addressed. The resuscitation record template includes all required elements in a checklist format including the new element, "veteran had a life-sustaining treatment plan at the time of the code and the plan followed." All code data is aggregated. Negative trends for action are identified and reported to the monthly Acute and Critical Care Committee. Effective May 1, 2019, a summary statement on the monthly Acute and Critical Care Committee minutes will include a comment for % of codes with all required elements assessed for each code with a target of 90% for 6 months. Also, a summary report for code monitoring is provided by the Acute and Critical Care Committee to the Medical Executive Board chaired by the Chief of Staff on an annual and semiannual basis. All code resuscitation reviews from December 1, 2018 through April 30, 2019 included assessment of all required elements.

## Medical Staff Privileging

VHA has defined procedures for the clinical privileging of all health care professionals who are permitted by law and the facility to practice independently—" without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).<sup>54</sup>

Clinical privileges need to be specific, based on the individual's clinical competence. They are 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 their expiration.<sup>55</sup>

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff, or the granting of new, additional privileges." "The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation[s] (OPPEs), [are] essential to confirm the quality of care delivered."<sup>56</sup>

According to TJC, the "FPPE for Cause" should be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care. The "FPPE for Cause" is limited to a particular timeframe and customized to the specific provider and related clinical concerns.<sup>57</sup> Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.<sup>58</sup>

To determine whether the facility complied with requirements for privileging, the OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members:

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<sup>54</sup> VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA Handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

<sup>55</sup> VHA Handbook 1100.19.

<sup>56</sup> VHA Handbook 1100.19.

<sup>57</sup> Office of Safety and Risk Awareness, Office of Quality and Performance, "Provider Competency and Clinical Care Concerns, Including: Focused Clinical Care Review and FPPE for Cause Guidance" July 2016 (Revision 2).

<sup>58</sup> VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. (This VHA Handbook was scheduled for recertification on or before the last working date of December 2014 and has not been recertified.)

- One solo/few practitioner<sup>59</sup> hired within 18 months before the site visit<sup>60</sup> or was privileged within the prior 12 months.<sup>61</sup>
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs re-privileged within 12 months before the visit
- No providers underwent a FPPE for cause within 12 months prior to the visit.<sup>62</sup>

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific<sup>63</sup>
  - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
  - Criteria defined in advance
  - Use of required criteria in FPPEs for selected specialty LIPs
  - Results and timeframes clearly documented
  - Evaluation by another provider with similar training and privileges
  - Medical Staff Executive Committee consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
  - Criteria specific to the service or section

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<sup>59</sup> This refers to circumstances where there are two or less practitioners in a particular specialty.

<sup>60</sup> The 18-month period was from May 5, 2017, through November 4, 2018.

<sup>61</sup> The 12-month review period was from November 4, 2017, through November 4, 2018; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers few practitioners as being less than three providers in the facility that are privileged in a particular specialty.

<sup>62</sup> The facility did not have providers who underwent a FPPE for cause.

<sup>63</sup> According to VHA Handbook 1100.19, facility-specific means that privileges are granted only for procedures and types of services performed at the facility; service-specific refers to privileges being granted in a specific clinical service, such as neurology; and provider-specific means that the privileges should be granted to the individual provider based on their clinical competence and capabilities.

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

### **Medical Staff Privileging Conclusion**

The OIG found general compliance with requirements for privileging and FPPEs. However, the OIG identified noncompliance with OPPEs that warranted a recommendation for improvement.

Specifically, VHA has defined specialty-specific elements to be used, where appropriate, for gastroenterology, pathology and laboratory medicine, nuclear medicine, and radiation oncology specialties. This OPPE process ensures a consistent approach to evaluating providers in these specialties and is essential to confirming the quality of care delivered.<sup>64</sup>

Of the 20 LIP profiles reviewed, six involved specialty providers (three pathology, two gastroenterology, and one nuclear medicine). For the two gastroenterologists, the OIG found no evidence of gastroenterology-specific criteria or data within the OPPE. As a result, providers delivered care without a thorough evaluation of their gastroenterology-specific practice. The chief of staff believed that the facility's OPPE process was sufficient and met requirements but acknowledged opportunities for improvement.

### **Recommendation 3**

3. The chief of staff makes certain that the Medicine Service Line chief includes required gastroenterology-specific criteria in ongoing professional practice evaluations of gastroenterology practitioners and monitors the Medicine Service Line chief's compliance.

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<sup>64</sup> VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*.

Facility concurred.

Target date for completion: November 30, 2019

Facility response: Required Gastroenterology-specific criteria for OPPE was updated. The Medicine Service Line Chief [MSL] will review the gastroenterology practitioner's patient care criteria per established VA guidelines monthly to assure compliance and document. Chief of Staff with the support of the Credential Coordinator will monitor the MSL Chief's compliance with assuring VA guidelines have been met for gastroenterology physicians. Credential Coordinator will audit GI OPPE files monthly to assure that the Medicine Service Line Chief has updated GI practitioner's OPPE with Gastroenterology-specific criteria data for six consecutive months with a 90% compliance for all GI practitioners. All audit results will be reported to Professional Standards Board with the % compliance for Chief MSL.

## Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional, but should also promote healing.<sup>65</sup>

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.<sup>66</sup>

VHA requires its facilities to have the “capacity for [providing] mental health services for Veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting;” however, for facilities that do not have inpatient mental health services, that “capacity” could mean facilitating care at a nearby VA or non-VA facility.<sup>67</sup>

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities’ efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.<sup>68</sup> Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,

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<sup>65</sup> VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.

