DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the North Texas VA Healthcare System

Dallas, Texas

HEALTHCARE INSPECTION | REPORT 19-06378-73 | JANUARY 23, 2020

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate concerns related to alleged deficiencies in the (a) Women Veterans Health Program, (b) Quality, Safety and Value (quality management) to include patient safety and clinical events leading to resuscitation attempts (codes), and (c) leaders' responses to recommendations from oversight bodies at the VA North Texas Health Care System (facility) in Dallas, Texas.[1] The OIG team determined the facility responded appropriately to oversight review recommendations; therefore, no further information regarding this concern will be presented in this report.

The Veterans Health Administration (VHA) Women Veterans Health Program policy identifies requirements related to comprehensive primary care for all women veterans, including gender-specific care, which involves basic gynecological care as well as breast and cervical cancer screenings. VHA's current goal is that 85 percent of women veterans be assigned to a designated women's health primary care provider.[2] The OIG determined that there was an insufficient number of designated women's health primary care providers assigned and trained to provide gender-specific comprehensive primary care for women veterans at the facility.[3] Besides a shortage of women's health primary care providers in the geographic area, recruiting was difficult. Additionally, staff reported to the OIG that women's health primary care providers' patient panel sizes had not been reduced as required by VHA and the amount of time allotted for appointments was not sufficient for unique gender-specific care needs.[4]

The OIG determined that the facility had a long-standing deficiency related to resources for women veterans healthcare, such as equipment, supplies and space that were required to ensure gender-specific care. One of the roles of the Women Veterans Program Manager is to ensure that construction and renovation projects comply with VHA policy to meet the privacy and dignity needs of women veterans. The OIG found that the Women Veterans Program Manager was not fully engaged with this process until February 2019 and did not routinely participate in weekly environment of care rounds as required by VHA policy. The OIG concluded that the lack of engagement contributed to a failure to identify resources needed for the provision of women

[1] The oversight bodies that had issued recommendations included The Joint Commission, Veterans Health Administration, and the Veteran Integrated Service Network 17.

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

[3] The facility had 11 designated women's health primary care providers in January 2017, the number increased to 34 by February 2019. Fourteen providers were sent to a women veterans health mini-residency training program. As of April 2019, 10 of the 14 providers were fully trained; the remaining four required additional training.

[4] VHA Directive 1330.01(2). Patient panel sizes must be reduced by 20 percent of the proportion of the panel that is female to reflect the unique needs of women veterans.

veterans healthcare including the renovation of existing space to ensure women veteran restroom access.

The facility had an extended gynecologist vacancy from February 2017 through December 2018. There was an advanced practice registered nurse who provided care within her scope of practice, and many women patients' consults were referred to Community Care. After hiring a gynecologist, the advanced practice registered nurse and the gynecologist shared a licensed vocational nurse from another clinical area to serve as the required chaperone during examinations. This impeded the ability for both providers to conduct examinations simultaneously. Staff reported that the advanced practice registered nurse also performed ancillary administrative duties that further reduced availability for women veteran appointments.

The OIG found that while Community Care provided a vital women veterans health resource during staff vacancies, the facility did not have a standard operating procedure that outlined the process for tracking and reporting Community Care results back to the requesting VHA provider. Community Care staff reported various timeframes for receiving medical records and identified that VHA policy allowed for administrative closure of consults to be completed if medical records have not been obtained after three separate attempts to obtain the records.[5] Facility staff stated, but were unable to confirm, due to the extensive manpower required, that consults were appropriately closed either through the administrative closure process or at the conclusion of care with receipt of the required documentation The OIG reviewed the electronic health records of 31 women veterans with abnormal gynecological test results between July 1 and December 31, 2018. The review identified that medical records were not received for seven of the 11 veterans referred through Community Care.

The OIG determined that prolonged vacancies within quality management and patient safety contributed to deficient performance measurement and evaluation processes that are intended to inform leaders of emerging or evolving quality of care or patient safety concerns. They also contributed to a lack of leaders' awareness for adverse events requiring potential institutional disclosure, which is required by VHA policy when patients experience harmful or potentially adverse events. The facility did not consistently comply with VHA required timelines to complete root cause analyses and did not conduct the required aggregate reviews for patient falls and missing patients.[6] The OIG attributed these deficiencies to the prolonged vacancies and inexperienced staff. The deficiencies resulted in delayed actions to complete corrective actions to prevent similar future adverse events.

[5] VHA Memorandum from the Deputy Under Secretary for Health for Operations and Management, *Clarification of Administrative Closure of Community Care Consults*, March 6, 2018.

[6] VHA Handbook 1050.01, *National Patient Safety Improvement Handbook*, March 4, 2011. A root cause analysis is a specific type of review that is used to identify factors that contribute to adverse events.

The OIG found that facility clinical staff lacked training and an understanding of nationally identified guidelines for conducting patients' goals of care conversations regarding life-sustaining treatments. Patients' wishes related to resuscitation attempts during a code were not consistently captured in the electronic health record. The OIG determined that due to a lack of a consistent and thorough process, the resuscitation committee did not capture and review all codes, nor did the committee take corrective actions to identify the causes surrounding these events, as required by VHA policy.

The OIG made 18 recommendations related to women veterans' health to include staffing for gender-specific care provided by designated women veterans health providers, comprehensive women veterans healthcare exam extended appointment times, comprehensive healthcare resources for women, Women Veterans Program Manager routine attendance in environment of care rounds, support staff to provide gynecology services, and tracking to ensure referring VHA providers receive results of patient care received within the community. Recommendations related to quality management processes addressed leadership, performance and evaluation, institutional disclosure, timeliness of root cause analyses, completion of required aggregated reviews, staff training, provider documentation regarding goals of care conversations and life-sustaining treatment plans, code event data capture and reporting, committee reporting and documentation of corrective actions and follow-up.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations. (See appendixes A–B for the Directors' comments.) The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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Contents

Abbreviations

APRN	advanced practice registered nurse
DNR	do not resuscitate
EHR	electronic health record
HFMEA	healthcare failure modes and effects analysis
OIG	Office of Inspector General
RCA	root cause analysis
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WH-PCP	women's health primary care provider
WVPM	Women Veterans Program Manager

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate concerns related to alleged deficiencies in (a) the Women Veterans Health Program, (b) Quality, Safety and Value (quality management) to include patient safety and clinical events leading to resuscitation attempts (codes), and (c) leaders' responses to recommendations from oversight bodies at the VA North Texas Health Care System (facility) in Dallas, Texas.[7]

Facility Background

The facility, along with ten associated community outpatient clinics, is part of Veterans Integrated Service Network (VISN) 17 and served 130,292 veterans between October 1, 2017, and September 30, 2018. The facility operated 794 beds, including 268 inpatient beds, 272 domiciliary beds, 235 community living beds, and 19 compensated work therapy transitional resident beds. The facility is designated as a Complexity Model Level 1a and provides primary care, medical, surgical, mental health, and rehabilitation services.[8] The facility includes specialty services for women veterans including mammography and gynecology services.[9]

Prior OIG Reports

A search of prior facility healthcare inspections from the last three years identified one facility OIG report with similar issues. The OIG published the facility's Comprehensive Healthcare Inspection Program report on March 29, 2018. The OIG made one recommendation for improving provider monitoring and communication of mammography results, which has been closed.

