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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the John J. Pershing VA Medical Center in Poplar Bluff, Missouri

CHIP REPORT | REPORT #19-09416-186 | JULY 9, 2020

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Figure 1. *John J. Pershing VA Medical Center in Poplar Bluff, MO (Source: https://vaww.va.gov/directory/guide/, accessed on January 28, 2020)*

Abbreviations

ADPCS	Associate Director for Patient Care Services
CBOC	community-based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
FPPE	focused professional practice evaluation
FY	fiscal year
HRS	high risk for suicide
LIP	licensed independent practitioner
LST	life-sustaining treatments
LSTD	life-sustaining treatments decision
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
RME	reusable medical equipment
SAIL	Strategic Analytics for Improvement and Learning
SLB	state licensing board
SOP	standard operating procedure
SPC	suicide prevention coordinator
SPS	Sterile Processing Services
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WH-PCP	women's health primary care provider

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the John J. Pershing VA Medical Center which includes multiple outpatient clinics in Missouri and Arkansas. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

The OIG team looks at leadership and organizational risks, and at the time of the inspection, focused on the following clinical areas:

1. Quality, safety, and value
2. Medical staff privileging
3. Environment of care
4. Medication management (targeting long-term opioid therapy for pain)
5. Mental health (focusing on the suicide prevention program)
6. Care coordination (spotlighting life-sustaining treatment decisions)
7. Women's health (examining comprehensive care)
8. High-risk processes (emphasizing reusable medical equipment)

The unannounced visit was conducted during the week of November 18, 2019, at the John J. Pershing VA Medical Center and Cape Girardeau VA Clinic. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of 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 medical center'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 medical center and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

Leadership and Organizational Risks

At the time of the OIG's visit, the medical center's leadership team consisted of the Interim Medical Center Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. Organizational communications and accountability were managed through a committee reporting structure with the Executive Leadership Board overseeing several working groups. The leaders monitored patient safety and care through the Quality, Safety and Value Council which was responsible for tracking and trending quality of care and patient outcomes.

When the OIG conducted this inspection, the medical center's leaders had been working together as a group for two months, although several had served in their positions for more than a year. The ADPCS was the most tenured leader, permanently assigned in March 2017. The Interim Medical Center Director was the newest member of the leadership team, detailed into the position in September 2019. The Chief of Staff served in the position since October 2018, and the Associate Director had served since September 2017.

Selected employee satisfaction survey results indicated opportunities for leaders to improve employee satisfaction and for the Associate Director to improve staff feelings of "moral distress" at work.[1] Patient experience survey results were similar or better than the VHA average. Patients appeared satisfied with the care provided.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and noted one open recommendation from the Long-Term Care Institute inspection but did not identify any substantial organizational risk factors.[2] The Chief of Quality Management, referred to locally as the Quality Manager, had been monitoring the medical center's progress and reported that the recommendation closure is pending funding from Veterans Integrated Service Network (VISN) 15. The OIG did not note any issues with routine medical supplies.

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (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.

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[1] The 2019 All Employee Survey defines moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing."

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

The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[3]

During the week of the review, the OIG's interviews did not include the ADPCS who was out of the office. However, the rest of the facility's executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to specific poorly-performing quality measures. Leaders also demonstrated understanding of Community Living Center (CLC) SAIL measures.[4] In individual interviews, the Interim Medical Center Director and Chief of Staff were also able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

The OIG noted opportunities for improvement in seven clinical areas reviewed and issued 17 recommendations to the Interim Medical Center Director, Chief of Staff, and ADPCS. These are briefly described below.

Quality, Safety, and Value

The medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions; aggregated data review; and most patient safety elements. However, the OIG identified a deficiency with the Utilization Management Committee's diversity of representation during data reviews.[5]

Medical Staff Privileging

The medical center met many of the selected elements of expected performance for ongoing professional practice evaluations. Until the time of the OIG site visit, there was no responsible individual to ensure timely completion of exit review forms and State Licensing Board reporting;

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[3] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL) Value Model*, http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=9428. (The website was accessed on March 6, 2020, but is not accessible by the public.)