<sup>66</sup> Applicable requirements for high-risk areas and emergency management include those detailed in or by various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

<sup>67</sup> VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA Handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

<sup>68</sup> VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

Occupational Safety and Health Administration,<sup>69</sup> and National Fire Protection Association standards.<sup>70</sup> The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.<sup>71</sup>

In all, the OIG team inspected six inpatient areas— surgical intensive care, 7th floor medical/surgical, 8th floor medical/surgical, acute rehabilitation, mental health, and the community living center—in addition to the post-anesthesia care unit, emergency department, outpatient women’s health clinic, and primary care clinic. The team also inspected the LaSalle VA Clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

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

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<sup>69</sup> The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA’s Mission is to assure safe and healthy working conditions “by setting and enforcing standards and by providing training, outreach, education, and assistance.” <https://www.osha.gov/about.html> (This website was accessed on June 28, 2018.)

<sup>70</sup> The National Fire Protection Association (NFPA) is a global nonprofit organization “devoted to eliminating death, injury, property, and economic loss due to fire, electrical, and related hazards.” <https://www.nfpa.org/About-NFPA> (This website was accessed on June 28, 2018.)

<sup>71</sup> TJC. Environment of Care standard EC.02.05.07.

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

## Environment of Care Conclusion

The facility's representative community based outpatient clinic, emergency management program, and locked inpatient mental health unit generally met the performance indicators evaluated. The OIG did not note any issues with the availability of medical equipment and supplies. However, two of nine areas inspected had dirty ventilation grills. The OIG identified general safety and infection prevention concerns that warranted recommendations for improvement.

TJC requires that, for fire safety, 18 inches or more of open space is maintained between fire sprinkler deflectors and the top of stored items.<sup>72</sup> The inspection team found items stored directly below the sprinkler deflectors in three of nine areas inspected.<sup>73</sup> Any obstruction may cause hazards and interrupt or prevent proper discharge of water. Facility managers were aware of the requirements but failed to ensure items are properly stored due to a lack of attention to detail.

## Recommendation 4

4. The associate director confirms storage rooms meet fire safety requirements by maintaining the required amount of open space between fire sprinkler deflectors and the top of stored items and monitors compliance.

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<sup>72</sup> TJC. Life Safety standard 02.01.35 EP6.

<sup>73</sup> Acute rehabilitation, 8th floor medical/surgical unit, and primary care clinic.

Facility concurred.

Target date for completion: May 30, 2019

Facility Response: The Occupational Safety office reviews and monitors EOC findings related to open space between fire sprinkler deflectors and top of stored items through weekly EOC rounds. EOC deficiencies are tracked through Performance Logic EOC Deficiencies software and reported monthly to Hospital Safety Committee Chaired by Associate Director and Co-Chaired by the Chief of Safety. Negative trends are identified through Performance Logic with corrective action documented by service. EOC audit results are reported monthly to the Hospital Safety Committee; a 90% compliance rate has been achieved for six consecutive months since the OIG survey. In addition, Services have been conducting monthly environment rounds utilizing an audit tool which incorporates open space between fire sprinkler deflectors and top of stored items. The compliance report is submitted to Quality and System Improvement. Negative trends identified will be discussed at Quality Board and actions addressed when applicable.

For infection prevention, TJC requires hospitals to minimize the possibility of transmitting infections by ensuring that dirty and used equipment are stored separately from clean equipment.<sup>74</sup> The OIG found dirty and clean equipment stored together in three of seven storage areas. This resulted in a lack of assurance of a clean and safe patient care environment that minimizes the spread of infection. The associate director was aware of storage requirements and attributed a shortage of storage areas throughout the facility as the reason for noncompliance.

## Recommendation 5

5. The associate director ensures that managers store clean and dirty medical equipment separately and monitors managers' compliance.

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<sup>74</sup> TJC. Environment of Care standard 02.02.01.

Facility concurred.

Target date for completion: May 30, 2019

Facility Response: The Occupational Safety office reviews and monitors EOC findings related to managers storing clean and dirty medical equipment separately through weekly EOC rounds. EOC deficiencies are tracked through Performance Logic EOC Deficiencies software and reported monthly to Hospital Safety Committee Chaired by Associate Director and Co-Chaired by Chief of Safety. Negative trends are identified through Performance Logic with corrective action documented by service. EOC audit results are reported monthly to the Hospital Safety Committee; a 90% compliance rate has been achieved for six consecutive months since the OIG survey. In addition, Services have been conducting monthly environment rounds utilizing an audit tool which incorporates storing clean and dirty medical equipment separately. The compliance report is submitted to Quality and System Improvement. Negative trends identified will be discussed at Quality Board and actions addressed when applicable.

## Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.<sup>75</sup> Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.<sup>76</sup>

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.<sup>77</sup>

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for two prior completed quarters;<sup>78</sup> and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
  - Monthly summary of findings to the director
  - Quarterly trend reports to the director
  - Quality Management Committee’s review of monthly and quarterly trend reports
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Staff restrictions for monthly review of balance adjustments<sup>79</sup>
- Requirements for controlled substances inspectors

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

<sup>76</sup> 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.

<sup>77</sup> VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

<sup>78</sup> The two quarters were from January 1, 2018, through June 30, 2018.

<sup>79</sup> Controlled substances balance adjustment reports list transactions in which the pharmacy vault inventory balance was manually adjusted.