Concerns

In October 2018, OIG staff received multiple, non-specific allegations that involved women veterans and quality management issues as well as leaders' responses to oversight reviews. As the allegations did not identify instances of deficiencies involving specific patients, the OIG

[7] The oversight bodies that had issued recommendations included The Joint Commission, Veterans Health Administration, and the Veteran Integrated Service Network 17.

[8] The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex.

[9] Gynecology is a specialized type of medicine that manages routine care and diseases of the female reproductive system. https://www.merriam-webster.com/dictionary/gynecology?src=search-dict-box. (The website was accessed on July 30, 2019).

reviewed certain aspects of the Women Veterans Health Program and the Quality Management Program and identified some areas of concern:

- Women Veterans Health Program including coordinating and tracking care, and communicating results for cervical and breast cancer screening at the facility and for care received in the community; assigning, staffing, and managing women veterans health patient aligned care teams; and access to women veterans healthcare
- Quality management processes including leadership vacancies; performance measurement and evaluation; institutional disclosure; patient safety, root cause analysis (RCA) and healthcare failure modes and effects analysis (HFMEA); life-sustaining treatment and codes including do not attempt resuscitation/do not resuscitate (DNR) processes, and code committee responsibilities [10]

The OIG team determined the facility responded appropriately to The Joint Commission, Veterans Health Administration (VHA), and VISN Women Veterans Health Program oversight review recommendations. The facility's response to oversight reviews is therefore not addressed in this report.

Scope and Methodology

The OIG team initiated the inspection in January 2019 and conducted three site visits on February 11–14, March 4–7, and May 13–15, 2019. The OIG team interviewed staff knowledgeable about the concerns under review including facility leaders, quality management staff, and patient safety staff. The OIG team reviewed VHA and facility policies and procedures, quality management documents, electronic health records (EHRs), pertinent meeting minutes, and other relevant documents. The scope of the inspection was expanded during the initial site visit to include quality management after the OIG identified additional potential concerns related to leadership vacancies, performance measurement and evaluation, patient safety, and committee activities.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

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

[10] VHA Handbook 1050.01. "An RCA is a specific type of focused review that is used for all adverse events or close calls."

Inspection Results

1. Deficiencies in the Women Veterans Health Program

During its review of the Women Veterans Health Program, the OIG identified concerns related to comprehensive women veterans health primary care, women veterans healthcare resources, the Women Veterans Program Manager (WVPM), gynecological care staffing, and gynecological care in the community referral processes. The facility has the fourth largest women veteran population in the nation.

In 2008, VHA published a report discussing deficiencies in women veterans health primary care, including fragmentation of care provided to women veterans.[11] VHA published policy in 2010 defining comprehensive care, which included the provision of gender-specific care.[12] In June 2017, the OIG published a report recommending that VHA routinely reviews and when appropriate, strengthens requirements for women veterans health providers.[13] In July 2018, VHA expanded the 2010 policy to help in ensuring all eligible and enrolled women veterans have access to medical services regardless of where they obtain VHA services.[14]

Comprehensive Women Veterans Health Primary Care

The facility provided primary care services to women but the OIG found that it did not consistently provide gender-specific care by a women's health primary care provider (WH-PCP). In addition, the OIG found WH-PCP staffing deficits and patient panel sizes that were not reduced as required by policy.[15]

VHA policy requires that gender-specific primary care be provided at all sites where care is received by a designated WH-PCP. In addition to gender-specific primary care, the WH-PCP

[11] United States Department of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group, Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans, November 2008.

[12] VHA Handbook 1330.01, *Health Care Services for Women Veterans,* May 21, 2010, was rescinded and replaced by VHA Directive 1330.01(2), *Health Services for Women Veterans*, February 15, 2017, amended July 24, 2018, with clarification on who can serve as the Women's Health Medical Director or Women's Health Champion; added planning, design, and construction standards; revised language for door locking security, restroom/toilet room privacy, and curtain/screen privacy; and added mandatory availability of diaper changing tables.

[13] Department of Veterans Affairs, Office of Inspector General, *Review of VHA Care and Privacy Standards for Women Veterans*, Report Number 15-03303-206, June 29, 2017. https://www.va.gov/oig/pubs/VAOIG-15-03303-206.pdf.

[14] VHA Directive 1330.01(2).

[15] VHA Directive 1330.01(2).

also provides comprehensive primary care including acute, chronic, and preventive care.[16] The policy holds primary care leaders accountable for ensuring all newly enrolled women veterans are assigned to WH-PCPs and all currently enrolled women veterans are offered reassignment to a WH-PCP.[17]

VHA policy set a national goal of 85 percent for enrolled women veterans to be assigned a designated WH-PCP. As of May 2, 2019, the facility was at 60 percent. [18] In addition, according to facility self-reported 2018 Women's Assessment Tool for Comprehensive Health data, fewer than half of enrolled women veterans received gender-specific care from their assigned provider.[19] These women veterans were referred to other providers either in the same site or to community providers to receive gender-specific services. In some instances, women veterans were required to travel more than 50 miles for appointments. The OIG noted that women veterans at community based outpatient clinics were more likely to receive gender-specific care from their primary care provider than women veterans seen by their assigned provider at facility based clinics.

The Women Veterans Health Care Program Committee minutes and staff interviews revealed a shortage of WH-PCPs in the geographic area and recruiting difficulties. Staff also stated that insufficient numbers of WH-PCPs impeded the facility's ability to reach the national goal. To improve the number of available WH-PCPs, the facility offered training and a mini-residency at another VA.[20] The facility had 11 designated WH-PCPs in January 2017; the number increased to 34 by February 2019. The facility acknowledged the need for yet additional assignment and training of WH-PCPs and sent 14 providers to a women veterans health mini-residency training program. As of April 2019, 10 of the 14 providers were fully trained.[21] Women veterans health staff indicated that the plan was to ensure all PCPs be designated as WH-PCPs after completion of gender-specific training.