[4] According to VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers,* June 1, 2017, CLCs, previously known as Nursing Home Care Units, provide a skilled nursing environment and a variety of interdisciplinary programs for persons needing short- and long-stay services.

[5] The definition of utilization management can be found within VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019. Utilization management involves the "forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria."

however, this was corrected prior to the end of the site visit. The OIG identified deficiencies with focused professional practice evaluations and provider exit review forms.[6]

Medication Management

The OIG observed compliance with pain screenings. However, the OIG found deficiencies with aberrant behavior risk assessments, concurrent opioid and benzodiazepine therapy, urine drug testing, informed consent, patient follow-up, and quality measure oversight.

Mental Health

The OIG found compliance with some of the requirements reviewed. However, the OIG noted concerns with follow-up appointments and suicide prevention training.

Women's Health

The OIG found compliance with many of the requirements for women's health, including care provision and the reviewed staffing requirements. However, the OIG noted concerns with community-based outpatient clinic women's health primary care providers and the Women Veterans Health Committee core membership.

High-Risk Processes

The medical center complied with some elements of expected performance for reprocessing reusable medical equipment. However, the OIG identified concerns with standard operating procedures, the annual risk analysis, and competency assessments.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued 17 recommendations for improvement to the Interim Medical Center Director, Chief of Staff, and ADPCS. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this medical center. The intent is for medical center 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.

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[6] The definitions of focused professional practice evaluation and ongoing 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."

Comments

The acting/interim Veterans Integrated Service Network Director and acting/interim Medical Director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 68–69, 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 conduct routine oversight of VA medical facilities providing healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the John J. Pershing VA Medical Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so that informed decisions can be made to improve care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[1] Investments in a culture of safety and continuous quality improvement, in concert with robust leadership and communication, significantly contribute to positive patient outcomes.[2] Figure 2 illustrates 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, the OIG focused on core processes in the following nine areas of administrative and clinical operations:

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (targeting long-term opioid therapy for pain)
6. Mental health (focusing on the suicide prevention program)
7. Care coordination (spotlighting life-sustaining treatment decisions)
8. Women's health (examining comprehensive care)
9. High-risk processes (emphasizing reusable medical equipment)[3]

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[1] 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 September 25, 2019.)

[2] Jamie Leviton and Jackie Valentine, "How risk management and patient safety intersect: Strategies to help make it happen," *Institute for Healthcare Improvement and National Patient Safety Foundation (NPSF)*, March 24, 2015.

[3] See Figure 2. CHIP inspections address these processes during FY 2020 (October 1, 2019, through September 30, 2020); they may differ from prior years' focus areas.