- No conflicts of interest
- Appointed in writing by the director for a term not to exceed three years
- Hiatus of one year between any reappointment
- Completion of required annual competency assessment
- Controlled substances area inspections
  - Completion of monthly inspections
  - Rotations of controlled substances inspectors
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of controlled substances orders
  - Performance of routine controlled substances inspections
- Pharmacy inspections
  - Monthly physical counts of the controlled substances in the pharmacy
  - Completion of inspections on day initiated
  - Security and verification of drugs held for destruction<sup>80</sup>
  - Accountability for all prescription pads in pharmacy
  - Verification of hard copy controlled substances prescriptions
  - Verification of 72-hour inventories of the main vault
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports<sup>81</sup>

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<sup>80</sup> According to VHA Directive 1108.02(1), The Destructions File Holding Report “lists all drugs awaiting local destruction or turn-over to a reverse distributor.” Controlled substances inspectors “must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.”

<sup>81</sup> When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists’ review of medications ordered by the providers.

## **Medication Management Conclusion**

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

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

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

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.<sup>84</sup> Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.<sup>85</sup>

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

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

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<sup>82</sup>VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

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

<sup>84</sup> VHA Directive 1115.

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

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

<sup>87</sup>VHA Directive 1115.

<sup>88</sup> VHA Handbook 1160.01.

<sup>89</sup> VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.<sup>90</sup>

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 48 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

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

## **Mental Health Conclusion**

Generally, the OIG found compliance with many of the performance indicators, including the designation of an MST coordinator, tracking of MST-related data, referral for MST-related care, and the provision of clinical care. However, the OIG identified noncompliance with providers' completion of mandatory MST training requirement.

Specifically, VHA requires that all primary care and mental health providers complete the mandatory MST training requirement no later than 90 days after assuming their position.<sup>91</sup> The OIG found that five of seven providers hired after July 1, 2012, did not complete the required

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

<sup>91</sup> VHA Directive 1115.01.

training within 90 days. This could potentially prevent clinicians from providing appropriate counseling, care, and service to veterans who experienced MST. The MST coordinator cited competing priorities impacting compliance rates and misperception of applicability to non-compliant areas as the reasons for noncompliance.

## Recommendation 6

6. The facility director makes certain that providers complete military sexual trauma mandatory training within the required timeframe and monitors providers' compliance.

Facility concurred.

Target date for completion: May 30, 2019

Facility response: MST Coordinator addresses all new employees at initial orientation and directs completion of the required MST training for all new staff who will have patient contact.

Education generates a compliance report daily which includes a list of specific individuals who have not completed the training. The most recent (5/15/2019) report of 1,128 employees for whom the training is required, lists only 20 (1.8%) who are deficient or 1108/1128=98% compliance. None of these are employees who have started since the time of survey. The MST Coordinator continues to follow up with each individual and supervisor who remains deficient and assures that a 90% compliance rate is achieved for MST training. A 90% compliance rate has been achieved since the OIG survey.

## Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."<sup>92</sup> The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.<sup>93</sup>

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition, and 50 [percent] have two or more." Further, "most older adults see an improvement in their symptoms when treated with antidepressant drugs, psychotherapy, or a combination of both."<sup>94</sup>

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.<sup>95</sup> The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."<sup>96</sup> In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.<sup>97</sup> Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.<sup>98</sup> The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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<sup>92</sup> Hans Peterson, "Late Life Depression," *U.S. Department of Veterans Affairs, Mental Health Featured Article*, March 1, 2011. [https://www.mentalhealth.va.gov/featureArticle\\_Mar11LateLife.asp](https://www.mentalhealth.va.gov/featureArticle_Mar11LateLife.asp). (The website was accessed on March 8, 2019.)

<sup>93</sup> VA/DoD *Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. <https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf> (The website was accessed November 20, 2018.)

<sup>94</sup> Centers for Disease Control and Prevention, "Depression is Not a Normal Part of Growing Older," January 31, 2017. <https://www.cdc.gov/aging/mentalhealth/depression.htm>. (The website was accessed on March 8, 2019.)

<sup>95</sup> American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." [http://www.sigot.org/allegato\\_docs/1057\\_Beers-Criteria.pdf](http://www.sigot.org/allegato_docs/1057_Beers-Criteria.pdf) (The website was accessed on March 22, 2018.)

<sup>96</sup> TJC. Provision of Care, Treatment, and Services standard PC 02.03.01.

<sup>97</sup> VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

<sup>98</sup> TJC. National Patient Safety Goal standard NPSG.03.06.01.

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.<sup>99</sup>

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 35 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.<sup>100</sup> The OIG evaluated the following performance indicators:

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

## Geriatric Care Conclusion

The OIG found compliance with providers justifying medication initiation. The OIG identified concerns with the patient/caregiver education, evaluation of patient/caregiver understanding when education was provided, and medication reconciliation processes that warranted recommendations for improvement.

TJC requires that clinicians educate patients and families about potential significant concerns, interactions, and side effects of new medication prior to administration,<sup>101</sup> and evaluate patient/caregiver understanding of the education provided.<sup>102</sup> The OIG estimated that clinicians provided education to 66 percent of the patients at the facility, based on electronic health records reviewed.<sup>103</sup> Of the records that contained evidence of education, the OIG estimated that clinicians assessed understanding of education for 65 percent of the patients at the facility, based on records reviewed.<sup>104</sup> Providing medication education and ensuring it is

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<sup>99</sup> VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

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

<sup>101</sup> TJC. Medication Management standard MM 06.01.01 and 06.01.03.

<sup>102</sup> TJC. Provision of Care, Treatment, and Services PC standard 02.03.01.

<sup>103</sup> The OIG is 95 percent confident that the true compliance rate is somewhere between 49.9 and 81.2 percent, which is statistically significantly below the 90 percent benchmark.