VHA policy states that patient panel sizes must be reduced by 20 percent of the proportion of the panel that is female to reflect the unique needs of women veterans. The OIG found primary care leaders did not ensure that designated WH-PCPs panel sizes were appropriately reduced as required by policy. Although facility leaders stated that local practice was to reduce the WH-PCPs panel size by the required 20 percent, staff interviewed stated this reduction had not

[16] VHA Directive 1330.01(2). VHA policy identifies comprehensive primary care for women veterans as coordinated care at one site by a designated WH-PCP and includes care for acute and chronic illnesses, gender-specific primary care, preventive services, and mental health services.

[17] VHA Directive 1330.01(2).

[18] VHA Directive 1330.01(2).

[19] An annual self-assessment of the Women Veterans Health Program is completed by each VA healthcare system.

[20] VHA Directive 1330.01(2).

[21] The remaining four required additional training.

occurred. VHA policy recommends extended scheduled appointment times for comprehensive women veterans healthcare examinations due to gender-specific needs; however, staff stated that appointment times had not been extended.[22]

Women Veterans Healthcare Resources

The OIG determined that the facility had not resolved long-standing deficiencies related to women veterans healthcare resources, including equipment, supplies, and space. Additionally, the WVPM was not included in construction and renovation project discussions that impacted women veterans healthcare, and did not routinely participate in environment of care rounds.

VHA policy states that facility leaders must ensure adequate equipment and resources needed to provide comprehensive women veterans healthcare.[23] VHA policy requires that women veterans, due to the use of gowns during examinations, have access to restrooms that do not require passage through public hallways or waiting rooms.[24] The policy also states that the WVPM has the authority to review and sign off on environmental designs that impact women veterans healthcare and must routinely participate in environment of care rounds to identify physical deficiencies and environmental issues.[25]

The OIG reviewed the Women Veterans Health Care Program Committee minutes from January 2017 through April 2019, and noted that equipment issues had been standing agenda items since July 2017. Specifically, some designated women veterans health exam rooms lacked equipment and supplies, such as exam stands and stools, and privacy curtains. During interviews, facility staff also reported a lack of speculums, drapes, and gowns and stated that the lack of ready access to restrooms in clinic areas impeded the ability to provide the full range of gender-specific care. During tours of Ambulatory Care Clinic 2 and Clinic Area 10–16, where both men and women veterans received care, the OIG team found limited or no access to women veterans restrooms within the clinic areas. Women veterans who were receiving care in a clinic examination room that required gowning and needed to access a restroom, would have to change into street clothes to walk through a public area to access restrooms, and then re-gown upon return to the examination room. Staff informed OIG team members that in an effort to avoid women veterans having to make this clothing change, nursing staff asked women veterans if they needed to use the restroom prior to and after gender-specific exams.

The WVPM was tasked with ensuring that construction and renovation projects complied with VHA policy and met the needs of women veterans but had not been included in discussions related to such projects. The Chief of Engineering stated being unaware of the requirement for

[22] VHA Directive 1330.01(2).
[23] VHA Directive 1330.01(2), VHA Directive 1330.02, *Women Veterans Program Manager*, August 10, 2018.
[24] VHA Directive 1330.01(2).
[25] VHA Directive 1330.01(2); VHA Directive 1330.02.

the WVPM involvement prior to the OIG inquiring about the matter. Since February 2019, the WVPM has been included in the discussions as required. The OIG reviewed facility documentation of identified deficiencies for women veteran restroom access. A review of the future renovation projects revealed that clinic area plans did not address deficient women veteran restroom access. The WVPM discussed attending environment of care rounds. The OIG found upon review of the environment of care rounds participation records from October 2017 through April 2019, that the WVPM attended 34 of 160 (21 percent) of the rounds which did not reflect the required routine participation.

Gynecological Care Staffing

The OIG found that the facility was limited in providing comprehensive gynecological care due to the prolonged vacancy of a gynecologist from February 2017 through December 2018. During this vacancy, staff reported that a gynecology advanced practice registered nurse (APRN) provided limited clinical care within the APRN's scope of practice thus requiring the supplemental use of Community Care. While the facility began rebuilding on-site gynecological services after hiring a gynecologist, additional staffing issues affected appointment availability.

VHA policy requires chaperones to be present with the provider during gynecological medical examinations or procedures.[26] The gynecologist and APRN shared a licensed vocational nurse from another service to chaperone during gynecology clinic appointments; therefore, gynecological medical examinations or procedures could not be performed simultaneously. Staff also reported that the APRN performed ancillary administrative duties that further reduced availability for women veteran appointments.

Gynecological Care in the Community

The OIG found that when the facility lacked available resources and access to needed gynecological care, the use of Community Care consults helped to secure the needed services. However, the facility did not have a standard operating procedure outlining the process to track and report results to the requesting provider.

VHA policy requires that all women veterans receive appropriate care, regardless of the location where care is rendered. The policy further requires a standard operating procedure to ensure tracking and coordination of breast and gynecological care, including care in the community.[27] Coordination of care includes documentation of care in the community, such as screening, result reporting, and follow-up care. Medical records from care provided in the community are to be obtained by the facility within 30 calendar days of the appointment date. Facility policy indicates

[26] VHA Directive 1330.01(2).
[27] VHA Directive 1330.01(2).

that Community Care staff are responsible for administratively tracking consults and ensuring receipt of consult results for ordering provider review.[28] According to VHA policy, care in the community consults can be administratively closed after three attempts to retrieve documentation from the care in the community provider.[29]

The OIG determined that facility providers placed 571 Community Care gynecology consults between March 30, 2018, and March 29, 2019. Facility staff stated, but were unable to confirm, due to the extensive manpower required, that consults were appropriately closed either through the administrative closure process or at the conclusion of care with receipt of the required documentation. Facility staff reported, and the OIG determined, that the tracking process for patients with abnormal gynecology test results who were referred to Community Care was inconsistent. As a result, the facility lacked the ability to identify pending consults and whether care had been provided or results communicated to the requesting provider. Facility staff noted that they were often unable to retrieve records, either by fax or through a portal system, from Community Care providers resulting in the administrative closure of the incomplete consults. One staff member reported retrieval of approximately 60 percent medical records for care in the community on the initial attempt. The OIG reviewed EHRs of 31 women veterans with abnormal gynecological test results between July 1 and December 31, 2018. The review identified that medical records were not received for 7 of the 11 veterans referred through Community Care.[30] Community Care staff also reported various timeframes to retrieve non-VA medical records ranging from 70–90 days.