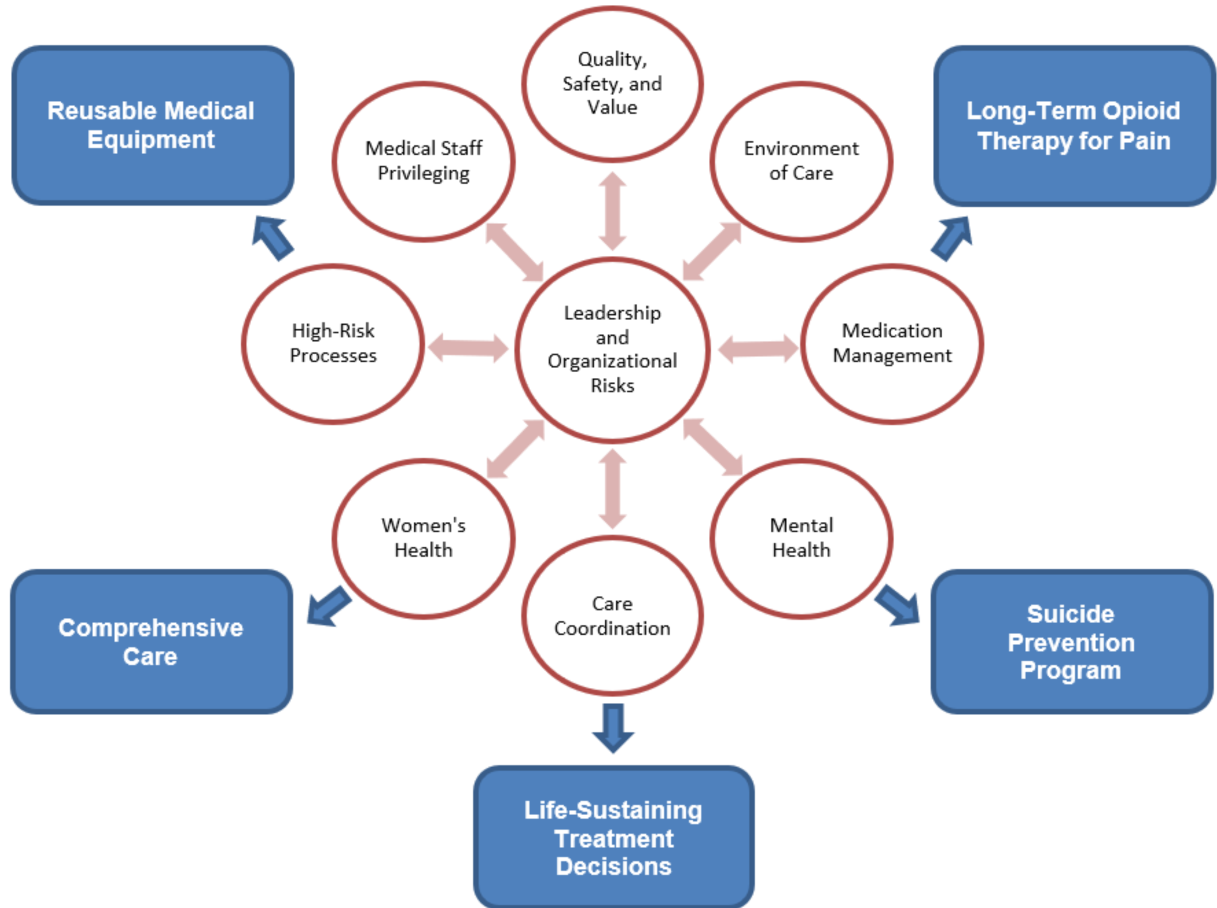

Figure 2. *Fiscal Year (FY) 2020 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

Methodology

The John J. Pershing VA Medical Center includes the medical center and multiple outpatient clinics in Missouri and Arkansas. Additional details about the types of care provided by the medical center can be found in Appendixes B and C.

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.[4]

The OIG team also selected and physically inspected the Cape Girardeau VA Clinic and the following areas at the John J. Pershing VA Medical Center:

- Community Living Center (CLC)[5]
- Dental clinic
- Endoscopy suite
- Medical/surgical inpatient unit
- Primary care clinic
- Specialty care
- Urgent Care Clinic
- Women's health clinic

The OIG inspection team interviewed executive leaders, discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection period examined operations from April 28, 2018, through November 21, 2019, the last day of the unannounced multiday site visit.[6] While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and

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

[5] According to VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers,* June 1, 2017, CLCs, previously known as Nursing Home Care Units, provide a skilled nursing environment and a variety of interdisciplinary programs for persons needing short- and long-stay services.

[6] The range represents the time period from the prior CHIP inspection to the completion of the unannounced, multiday CHIP site visit in November 2019.

methodology and makes recommendations to VA leadership, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the medical center completes corrective actions. The Interim Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that the system leaders developed based on the reasons for noncompliance.

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA medical center. Leadership and organizational risks can impact the medical center's ability to provide care in the clinical focus areas.[7] To assess the medical center's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation surveys and oversight inspections
5. Identified factors related to possible lapses in care and medical center response
6. VHA performance data (medical center)
7. VHA performance data (CLC)

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 medical center's reported organizational structure. The medical center has a leadership team consisting of the Interim Medical Center Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. The Chief of Staff and ADPCS oversee patient care which requires managing service directors and chiefs of programs and practices.