<sup>104</sup> The OIG is 95 percent confident that the true compliance rate is somewhere between 44.9 and 84.6 percent, which is statistically significantly below the 90 percent benchmark.

understood is critical to ensuring that patients or their caregivers have the information they need to manage their own health at home.<sup>105</sup> Clinical managers stated they were aware of the requirements, but competing priorities and limited patient care time led to inconsistency in providing patient education.

## Recommendation 7

7. The chief of staff confirms that clinicians provide and document patient/caregiver education and assess understanding of education provided about newly prescribed medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: The Associate Chief of Staff (ACOS) for Geriatrics and Extended Care (GEC) will revise the current CPRS template to include: (1) certification the provider educated the patient and/or caregiver, and (2) an evaluation indicating the patient and/or caregiver understood the education. Audit results conducted by the GEC Performance Improvement Facilitator will be reported at the monthly GEC Performance Sub-Improvement Committee of the Quality Board until 90% compliance is demonstrated for six consecutive months.

According to TJC, "In medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies."<sup>106</sup> VHA requires that clinicians review and reconcile medications relevant to the episode of care.<sup>107</sup> The OIG estimated that providers performed medication reconciliation for 66 percent of the patients at the facility, based on electronic health records reviewed.<sup>108</sup> Failure to reconcile medications increases the risk that there may be duplications, omissions, and interactions in the patient's actual drug regimen. Clinical managers were aware of the requirements and believed that medication reconciliation was a common practice, which led to inconsistent or lack of documentation.

## Recommendation 8

8. The chief of staff makes certain clinicians review and reconcile medications and monitors clinicians' compliance.

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<sup>105</sup> TJC Introduction to standard PC.02.03.01.

<sup>106</sup> TJC. Medication Management standard MM06.01.01.

<sup>107</sup> VHA Directive 1164.

<sup>108</sup> The OIG is 95 percent confident that the true compliance rate is somewhere between 49.9 and 81.1 percent, which is statistically significantly below the 90 percent benchmark.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: The Associate Chief of Staff (ACOS) for Geriatrics and Extended Care (GEC) will initiate a weekly audit of admissions to the Community Living Center (CLC) to determine if medications are being reconciled and documented per policy. Audit results will be provided weekly to the ACOS for information and action. Audit results conducted by the GEC Performance Improvement Facilitator will be reported monthly at the GEC MD/NP meeting until 90% compliance is achieved for six consecutive months.

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

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.<sup>109</sup> Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.<sup>110</sup> In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.<sup>111</sup> Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.<sup>112</sup>

VA is authorized to provide “gender-specific services, such as Papanicolaou tests (Pap smears),” to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.<sup>113</sup>

VHA requires that each facility have a “full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women’s health care.” VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women’s health program. Each facility must also have a “Women Veterans Health Committee (WVHC), comprised of appropriate facility leadership and program directors, which develops and implements a Women’s Health Program strategic plan.” The Women Veterans Health Committee must meet at least quarterly and report to the executive leadership. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.<sup>114</sup>

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

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<sup>109</sup> Centers for Disease Control and Prevention. “Cervical Cancer” *Inside Knowledge* fact sheet, December 2016. [https://www.cdc.gov/cancer/cervical/pdf/cervical\\_facts.pdf](https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf). (The website was accessed on February 28, 2018.)

<sup>110</sup> Center for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. [https://www.cdc.gov/cancer/cervical/basic\\_info/index.htm](https://www.cdc.gov/cancer/cervical/basic_info/index.htm). (The website was accessed on March 8, 2019.)

<sup>111</sup> Centers for Disease Control and Prevention. *What Are the Risk Factors for Cervical Cancer?* February 13, 2017. [https://www.cdc.gov/cancer/cervical/basic\\_info/risk\\_factors.htm](https://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm). (The website was accessed on March 8, 2019.)

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

<sup>113</sup> VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended July 24, 2018).

<sup>114</sup> VHA Directive 1330.01(2).

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.<sup>115</sup>

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of 19 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Appointment of a women veterans program manager
- Appointment of a women’s health medical director or clinical champion
- Facility Women Veterans Health Committee
  - Core membership
  - Quarterly meetings
  - Reports to clinical executive leadership
- Collection and tracking of cervical cancer screening data
  - Notification of patients due for screening
  - Completed screenings
  - Results reporting
  - Follow-up care
- Communication of abnormal results to patients within required timeframe
- Provision of follow-up care for abnormal cervical pathology results, if indicated

## **Women’s Health Conclusion**

Generally, the OIG found compliance with many of the performance indicators, including requirements for a designated women veterans program manager, clinical oversight of the women’s health program by a women’s health medical director or clinical champion, communication of abnormal results to the patient, and follow-up care when indicated. The OIG identified noncompliance with the Women Veterans Health Committee membership and data tracking related to cervical cancer screenings that warranted recommendations for improvement.

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

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<sup>115</sup> VHA Directive 1330.01(2).

“representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, emergency department, radiology, laboratory, quality management, business office/non-VA medical care; and a member from executive leadership.”<sup>116</sup>

From October 2017 through July 2018, the committee did not include representation from laboratory, quality management, business office/non-VA medical care, and a member from executive leadership. Additionally, other designated committee members did not consistently attend meetings. This resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality care for women veterans. Program managers were aware of the requirement and cited a lack of oversight due to the appointment of multiple interim women veterans program managers.

## Recommendation 9

9. The facility director confirms that the Women Veterans Health Committee includes required core members, designated members consistently attend meetings, and monitors the committee’s compliance.