The OIG determined that the facility had an insufficient number of WH-PCPs assigned and trained to provide gender-specific comprehensive primary care for women veterans. The current WH-PCPs were over-paneled and appointment lengths did not support the additional time needed for care. Resources needed to support comprehensive women veterans healthcare, such as equipment, supplies, and space, were insufficient. Further, the WVPM was not included in construction activations or renovation meetings and did not participate in environment of care rounds to identify issues that could affect women veterans privacy and dignity concerns, allowing issues related to women veterans access to restrooms to go unaddressed.

The gynecology clinic staffing was insufficient and unable to support the gynecologist and gynecology APRN, requiring consults to care in the community. There was no mechanism to ensure that VA referring providers received results of patient care provided in the community. These deficiencies and fragmented care placed the health and dignity of women veterans at risk.

[28] VA North Texas Health Care System Patient Administration Service Community Care Process SOP, November 11, 2018.

[29] VHA Memorandum from the Deputy Under Secretary for Health for Operations and Management, *Clarification of Administrative Closure of Community Care Consults*, March 6, 2018.

[30] Incomplete records included colposcopy results.

2. Deficiencies in Quality Management

The OIG determined that long-standing quality management and patient safety leadership vacancies contributed to deficient processes and practices. Deficiencies included performance measurement and evaluation processes that did not ensure compliance with VHA and The Joint Commission requirements. Processes did not ensure facility leaders' awareness and consideration of potential events for institutional disclosure. The OIG team also found that patient safety processes related to RCAs required improvement but did not identify deficiencies related to the evaluation of patient safety events and completion of HFMEAs. Additionally, facility staff were unclear about national guidelines related to goals of care conversations and life-sustaining treatment processes and code status was not consistently documented in patient EHRs. The resuscitation committee did not capture and review all codes, nor did the committee take corrective actions to identify the causes surroundings these events as required by VHA policy.

VHA policy requires integration of an organizational structure to promote exchange and flow of quality information and avoidance of organizational silos.[31] The policy outlines the requirements to develop facility-wide integration of key quality functions with the goal of delivering high quality, safe, and reliable care, and the need to designate leaders with appropriate backgrounds and skills to lead crucial quality management functions. An integrated quality management program should include functions related to performance measurement and evaluation, risk management including peer review and institutional disclosure, and patient safety. For purposes of this report, quality management refers to a framework to help medical facilities organize for, communicate about, monitor, and continuously improve all aspects of care delivery. VHA has also outlined its policy related to patient safety program and processes, including the designation of a patient safety manager.[32]

The OIG-identified deficiencies during documentation review and interviews in six quality management areas as outlined in table 1.

Table 1. Summary of OIG-Identified Quality Management Deficiencies

Deficient Area	Findings
Leadership Vacancies	• Chief of quality management duties were fulfilled by assigning rotating quality management staff from March 2016 to October

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

[32] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This handbook was scheduled for recertification on or before the last working date of March 2016 but has not been recertified.

Deficient Area	Findings
	2017; the current acting chief of quality management was assigned in January 2019.[33] • Patient safety manager position was fulfilled by assigning rotating patient safety specialists from 2014 to 2018 who performed management duties. The current patient safety manager was assigned in July 2018. **Impact**: These long-term vital leadership vacancies resulted in a lack of consistent leadership that would have helped to ensure strong quality management projects; the vacancies negatively impacted work products.
Performance Measurement and Evaluation	• Quality management staff relied on a tracer process to gather information about facility quality management processes.[34] • While the creation and training of the tracer process and a mechanism to track findings was launched in June 2016, the facility did not issue an official standard operating procedure until March 2019. • Tracer findings tracking documentation did not consistently include individual(s) responsible for action, action due date, action completed/closed date, action verification, and the required standard or regulation not listed. • Tracer process focused on environment of care rounds in lieu of quality of care and patient safety issues. **Impact:** The deficient performance and evaluation process did not provide the intended assessment of the facility's compliance with VHA requirements or inform leaders of emerging or evolving quality of care or patient safety concerns.[35]
Institutional Disclosure	• Unexplained decrease in the number of facility institutional disclosures since fiscal year 2017. Facility leaders were unable to provide evidence of institutional disclosure for four events that met disclosure criteria. • Facility leader's reasons for the non-disclosures varied and were not supported by VHA policy requirements. **Impact**: The lack of disclosure of harmful or potentially harmful adverse events to patients and/or their representatives did not allow an opportunity for decisions regarding their rights and recourse.[36]

[33] A permanent chief of quality management was in place between October 2017 and January 2019.

[34] Tracers offer a framework to assess facilities for providing care, treatment, or services and compliance with VHA, facility policies, and accreditation requirements. Standard Operating Procedure 00QSV-01, *Tracer Process,* March 7, 2019.

[35] VHA Directive 1026.

[36] VHA Directive 1004.08. *Disclosure of Adverse Events to Patients*, October 31, 2018. Adverse events include events that resulted in, or reasonably expected to result in, death or serious injury; prolonged hospitalization; or life-sustaining intervention or intervention to prevent impairment or damage.

Deficient Area	Findings
Patient Safety Processes	• Facility patient safety staff did not complete the required total combined number of eight RCAs and aggregated reviews during fiscal year 2018. • Two of the four RCAs were not completed within 45 days of facility awareness of the event and the aggregated reviews did not include the required reviews of missing patient or falls. **Impact:** The lack of required and timely RCAs did not allow facility leaders to accurately identify and review events to avoid future, similar events.[37]
Life-Sustaining Treatment and Codes	• Facility staff reported inconsistent knowledge and training about VHA policy requirements related to goals of care conversations and life-sustaining treatment. • Facility staff identified confusion on processes regarding code status documentation in patient EHRs. • Facility providers did not consistently document code status in EHRs reflecting patients' advance care planning.[38] • Practitioners did not document required goals of care conversations and life-sustaining treatment plans in the EHR for high-risk patients and did not write orders reflecting the patient's life-sustaining treatment decisions.[39] • Facility staff's lack of clarity in guidelines and training regarding patient decisions for life-sustaining treatments, such as initiation or refusal of resuscitation attempts led to inconsistent response to patient codes. **Impact:** The lack of facility staff training, clarity, and knowledge about goals of care conversation requirements and code status documentation in patient EHRs, may result in patients' advance care planning and high-risk patients' life-sustaining treatments not being honored.[40]
Code Committee	• Facility's resuscitation subcommittee did not capture or review all codes occurring at the facility as required by VHA policy. A review of occurrence screens identified patient deaths after a code that were not reviewed by the resuscitation committee and the code was not documented in the patient's EHR.[41] • The Critical Care Committee and the resuscitation subcommittee did not create corrective actions or complete follow-through to remediate identified areas of concern.

[37] VHA Handbook 1050.01.