[7] L. Botwinick, M. Bisognano, and C. Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare Improvement, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on November 6, 2019.)

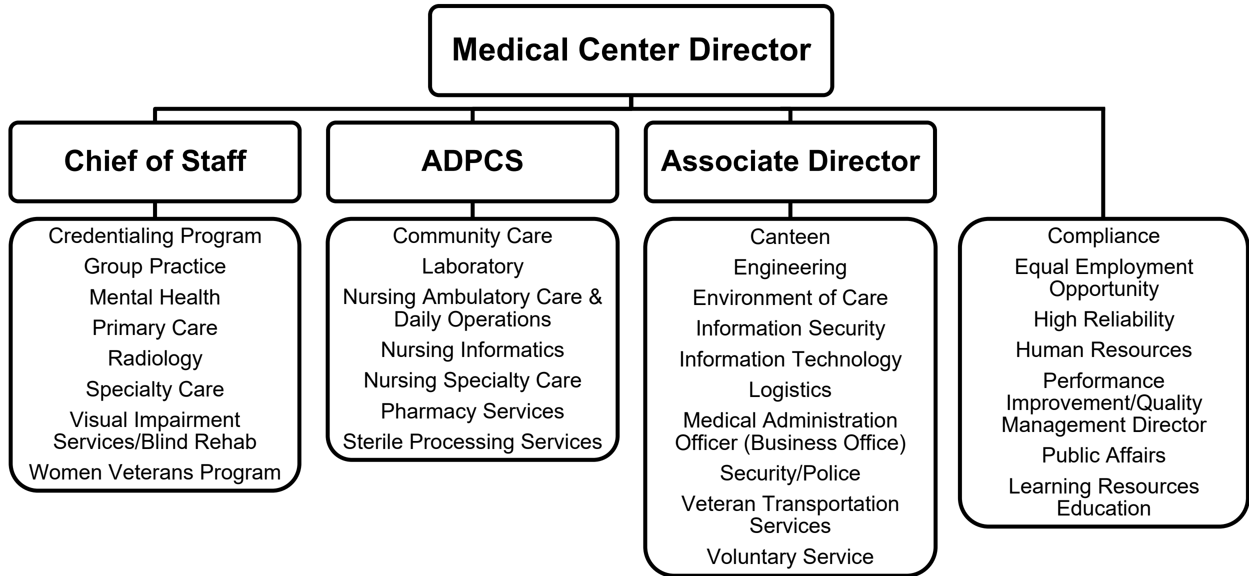

Figure 3. *Medical Center Organizational Chart*
Source: John J. Pershing VA Medical Center (received November 21, 2019)

At the time of the OIG site visit, the executive team had been working together as a group for two months, although several team members had been in their positions for more than a year (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Interim Medical Center Director	September 1, 2019
Chief of Staff	October 14, 2018
Associate Director for Patient Care Services	March 19, 2017
Associate Director	September 17, 2017

Source: John J. Pershing VA Medical Center Assistant Chief of Human Resources (received November 18, 2019)

To help assess the medical center executive leaders' engagement, the OIG interviewed the Interim Medical Center Director, Chief of Staff, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance. During the week of the review, the OIG did not interview the ADPCS, who was out of the office.

The Interim Medical Center Director and Chief of Staff were generally knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to specific poorly-performing Strategic Analytics for Improvement and Learning (SAIL) quality of care measures. The Chief of Staff also demonstrated understanding of CLC SAIL measures. In individual interviews, the Interim Medical Center Director and Chief of Staff were able to speak

in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

The Interim Medical Center Director serves as the chairperson of the Executive Leadership Board, which has the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Board oversees various working groups such as the Executive Committee of Medical Staff, Nursing Executive, and Operations Councils.

These leaders monitor patient safety and care through the Quality, Safety and Value Council. The Quality, Safety and Value Council is responsible for tracking, trending, and monitoring quality of care and patient outcomes and reports to the Executive Leadership Board. See Figure 4.