Facility concurred.

Target date for completion: November 29, 2019

Facility response: Women Veterans Health Committee Charter has been updated as of December 2018 to include all required members per directive. Designees have been established due to mandated positions with recent vacancies. The Chair of Women Veterans Health Committee monitors attendance 90% compliance is achieved for six consecutive months for all representatives. Negative attendance trends are reported by the Chair of Women Veterans Health Committee to the MEB for action and follow through monthly.

VHA requires that each facility has a process to track data, “including notification of patients who are due for screening, tracking of completion of screening, results reporting, and follow-up care” related to cervical cancer screenings.<sup>117</sup> The OIG found that the facility did not have a systematic process for tracking results notification and follow-up care data. One Women Veterans Health Committee member acknowledged informally tracking follow-up care; however, the results were not collated, analyzed, or reported in a manner consistent with quality improvement activities. Lack of a systematic process for tracking results notification and follow-up care may cause delays in addressing abnormal cervical screening results and implementing appropriate action plans. Program managers were not aware of the requirements, believed they were in compliance by collecting performance measure data related to completed screenings, and

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<sup>116</sup> VHA Directive 1330.01(2).

<sup>117</sup> VHA Directive 1330.01(2).

cited frequent turnover in the women veterans program manager position as reasons for noncompliance.

### **Recommendation 10**

10. The chief of staff ensures that program managers implement a process for tracking results notification and follow-up care data for abnormal cervical cancer screenings and monitors program managers' compliance.

Facility concurred.

Target date for completion: November 29, 2019

Facility response: All abnormal cervical cancer screen results are tracked by the Women's Health Committee (WHC) Chair. Patients are notified by the ordering physician in person, by phone, or letter within 7 days as per VA guidelines and documented in CPRS. Compliance will be reported monthly to the Medical Executive Board chaired by the Chief of Staff. Results notification and follow up care data for abnormal cervical cancer screenings will be monitored until achieving six consecutive months with a 90% compliance.

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

VHA defines an emergency department as a “unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations.” An urgent care center (UCC) “provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries.”<sup>118</sup> A variety of emergency services may exist, dependent on “capability, capacity, and function of the local VA medical facility;” however, emergency care must be uniformly available in all VHA emergency departments and UCCs.<sup>119</sup>

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide “unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week.” VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that “evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care.”<sup>120</sup>

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can “undermine the timeliness of care and, ultimately, patient safety.” Effective management processes that “support patient flow [in the ED or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care.”<sup>121</sup>

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement (EMI) initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software (EDIS) tracking program to document and manage the flow of patients.<sup>122</sup>

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<sup>118</sup> VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016 (amended March 7, 2017).

<sup>119</sup> VHA Directive 1101.05(2).

<sup>120</sup> VHA Directive 1101.05(2).

<sup>121</sup> TJC. Leadership standard LD.04.03.11.

<sup>122</sup> VHA Directive 1101.05(2); The Emergency Medicine Management Tool (EMMT) uses data collected from EDIS to generate productivity metrics. The use of EDIS and EMMT are key tools in accomplishing EMI initiative goals.

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

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

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

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<sup>123</sup> TJC. Medication Management standard MM.03.01.01.

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

<sup>125</sup> VHA Directive 1101.05(2).

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

### **High-Risk Processes Conclusion**

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

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<sup>126</sup> The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated.

## Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	<ul style="list-style-type: none"> <li>• Executive leadership position stability and engagement</li> <li>• Employee satisfaction</li> <li>• Patient experience</li> <li>• Accreditation and/or for-cause surveys and oversight inspections</li> <li>• Factors related to possible lapses in care</li> <li>• VHA performance data</li> </ul>	Ten OIG recommendations, ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events, are attributable to the director, chief of staff, and associate director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> <li>• Protected peer reviews</li> <li>• UM reviews</li> <li>• Patient safety</li> <li>• Resuscitation episode review</li> </ul>	<ul style="list-style-type: none"> <li>• The Acute and Critical Care Committee conducts a complete analysis of resuscitation episodes by reviewing required elements.</li> </ul>	<ul style="list-style-type: none"> <li>• The interdisciplinary group or committee that reviews UM data includes a representative from the chief Business Office revenue-utilization review.</li> </ul>
Medical Staff Privileging	<ul style="list-style-type: none"> <li>• Privileging</li> <li>• FPPEs</li> <li>• OPPEs</li> <li>• FPPEs for cause</li> <li>• Reporting of privileging actions to National Practitioner Data Bank</li> </ul>	<ul style="list-style-type: none"> <li>• The OPPEs of gastroenterology practitioners include required gastroenterology-specific criteria.</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	<ul style="list-style-type: none"> <li>• Parent facility               <ul style="list-style-type: none"> <li>○ General safety</li> <li>○ Environmental cleanliness and infection prevention</li> <li>○ General privacy</li> <li>○ Women veterans program</li> <li>○ Availability of medical equipment and supplies</li> </ul> </li> <li>• Community based outpatient clinic               <ul style="list-style-type: none"> <li>○ General safety</li> <li>○ Environmental cleanliness and infection prevention</li> <li>○ General privacy</li> <li>○ Women veterans program</li> <li>○ Availability of medical equipment and supplies</li> </ul> </li> <li>• Locked inpatient mental health unit               <ul style="list-style-type: none"> <li>○ Mental health environment of care rounds</li> <li>○ Nursing station security</li> <li>○ Public area and general unit safety</li> <li>○ Patient room safety</li> <li>○ Infection prevention</li> <li>○ Availability of medical equipment and supplies</li> </ul> </li> <li>• Emergency management               <ul style="list-style-type: none"> <li>○ Hazard vulnerability analysis (HVA)</li> <li>○ Emergency operations plan (EOP)</li> <li>○ Emergency power testing and availability</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Storage areas meet fire safety requirements.</li> <li>• Clean and dirty medical equipment are stored separately.</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	<ul style="list-style-type: none"> <li>• Controlled substances coordinator reports</li> <li>• Pharmacy operations</li> <li>• Controlled substances inspector requirements</li> <li>• Controlled substances area inspections</li> <li>• Pharmacy inspections</li> <li>• Facility review of override reports</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	<ul style="list-style-type: none"> <li>• Designated facility MST coordinator</li> <li>• Evidence of tracking MST-related data</li> <li>• Provision of clinical care</li> <li>• Completion of MST mandatory training requirement for mental health and primary care providers</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• Providers complete MST mandatory training within the required timeframe.</li> </ul>
Geriatric Care: Antidepressant Use among the Elderly	<ul style="list-style-type: none"> <li>• Justification for medication initiation</li> <li>• Evidence of patient and/or caregiver education specific to the medication prescribed</li> <li>• Clinician evaluation of patient and/or caregiver understanding of the education provided</li> <li>• Medication reconciliation</li> </ul>	<ul style="list-style-type: none"> <li>• Clinicians review and reconcile patients' medications.</li> </ul>	<ul style="list-style-type: none"> <li>• Clinicians provide and document patient/caregiver education and assess understanding of education provided about newly prescribed medications.</li> </ul>
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	<ul style="list-style-type: none"> <li>• Appointment of a women veterans program manager</li> <li>• Appointment of a women's health medical director or clinical champion</li> <li>• Facility Women Veterans Health Committee</li> <li>• Collection and tracking of cervical cancer screening data</li> <li>• Communication of abnormal results to</li> </ul>	<ul style="list-style-type: none"> <li>• None.</li> </ul>	<ul style="list-style-type: none"> <li>• The Women Veterans Health Committee includes core members, and designated members consistently attend meetings.</li> <li>• Program managers track results notification and follow-up care data for abnormal cervical cancer screenings.</li> </ul>