[38] The number of code events does not reflect the number of patients who coded; at times, the same patient had more than one code event.

[39] VHA Handbook 1004.03.

[40] VHA Handbook 1004.03.

[41] The facility has a Critical Care Committee (formerly known as the Critical Care Workgroup Committee) and a resuscitation subcommittee.

Deficient Area	Findings
	• A review of Critical Care Committee minutes identified instances of concern by the resuscitation subcommittee were discussed; however, corrective action plans and follow-through did not occur to remediate the condition. **Impact:** The lack of a process to consistently and thoroughly assess issues surrounding codes and actions to remediate identified concerns placed patients at risk for similar future adverse events.[42]

Source: OIG analysis of facility quality management data and documentation

Conclusion

The facility had an insufficient number of WH-PCPs assigned and trained to provide gender-specific comprehensive primary care for women veterans. The current WH-PCPs were over-paneled, and length of appointment times were not adjusted as required for unique gender-specific care needs. Resources needed to support comprehensive women veterans healthcare, such as equipment, supplies, and space, were insufficient. The WVPM has been included in construction and renovation discussions since February 2019. Future renovation projects did not include clinic area plans to address women veterans restroom access. The WVPM did not routinely participate in environment of care rounds to identify issues that could affect women veterans, which contributed to unaddressed issues regarding women veterans access to restrooms.

The gynecology clinic staffing was insufficient and unable to support the gynecologist and gynecology APRN, requiring consults to Community Care. There was no mechanism to ensure that the facility's referring providers received results of patient care provided through Community Care. These deficiencies and the fragmented care placed the health and dignity of women veterans at risk.

VHA policies dictate the requirements for quality management in healthcare delivery, specifically in the areas of quality, patient safety, and codes. The OIG found that the facility's performance measurement and evaluation processes did not ensure compliance with VHA and The Joint Commission requirements. Institutional disclosure processes did not ensure awareness of quality of care concerns to inform facility leaders' decision-making. In addition, two of the four RCAs were not completed within 45 days of facility awareness of the event and the aggregated reviews did not include the required missing patient or falls reviews.

Despite training on the VHA life-sustaining treatment guideline requirements, the OIG found inconsistencies in healthcare staff and provider knowledge and awareness of responsibilities for high-risk patient goals of care conversations for life-sustaining treatment plans and

[42] VHA Handbook 1004.03.

documentation of patient decisions in the required EHR template. The resuscitation committee did not capture and review all codes, nor did the committee take corrective actions to identify the causes surrounding these events, as required by VHA policy. Areas of concern with codes were documented in the Critical Care Committee minutes as reported by the resuscitation subcommittee; however, corrective action plans and follow-through did not occur to remediate the condition.

Recommendations 1–18

1. The VA North Texas Health Care System Director takes steps to ensure sufficient staffing to provide gender-specific care by designated women's health primary care providers.
2. The VA North Texas Health Care System Director ensures steps are taken to reduce panel sizes of designated women's health primary care providers as required by Veterans Health Administration policy.
3. The VA North Texas Health Care System Director reviews the Veterans Health Administration policy recommended extended appointment times for comprehensive women veterans healthcare examinations and takes action as appropriate to achieve compliance.
4. The VA North Texas Health Care System Director takes steps to ensure that appropriate resources, such as equipment, supplies, and space, are adequate to support comprehensive women veterans healthcare.
5. The VA North Texas Health Care System Director takes steps to ensure that the Women Veterans Program Manager participates in the environment of care rounds and monitors for compliance with Veterans Health Administration policy.
6. The VA North Texas Health Care System Director evaluates clinic areas where gender-specific primary care is currently provided and when planning renovations to existing areas to ensure adequate restroom access for women veterans and takes action as appropriate.
7. The VA North Texas Health Care System Director continues to evaluate and support staffing changes in the gynecology specialty clinic to enhance services.
8. The VA North Texas Health Care System Director ensures implementation of an effective tracking mechanism to ensure VA providers receive results for women veterans referred to care in the community and monitors for compliance with Veterans Health Administration policy.
9. The VA North Texas Health Care System Director verifies review of the electronic health records of women veterans referred to Care in the Community whose medical records have not been obtained and takes action if indicated.

10. The VA North Texas Health Care System Director takes steps to ensure performance and evaluation processes provide the intended assessment of compliance with Veterans Health Administration requirements and monitors for compliance.
11. The VA North Texas Health Care System Director verifies that institutional disclosures are conducted for events that meet disclosure criteria and monitors for compliance with Veterans Health Administration policy.
12. The VA North Texas Health Care System Director takes steps to ensure the required number of combined totals of root cause analyses and aggregated reviews are completed, and monitors for compliance with Veterans Health Administration policy.
13. The VA North Texas Health Care System Director ensures completion of root cause analyses within the required timeframes and monitors for compliance with Veterans Health Administration policy.
14. The VA North Texas Health Care System Director verifies that staff complete training on policy related to high-risk patient goals of care conversations for life-sustaining treatment plans and monitors for completion of training.
15. The VA North Texas Health Care System Director ensures staff conduct high-risk patient goals of care conversations for life-sustaining treatment plans as required and monitors for compliance with Veterans Health Administration policy.
16. The VA North Texas Health Care System Director takes steps to ensure provider documentation of high-risk patient goals of care and life-sustaining treatment plan in the required electronic health record template and monitors for compliance with Veterans Health Administration policy.
17. The VA North Texas Health Care System Director verifies capture and reporting of all codes to the resuscitation subcommittee and monitors for compliance with Veterans Health Administration policy.
18. The VA North Texas Health Care System Director ensures that the Critical Care Committee minutes reflect corrective action plans and follow-through to remediate concerns identified by the resuscitation subcommittee and monitors for compliance.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 20, 2019

From: Director, VA Heart of Texas Health Care Network (10N/17)

Subj: Healthcare Inspection—Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the VA North Texas Health Care System, Dallas, Texas

To: Director, Office of Healthcare Inspections (54HL03)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

Thank you for allowing me to respond to this report.

1. VANTHCS (VA North Texas Health Care System) has included their response to the Draft report.
2. I concur with their actions and support their request for closure of recommendations 1-7; 9-13; and 17-18.

(Original signed by:)

Jeff Milligan
Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 19, 2019

From: Director, VA North Texas Health Care System, Dallas, Texas (549/00)

Subj: Healthcare Inspection—Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the VA North Texas Health Care System, Dallas, Texas

To: Director, VA Heart of Texas Health Care Network (10N/17)

1. VANTHCS submits draft response as required.
2. Recommend closure of the following items:
   - 1-7
   - 9-13
   - 17-18
3. If you have further questions, please contact Dr. Keshi Veasey, Chief, Quality, Safety, & Value, at ext. 70200

(Original signed by:)

Stephen R. Holt, MD, MPH, MSNRS
Director

Facility Director Response

Recommendation 1

The VA North Texas Health Care System Director takes steps to ensure sufficient staffing to provide gender-specific care by designated women's health primary care providers.