Figure 4. *Medical Center Committee Reporting Structure*
Source: John J. Pershing VA Medical Center (received November 19, 2019)

Employee Satisfaction

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

To assess employee attitudes toward medical center leaders, the OIG reviewed specific employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2018, through September 30, 2019.[8] Table 2 provides relevant survey results for VHA, the medical center, and executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center average for specific survey leadership questions was lower than the VHA average.[9] The same trend was noted for the Chief of Staff, ADPCS, and Associate Director; however, scores for the Medical Center Director were consistently higher than those for VHA and the medical center.[10]

Table 2. Survey Results on Employee Attitudes toward Medical Center Leaders (October 1, 2018, through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Medical Center Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[11]	0–100 where higher scores are more favorable	72.6	71.5	77.1	77.0	69.7	69.1
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.4	3.2	3.7	2.9	3.2	3.1
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.2	3.8	3.2	3.2	3.1

[8] Ratings are based on responses by employees who report to or are aligned under the Medical Center Director, Chief of Staff, ADPCS, and Associate Director.

[9] 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.

[10] It is important to note that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current Interim Medical Center Director or Chief of Staff, who assumed the role after the survey was administered.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Medical Center Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.4	3.9	3.2	3.3	3.2

Source: VA All Employee Survey (accessed October 8, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[12] The medical center average for selected questions was generally similar to the VHA average. The Medical Center Director averages were consistently better than those for VHA and the medical center.[13] The Chief of Staff scores were slightly better than VHA and facility averages. However, opportunities appear to exist for the Associate Director to improve employees' feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what they believed to be the right thing) and to support an environment where employees feel safe reporting concerns. The Associate Director stated that the challenging labor relations environment was a factor in the low scores. Also, the Interim Medical Center Director stated that union presence had been negative and provoking for leadership and staff and despite reporting concerns, the VISN had not been supportive.

Table 3. Survey Results on Employee Attitudes toward the Workplace (October 1, 2018, through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Medical Center Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.7	4.2	3.9	3.6	3.5

[12] Ratings are based on responses by employees who report to or are aligned under the Medical Center Director, Chief of Staff, ADPCS, and Associate Director.

[13] It is important to note that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current Medical Center Director or Chief of Staff, who assumed the role after the survey was administered.

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Medical Center Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.7	4.1	3.8	3.6	3.6
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.4	1.4	1.2	1.1	1.3	1.6

Source: VA All Employee Survey (accessed October 8, 2019)

Patient Experience

To assess patient experiences with the medical center, which directly reflect on its leaders, the OIG team reviewed patient experience survey results that relate to the period of October 1, 2018, through June 30, 2019. 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 VHA and the John J. Pershing VA Medical Center.[14]

VHA also collects SHEP survey data from Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward their healthcare experiences (see Table 4). For this medical center, the patient survey results reflected higher care ratings than the VHA average, except for the question "Would you recommend this hospital to family and friends?" Patients appeared satisfied with their customer experience.

[14] Ratings are based on responses by patients who received care at this medical center.

Table 4. Survey Results on Patient Experience (October 1, 2018, through June 30, 2019)

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.1	60.5
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	90.5
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	77.3	80.8
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	78.0	85.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 8, 2019)

In 2015, women represented 9.4 percent of the total veteran population in the United States, and it is projected that women will represent 16.3 percent of living veterans by 2043. Further, from 2005 to 2015, the number of women veterans using VA health care increased by 46.4 percent, from almost 240,000 to 455,875.[15] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients' experiences by gender (see Tables 5–7), including those for Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG noted that the results for both male and female respondents were generally similar to or more favorable than the corresponding VHA averages. Based on available data, medical center leaders appeared to be actively engaged with male and female patients.

[15] VA National Center for Veterans Analysis and Statistics, *The Past, Present and Future of Women Veterans*, February 2017.

Table 5. Inpatient Survey Results on Experiences by Gender (October 1, 2018, through June 30, 2019)

Questions	Scoring	VHA[16]		Medical Center[17]	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.3	83.6	90.9	—[18]
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.7	83.0	93.0	—
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	68.5	62.0	60.8	—

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 2019)

Table 6. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2018, through June 30, 2019)

Questions	Scoring	VHA[19]		Medical Center[20]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.8	43.2	60.2	41.7

[16] The VHA averages are based on 34,077–34,469 male and 1,647–1,665 female respondents, depending on the question.