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	<p>patients within required timeframe</p> <ul style="list-style-type: none"> <li>• Provision of follow-up care for abnormal cervical pathology results, if indicated</li> </ul>		
<p>High-Risk Processes: Operations and Management of Emergency Departments and UCCs</p>	<ul style="list-style-type: none"> <li>• General</li> <li>• Staffing for emergency department/UCC</li> <li>• Support services for emergency department/UCC</li> <li>• Patient flow</li> <li>• General safety</li> <li>• Medication security and labeling</li> <li>• Management of patients with mental health disorders</li> <li>• Emergency department participation in local/regional EMS system</li> <li>• Women veteran services</li> <li>• Life support equipment</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

## Appendix B: Facility Profile and VA Outpatient Clinic Profiles

### Facility Profile

The table below provides general background information for this high complexity (1a) affiliated<sup>127</sup> facility reporting to VISN 12.<sup>128</sup>

**Table B.1. Facility Profile for Edward Hines, Jr. VA Hospital (578)  
(October 1, 2015, through September 30, 2018)**

Profile Element	Facility Data FY 2016 <sup>129</sup>	Facility Data FY 2017 <sup>130</sup>	Facility Data FY 2018 <sup>131</sup>
Total medical care budget dollars	\$702,725,121	\$684,997,411	\$712,853,467
Number of:			
• Unique patients	58,911	58,288	58,208
• Outpatient visits	855,725	867,445	875,165
• Unique employees <sup>132</sup>	3,137	3,215	3,369
Type and number of operating beds:			
• Blind rehabilitation	34	34	34
• Community living center	210	210	210
• Domiciliary	25	25	25
• Medicine	66	66	66
• Mental health	29	29	29
• Rehabilitation medicine	10	10	10
• Spinal cord injury	68	68	68
• Surgery	41	41	41
Average daily census:			
• Blind rehabilitation	27	28	27
• Community living center	124	132	121

<sup>127</sup> Associated with a medical residency program.

<sup>128</sup> The VHA medical centers are classified according to a facility complexity model; 1a designation indicates a facility with high volume, high risk patients, most complex clinical programs, and large research and teaching programs.

<sup>129</sup> October 1, 2015, through September 30, 2016.

<sup>130</sup> October 1, 2016, through September 30, 2017.

<sup>131</sup> October 1, 2017, through September 30, 2018.

<sup>132</sup> Unique employees involved in direct medical care (cost center 8200).

<b>Profile Element</b>	<b>Facility Data FY 2016<sup>129</sup></b>	<b>Facility Data FY 2017<sup>130</sup></b>	<b>Facility Data FY 2018<sup>131</sup></b>
• Domiciliary	18	20	17
• Medicine	69	74	69
• Mental health	17	18	15
• Neurology	2	2	2
• Rehabilitation medicine	6	5	5
• Spinal cord injury	34	42	34
• Surgery	20	19	20

*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<sup>133</sup>

The VA outpatient clinics in communities within the catchment area of the facility provide primary care integrated with women’s health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table B.2. provides information relative to each of the clinics.

**Table B.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)<sup>134</sup>**

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services <sup>135</sup> Provided	Diagnostic Services <sup>136</sup> Provided	Ancillary Services <sup>137</sup> Provided
Aurora-Illinois, IL	578GD	8,767	3,840	Dermatology Endocrinology	n/a	Nutrition Pharmacy Weight management
Hoffman Estates, IL	578GE	7,266	3,391	Dermatology Endocrinology	n/a	Nutrition Pharmacy Weight management

<sup>133</sup> Includes all outpatient clinics in the community that were in operation as of August 15, 2018.