Concur.

Target date for completion: Completed as of 12/10/2019

Director Comments

VANTHCS has taken the following steps to ensure there is a sufficient number of DWHPs (Designated Women's Health Providers) to provide gender-specific care.

1. Training availability for all providers. Providers were given the chance to participate in all Women's Health Mini-residencies sponsored by VISN and VACO (VA Central Office).
2. Training was also made available via online delivery. After the completion of the training providers were given the opportunity to have a dedicated preceptor to ensure knowledge retention and practical time.
3. All providers were given the opportunity to rotate through the Women's Health Clinics to accommodate for refresher trainings and additional skill practice.

With these steps VANTHCS has increased its number of DWHPs from 11 in 2017 to a total of 75 as of December 9, 2019 (77% of all VANTHCS primary care providers are DWHPs), more than four times the amount of DWHPs needed to serve our women Veteran population.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 2

The VA North Texas Health Care System Director ensures steps are taken to reduce panel sizes of designated women's health primary care providers as required by Veterans Health Administration policy.

Concur.

Target date for completion: Completed as of 12/10/2019

Director Comments

All DWHP panel capacities have already been adjusted to reflect the number of females in each panel. The formula used to adjust the capacity is the following: (previous capacity) - [(total number of females in the panel) × (0.2)]. Therefore, each DWHP panel now reflects the accurate adjustment to the capacity availability by taking into account the number of female Veterans served, in accordance with VHA Directive 1330.01(2). No new patient assignments will be made to panels currently populated over the adjusted capacity to ensure there is no additional growth and to allow panel reduction by attrition.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The VA North Texas Health Care System Director reviews the Veterans Health Administration policy recommended extended appointment times for comprehensive women veterans healthcare examinations and takes action as appropriate to achieve compliance.

Concur.

Target date for completion: Completed as of 12/10/2019

Director Comments

After reviewing VHA Directive 1330.01(2) and with the assistance of Medical Administration Services leadership, clinic profiles of all DWHPs have been modified to permit variable length appointments. Based upon the providers guidance in their Return To Clinic order, schedulers now have the ability to secure 60-minute slots for new women's health appointments and comprehensive visits that include a Pap smear in compliance with the Directive.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 4

The VA North Texas Health Care System Director takes steps to ensure that appropriate resources, such as equipment, supplies, and space, are adequate to support comprehensive women veterans healthcare.

Concur.

Target date for completion: Completed as of 12/10/2019

Director Comments

Steps taken as part of the DWHP expansion to ensure the availability of appropriate resources to support comprehensive women Veterans care included:

1. Ambulatory Care Service identified all items needed to provide appropriate comprehensive women for each examination room.
2. Ambulatory Care Service reached out to all PACT (patient-aligned care team) team nursing members and requested them to inventory each examination room where comprehensive women's health care is delivered based on the items list provided.
3. Ambulatory Care Service ordered all items requested and delivered them to the specific locations.
4. Items needed not under this category (e.g. door locks) where requested through the appropriate channels. Currently, all exam rooms where comprehensive women's health care is delivered are fully-stocked, have curtains, doors locks, and examination tables that are positioned with the correct orientation to meet VHA Women's Health Directive.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 5

The VA North Texas Health Care System Director takes steps to ensure that the Women Veterans Program Manager participates in the environment of care rounds and monitors for compliance with Veterans Health Administration policy.

Concur.

Target date for completion: Completed as of 12/12/2019

Director Comments

VHA Directive 1330.01(2) requires the WVPM or designee to "participate in [environment of care] reviews on a routine basis." On December 12, 2019, the Acting Chief of Staff took steps to this effect by meeting with the WVPM and discussing with her the requirement to participate in EOC (environment of care) rounds on a routine basis, as well as the pertinent WVPM responsibilities outlined in VHA Directive 1330.02, specifically:

(a) Identifying deficiencies and opportunities for improvement and work with facility leadership, facility planner, and other staff to ensure that new construction and renovations are appropriate to meet the needs of women Veterans; and

(b) Exercising direct authority to sign off on renovation, construction design and architectural plans.

Leveraging the Performance Logic software as directed by VHA Environmental Programs Service, VANTHCS Environment of Care Council will continue to monitor EOC rounds attendance and report to the Executive Quality, Safety & Value Board chaired by the Director. To ensure accurate reporting of WVPM attendance to EOC rounds, on December 6, 2019, the Acting Chief of Staff communicated with the Chief of Safety Service and updated the list of people whose attendance should be considered as WVPM or designees.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 6

The VA North Texas Health Care System Director evaluates clinic areas where gender-specific primary care is currently provided and when planning renovations to existing areas to ensure adequate restroom access for women veterans and takes action as appropriate.

Concur.

Target date for completion: Completed as of 12/06/2019

Director Comments

The VA North Texas Health Care System Facility Planners conducted a survey of the clinic areas where gender-specific primary care is currently provided and assessed that they all have a restroom within "close proximity" in compliance with VHA Directive 1330.01(2). As VA North Texas Health Care System renovates existing areas, we will ensure continued adequate restroom access for women Veterans.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 7

The VA North Texas Health Care System Director continues to evaluate and support staffing changes in the gynecology specialty clinic to enhance services.

Concur.

Target date for completion: Completed as of 12/11/2019

Director Comments

Surgical Service continues to support the gynecology specialty clinic by an ongoing monitoring process to ensure appropriate staffing levels. For example, the addition of a full-time gynecologist over a year ago has improved access and quality of care in the clinic. Moreover, increased Medical Support Assistance (MSA) staffing has allowed scheduling to be performed by Medical Administration Service clerks, rather than the NP (nurse practitioner) having to schedule clinic appointments. Acknowledging the need for additional RN (registered nurse) and LVN (licensed vocational nurse) support, Surgical Service continues to work with Nursing Service and Women's Health to ensure that appropriate nursing coverage is in place for the gynecology specialty clinic, while exploring the possibility of dedicated resources to enhance services.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 8

The VA North Texas Health Care System Director ensures implementation of an effective tracking mechanism to ensure VA providers receive results for women veterans referred to care in the community and monitors for compliance with Veterans Health Administration policy.

Concur.

Target date for completion: 02/01/2020

Director Comments

In accordance with VHA consults standard operating procedures, VA North Texas Health Care System's Community Care staff are responsible for administratively tracking consults to community providers, including those for women Veterans, and ensuring receipt of consults results for ordering provider review. To this effect, VA providers are alerted in CPRS (computerized patient record system) when a consult is completed with records, so that the VA provider can view the results in VistA Imaging. To monitor compliance with VHA policy, Patient Administration Service is creating an audit tool to assess observance of the VHA consults SOP (standard operating procedure) by Community Care staff. Audit results will be reported to the Compliance and Business Integrity Council, which, in turn, reports to the Executive Quality, Safety and Value Board chaired by the Director.

Recommendation 9

The VA North Texas Health Care System Director verifies review of the electronic health records of women veterans referred to Care in the Community whose medical records have not been obtained and takes action if indicated.

Concur.

Target date for completion: Completed as of 12/10/2019

Director Comments

In accordance with VHA consults standard operating procedures, VA North Texas Health Care System's Community Care staff are responsible for administratively tracking consults to community providers, including those for women Veterans. According to VHA policy, care in the community consults for which medical records have not been obtained are administratively closed after verification that the requested care has been delivered, the available documentation has been reviewed, and three attempts to retrieve medical records from the care in the community provider are made. This action automatically generates an electronic alert to the referring VA provider in CPRS. Of note, community providers have a contractual obligation with the Third Party Administrator (TPA), TriWest, to report critical and urgent findings, even if medical records have not been made available to VA. Moreover, the authorization that the community provider receives from the TPA includes the Standard Episode of Care (SEOC), which allows for follow-up care and procedures based on the results of the original consult, including those that are administratively closed after failed attempts to retrieve medical records.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 10

The VA North Texas Health Care System Director takes steps to ensure performance and evaluation processes provide the intended assessment of compliance with Veterans Health Administration requirements and monitors for compliance.

Concur.

Target date for completion: Completed as of 10/01/2019

Director Comments

The VA North Texas Health Care System Director designated an Interim Chief of Quality, Safety and Value (QSV) on January 23, 2019. The Interim Chief performed a gap analysis of the

QSV department and determined the need to develop a standard operating procedure for tracer activities. On March 23, 2019, a SOP for Tracers was published for the QSV Consultants. In addition, the Quality department revised its process of tracking and monitoring open action items from recent survey activity, and reports compliance, barriers and/or challenges in the External and Internal Review Council meeting monthly. The External and Internal Review Council reports to the Executive Quality, Safety and Value Board. In June 2019, the Interim Chief of QSV was appointed as the Chief of QSV and began developing an accreditation program for VA North Texas Health Care System. The accreditation program includes: (a) standardized tracer tools utilizing the AMP database, (b) standardized action plan template, (c) individualized tracer schedules for each consultant, (d) monthly reporting of tracer activities, and (d) frequent monitoring of open tracer action items. The new accreditation program was launched October 1, 2019 with a comprehensive focus on TJC (The Joint Commission) chapter compliance, FY19 and FY20 OIG CHIP guides, CARF accreditation, and LTCI. QSV Consultant tracer schedules are inclusive of recent mock survey findings, TJC 4-1-1, OIG CHIP guides, policy reviews, and VHA identified vulnerabilities. The QSV Consultants meet with the facility Director bi-monthly to discuss survey preparedness efforts and vulnerabilities identified at VA North Texas Health Care System. Finally, beginning 12/16/2019, the QSV department will share Quality Tips of the Day (M-F) in the Directors' morning report to inform leaders of emerging or evolving quality of care or patient safety concerns.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 11

The VA North Texas Health Care System Director verifies that institutional disclosures are conducted for events that meet disclosure criteria and monitors for compliance with Veterans Health Administration policy.

Concur.

Target date for completion: Completed as of 12/10/2019

Director Comments

The Quality Department and the Chief of Staff adhere to VHA Directive 1004.08 (Disclosure of Adverse Events to Patients) by using an established "Disclosure of Adverse Events" algorithm to verify institutional disclosures are conducted for events that meet disclosure criteria. The Quality Department reports institutional disclosures monthly in the Executive Quality, Safety and Value Board that is chaired by the facility Director.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 12

The VA North Texas Health Care System Director takes steps to ensure the required number of combined totals of root cause analyses and aggregated reviews are completed, and monitors for compliance with Veterans Health Administration policy.

Concur.

Target date for completion: Completed as of 06/22/2019

Director Comments

There is a total of four individual and four aggregate root cause analyses (RCAs) required each fiscal year. When an RCA is chartered, the Patient Safety Manager monitors the progress of the RCA meetings to ensure we meet established deadlines. The Patient Safety Manager monitors and tracks RCA actions and outcome measures in the Web SPOT database on a weekly basis and daily throughout the RCA process. In June 2019, the Quality department revised its process of tracking and monitoring open RCA action items, and reports compliance, barriers and/or challenges to the Director in the Executive Quality, Safety, and Value Board meeting monthly.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 13

The VA North Texas Health Care System Director ensures completion of root cause analyses within the required timeframes and monitors for compliance with Veterans Health Administration policy.

Concur.

Target date for completion: Completed as of 06/22/2019

Director Comments

Root cause analysis (RCA) completion dates are reported to the Director on a monthly basis via the Executive Quality, Safety and Value Board. To reinforce the RCA completion timeframe, the Patient Safety Manager monitors and tracks RCA actions and outcome measures via a

system-generated suspense in Web SPOT. The Patient Safety Manager also provides monthly RCA action plan updates to the External and Internal Review Council that, in turn, reports to the Executive Quality, Safety and Value Board chaired by the Director.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 14

The VA North Texas Health Care System Director verifies that staff complete training on policy related to high-risk patient goals of care conversations for life-sustaining treatment plans, and monitors for completion of training.

Concur.

Target date for completion: March 31, 2020

Director Comments

As of December 9, 2019, Talent Management System (TMS) module VA 31722 (VA Life Sustaining Treatment Decision Initiative) was assigned as required training to all pertinent staff. Their respective Service Chiefs were also notified of said assignment. Starting on December 16, 2019, Education Service will monitor training completion and provide weekly reports to the services, with a goal of 90% completion by the end of FY20Q2.

Recommendation 15

The VA North Texas Health Care System Director ensures staff conduct high-risk patient goals of care conversations for life-sustaining treatment plans as required and monitors for compliance with Veterans Health Administration policy.

Concur.