<sup>134</sup> The definition of an “encounter” can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015, and has not been updated.) An encounter is a “professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating and treating the patient’s condition.”

<sup>135</sup> Specialty care services refer to non-primary care and non-mental health services provided by a physician.

<sup>136</sup> Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

<sup>137</sup> Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

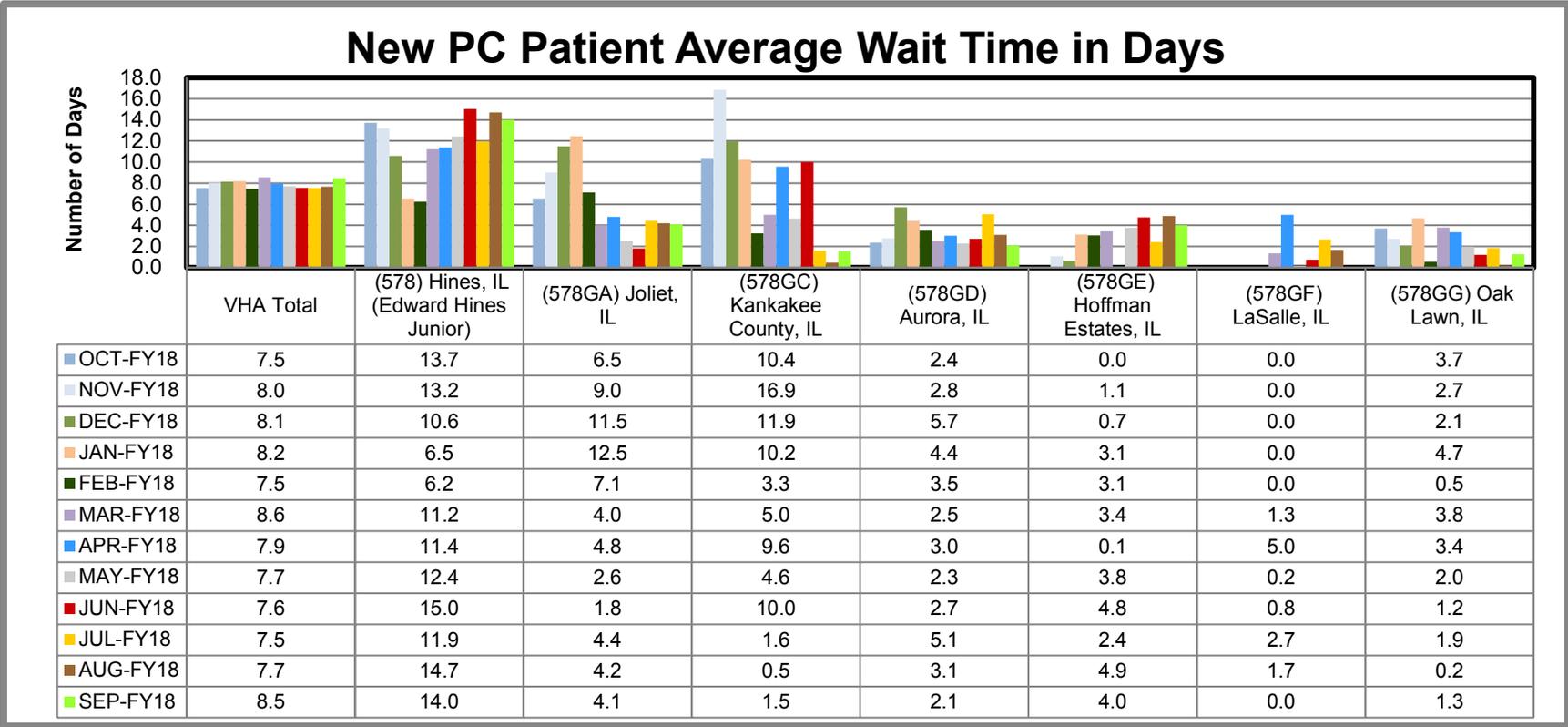
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services <sup>135</sup> Provided	Diagnostic Services <sup>136</sup> Provided	Ancillary Services <sup>137</sup> Provided
Joliet, IL	578GA	14,476	6,875	Dermatology Neurology Poly-trauma Rehab physician Eye Podiatry	n/a	Nutrition Pharmacy Weight management
Kankakee County, IL	578GC	6,314	2,350	Dermatology Endocrinology Poly-trauma	n/a	Nutrition Pharmacy Weight management
LaSalle-Peru, IL	578GF	6,162	4,178	Dermatology Endocrinology Poly-trauma Eye	n/a	Nutrition Pharmacy Social work Weight management
Oak Lawn, IL	578GG	12,392	3,903	Dermatology Endocrinology	n/a	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<sup>138</sup>



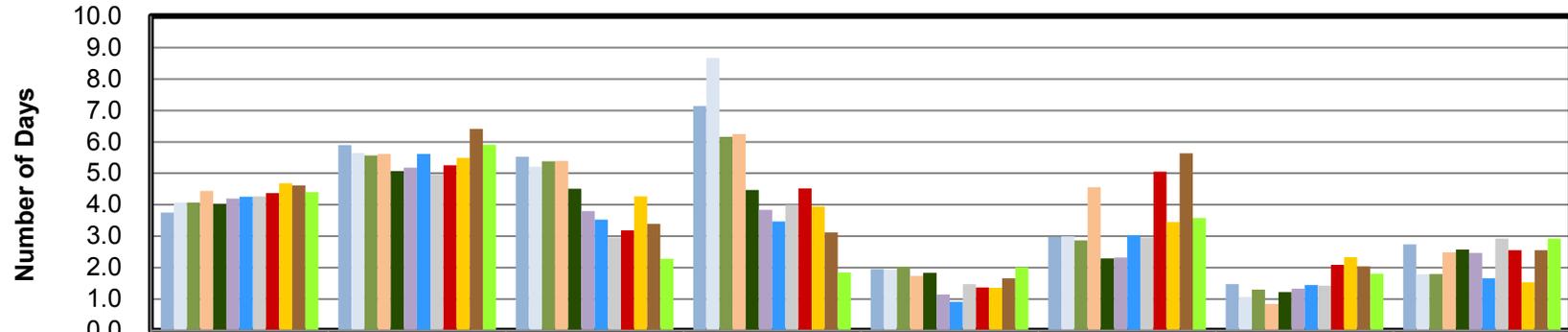
Source: VHA Support Service Center

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

Data Definition: “The average number of calendar days between a New Patient’s Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of 3 possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. Note that prior to FY15, this metric was calculated using the earliest possible create date.”

<sup>138</sup> Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 13, 2018.

### Established PC Patient Average Wait Time in Days



	VHA Total	(578) Hines, IL (Edward Hines Junior)	(578GA) Joliet, IL	(578GC) Kankakee County, IL	(578GD) Aurora, IL	(578GE) Hoffman Estates, IL	(578GF) LaSalle, IL	(578GG) Oak Lawn, IL
OCT-FY18	3.7	5.9	5.5	7.1	2.0	3.0	1.5	2.7
NOV-FY18	4.1	5.6	5.2	8.7	1.9	3.0	1.1	1.8
DEC-FY18	4.1	5.6	5.4	6.2	2.0	2.9	1.3	1.8
JAN-FY18	4.4	5.6	5.4	6.2	1.7	4.6	0.8	2.5
FEB-FY18	4.0	5.1	4.5	4.5	1.8	2.3	1.2	2.6
MAR-FY18	4.2	5.2	3.8	3.8	1.1	2.3	1.3	2.5
APR-FY18	4.3	5.6	3.5	3.5	0.9	3.0	1.4	1.7
MAY-FY18	4.3	5.0	3.0	4.0	1.5	3.0	1.4	2.9
JUN-FY18	4.4	5.3	3.2	4.5	1.4	5.1	2.1	2.6
JUL-FY18	4.7	5.5	4.3	3.9	1.4	3.4	2.3	1.5
AUG-FY18	4.6	6.4	3.4	3.1	1.7	5.6	2.0	2.6
SEP-FY18	4.4	5.9	2.3	1.8	2.0	3.6	1.8	2.9

Source: VHA Support Service Center

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

Data Definition: “The average number of calendar days between an Established Patient’s Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of 3 possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.”

## Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions<sup>139</sup>

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
APP capacity	Advanced practice provider capacity	A lower value is better than a higher value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Care transition	Care transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont stay reviews met	% Acute continued stay reviews that meet interqual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/capacity	Efficiency and physician capacity	A higher value is better than a lower value
Employee satisfaction	Overall satisfaction with job	A higher value is better than a lower value

<sup>139</sup> VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). <http://vawww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

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

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

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

Source: VHA Support Service Center

## Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions<sup>140</sup>

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

<sup>140</sup> *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>. (The website was accessed on March 6, 2019, but is not accessible by the public.)

## Appendix F: VISN Director Comments

### Department of Veterans Affairs Memorandum

Date: May 24, 2019

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

Subj: Comprehensive Healthcare Inspection of the Edward Hines, Jr, VA Hospital,  
Hines, IL

To: Director, Los Angeles Office of Healthcare Inspections (54CH01)  
Director, GAO/OIG Accountability Liaison (VHA 10EG GOAL Action)

1. I have reviewed the draft Comprehensive Healthcare Inspection of the Edward Hines, Jr VA Hospital, Hines, IL. I concur with the recommendations made by the inspection team.
2. Hines concurs with all recommendations. Evidence of the corrective action plan with quality improvements to address the recommendations are provided for review.
3. I would like to thank the OIG inspections team for comprehensive review at the Edward Hines, Jr. VA Hospital, Hines, IL.

*(Original signed by:)*

Victoria P. Brahm, MSN, RN, VHA-CM  
Acting 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 G: Facility Director Comments

### Department of Veterans Affairs Memorandum

Date: May 21, 2019

From: Director, Edward Hines, Jr. VA Hospital (578/00)

Subj: Comprehensive Healthcare Inspection of the Edward Hines, Jr. VA Hospital,  
Hines, IL

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

1. Thank you for conducting a comprehensive review at the Edward Hines, Jr. VA Hospital, Hines, IL.
2. Hines concurs with all recommendations. Please see attached action plans for the recommendations identified from the recent review.
3. Significant improvements were made in the Hines' Community Living Center (CLC) Compare star-rating system scores since the OIG's onsite visit in November 2018. As of FY2019Q2, Hines CLC has achieved a 4-star rating in Quality and a 4-star rating Overall improving from respective 1-star and 2-star ratings. These improvements are significant and relevant to the report.
4. I have reviewed the document and concur with the response as submitted.

*(Original signed by:)*

Steven E. Braverman, M.D.  
Director, Edward Hines Jr. VA

*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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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Director, VISN 12: VA Great Lakes Health Care System  
Director, Edward Hines, Jr. VA Hospital (578/00)

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