Target date for completion: March 31, 2020

Director Comments

Pertinent staff will receive education on policy related to high-risk patient's goals of care conversations for life-sustaining treatment plans as described above. To ensure compliance with this policy, monthly CPRS chart audits will be conducted from a representative sample of high-risk patients for whom goals of care conversations are required by VHA Handbook 1004.03. These audits will monitor for compliance with provider documentation of goals of care conversations and life-sustaining treatment plans in the required EHR templates. Given that clinical judgment is the primary basis for identifying high-risk patients, a programmatic approach for selecting a random sample of high-risk patients from various clinical areas to perform these audits is problematic. Therefore, audits will be conducted on critically-ill patients admitted to intensive care units, a well-defined population with serious life-limiting medical conditions associated with a significantly shortened lifespan. Accordingly, results of these audits will be reported to the Critical Care Committee with a goal of 90% compliance by the end of FY20Q2.

Recommendation 16

The VA North Texas Health Care System Director takes steps to ensure provider documentation of high-risk patient goals of care and life-sustaining treatment plan in the required electronic health record template and monitors for compliance with Veterans Health Administration policy.

Concur.

Target date for completion: March 31, 2020

Director Comments

Pertinent staff will receive education on policy related to high-risk patient's goals of care conversations for life-sustaining treatment plans as described above. To ensure compliance with this policy, monthly CPRS chart audits will be conducted among a representative sample of high-risk patients for whom goals of care conversations are required by VHA Handbook 1004.03. These audits will monitor for compliance with provider documentation of goals of care conversations and life-sustaining treatment plans in the required EHR templates. Given that clinical judgment is the primary basis for identifying high-risk patients, a programmatic approach for selecting a random sample of them from various clinical areas to perform these audits is problematic. Therefore, audits will be conducted on critically-ill patients admitted to our intensive care units, a well-defined population with serious life-limiting medical conditions

associated with a significantly shortened lifespan. Accordingly, results of these audits will be reported to the Critical Care Committee with a goal of 90% compliance by the end of FY20Q2.

Recommendation 17

The VA North Texas Health Care System Director verifies capture and reporting of all codes to the resuscitation subcommittee and monitors for compliance with Veterans Health Administration policy.

Concur.

Target date for completion: Completed as of 12/10/2019

Director Comments

In accordance with VHA Directive 1177 and TJC standard PI.01.01.01 EP10, VANTHCS Memorandum 11-16 establishes that our Critical Care Committee will collect data for resuscitation episodes, reviewing all episodes of care where resuscitation was attempted and screening for clinical issues that may have contributed to their occurrence. The Executive Council of the Medical Staff (ECMS) monitors the activities of the Critical Care Committee, and, in turn, reports to the Executive Quality, Safety and Value Board chaired by the Director.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 18

The VA North Texas Health Care System Director ensures that the Critical Care Committee minutes reflect corrective action plans and follow-through to remediate concerns identified by the resuscitation subcommittee and monitors for compliance.

Concur.

Target date for completion: Completed as of 12/10/2019

Director Comments

The Critical Care Committee Chairman has been directed to ensure that their minutes reflect corrective action plans and follow-through to remediate concerns identified by the resuscitation subcommittee, and to regularly post their minutes to the committee's SharePoint site to facilitate monitoring for compliance. The Executive Council of the Medical Staff (ECMS) will continue to monitor the activities of the Critical Care Committee, to include compliance with this

requirement, and, in turn, report to the Executive Quality, Safety and Value Board chaired by the Director.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Glossary

aggregated reviews. A patient safety process used to look at multiple events for patterns or trends to identify a common cause. It provides an opportunity to correct minor events prior to potentially becoming serious events.[43]

codes. A medical emergency associated with a broadcasted alert for certain medical staff to respond to a patient who needs emergency assistance often associated with a heart attack or loss of breathing.[44]

chaperone. A person present during medical examinations or procedures who serves as witness for both the provider and patient.[45]

DNR. An order instructing healthcare personnel to withhold cardiopulmonary resuscitation (CPR) in the event of cardiac and/or pulmonary arrest.[46]

gender-specific primary care. Primary care that includes basic gynecological care, and breast and cervical cancer screenings with referrals to specialty providers for abnormal findings and follow-up care.

goals of care conversation. The conversation between a healthcare practitioner and a patient or surrogate to understand the patient's values, goals, and preferences for care, which assists with making decisions about whether to initiate, limit, or discontinue life-sustaining treatments.[47]

high-risk patient. A patient that is identified to be at a higher risk for a life-threatening clinical event because they have a serious life-limiting medical condition associated with a significantly shortened lifespan.[48]

life-sustaining treatment. A medical treatment given in an attempt to prolong the life of a patient who would be expected to die soon without the treatment.[49]

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[43] VHA Handbook 1050.01.

[44] https://www.merriam-webster.com/medical/code%20blue. (The website was accessed on March 18, 2019.)

[45] VHA Directive 1330.01 (2).

[46] System Policy Memorandum 2014-11-06. The term Do Not Resuscitate, DNR, do not attempt resuscitation, No-CPR, and No Code are synonymous. The abbreviation DNR will be used in this report; CPR is the emergency medical protocol used to restart circulation and breathing in a patient experiencing cardiopulmonary arrest.

[47] VHA Handbook 1004.03.

[48] VHA Handbook 1004.03.

[49] VHA Handbook 1004.03.

occurrence screen. A quality improvement document used to identify and review the circumstances surrounding certain triggering events, such as death, and follow-up actions.[50]

oversight. VA facilities undergo an oversight review for purposes of accreditation and/or addressing quality of care concerns. Facility leaders are expected to participate in site reviews, formulate action plans to address recommendations, and ensure that action plans are sustainable. Oversight reviews such as the OIG, Joint Commission, and the VISN, review focused areas and make recommendations for the facility to improve or bring the program into compliance with VHA directives.

practitioner. An attending physician or other licensed independent practitioner in charge of the patient's care and is considered as a consultant for goals of care conversations and life-sustaining treatment planning.[51]

women's health primary care provider (WH-PCP). A primary care provider who is trained and experienced in women veterans health. WH-PCPs do not have to be of female gender and are preferentially assigned women veterans to their primary care patient panels.[52]

[50]Melvin, Valerie C. Veteran Affairs: Information Systems Modernization Far from Complete, 2008. Page 38. https://books.google.com/books?id=dN8s_BImjWsC&pg=PA38&lpg=PA38&dq=VHA+occurrence+screen&source=bl&ots=XR5RXx3Gmo&sig=ACfU3U15A5JT8A3WSTGfP0eyWztRSWJLSQ&hl=en&sa=X&ved=2ahUKEwj2zJvLjPniAhUmmeAKHUXrCbsQ6AEwAnoECAoQAQ#v=onepage&q=VHA%20occurrence%20screen&f=false (The website was accessed on June 20, 2019).

51 VHA Handbook 1004.03.

[52] VHA Directive 1330.01 (2).

OIG Contact and Staff Acknowledgments

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