[17] The medical center averages are based on 130–131 male and four female respondents, depending on the question.

[18] Data are not available due to a low number of respondents.

[19] The VHA averages are based on 60,437–183,790 male and 4,400–9,816 female respondents, depending on the question.

[20] The medical center averages are based on 503–1358 male and 31–58 female respondents, depending on the question.

Questions	Scoring	VHA[19]		Medical Center[20]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.8	49.5	68.7	54.5
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.0	64.8	67.0	69.1

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 2019)

Table 7. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2018, through June 30, 2019)

Questions	Scoring	VHA[21]		Medical Center[22]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.3	44.4	52.9	—[23]
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	53.9	67.0	—

[21] The VHA averages are based on 50,373–158,294 male and 2,617–8,357 female respondents, depending on the question.

[22] The medical center averages are based on 245–638 male and 6–21 female respondents, depending on the question.

[23] Data are not available due to a low number of respondents.

Questions	Scoring	VHA[21]		Medical Center[22]	
		Male Average	Female Average	Male Average	Female Average
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	69.9	69.4	74.6	69.8

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 2019)

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.[24] Table 8 summarizes the relevant medical center inspections most recently performed by the OIG and The Joint Commission (TJC).[25] Of note, at the time of the OIG visit, the medical center had closed all recommendations for improvement issued since the previous comprehensive healthcare inspection conducted in April 2018.

At the time of the site visit, the OIG also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[26] The Long Term Care Institute also conducted an inspection of the medical center's CLC on March 11, 2019; one recommendation remained open at the time of the OIG's

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[24] The Joint Commission 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.

[25] 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."

[26] 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 February 20, 2019.) In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

site visit.[27] The Chief of Quality Management, referred to locally as the Quality Manager, had been monitoring the facility's progress and reported that recommendation closure is pending funding from VISN 15.

Table 8. Office of Inspector General Inspection/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the John J. Pershing VA Medical Center, Poplar Bluff, MO,* Report No. 18-01011-253, August 22, 2018)	April 2018	2	0
TJC Hospital Accreditation TJC Behavioral Health Care Accreditation TJC Home Care Accreditation	June 2019	26 3 5	0 0 0

Source: OIG and TJC (inspection/survey results verified with the Chief of Quality Management on December 3, 2019)

Identified Factors Related to Possible Lapses in Care and Medical Center Response

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 9 lists the reported patient safety events from April 28, 2018 (the prior OIG comprehensive healthcare inspection), through November 21, 2019.[28] The OIG identified no concerns related to the potential for patient harm.

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

[28] 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 John J. Pershing VA Medical Center is a low complexity (3) medical center as described in Appendix B.)

Table 9. Summary of Selected Organizational Risk Factors (April 28, 2018, through November 21, 2019)

Factor	Number of Occurrences
Sentinel Events[29]	0
Institutional Disclosures[30]	0
Large-Scale Disclosures[31]	0

Source: John J. Pershing VA Medical Center's Chief of Quality Management (received November 19, 2019)

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adopted 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.[32]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2019. Of note, Figure 5 uses blue and green data points to indicate high performance for the John J. Pershing VA Medical Center (for example, in the areas of registered nurse (RN) turnover, mental health (MH) continuity (of) care, and best place to work). Metrics that need improvement are denoted in orange and red (for

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[29] 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."

[30] 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 leaders together with clinicians and others, as appropriate, inform the patient or [his or her] personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."

[31] According to VHA Directive 1004.08, 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."

[32] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL) Value Model*, https://vaww.vssc.med.va.gov/vsscenhancedproductmanagement/displaydocument.aspx?documentid=9428. (The website was accessed on March 6, 2020, but is not accessible by the public.)

example, patient-centered medical home (PCMH) care coordination, ambulatory care sensitive condition (ACSC) hospitalization, and [in-hospital] complications).[33]

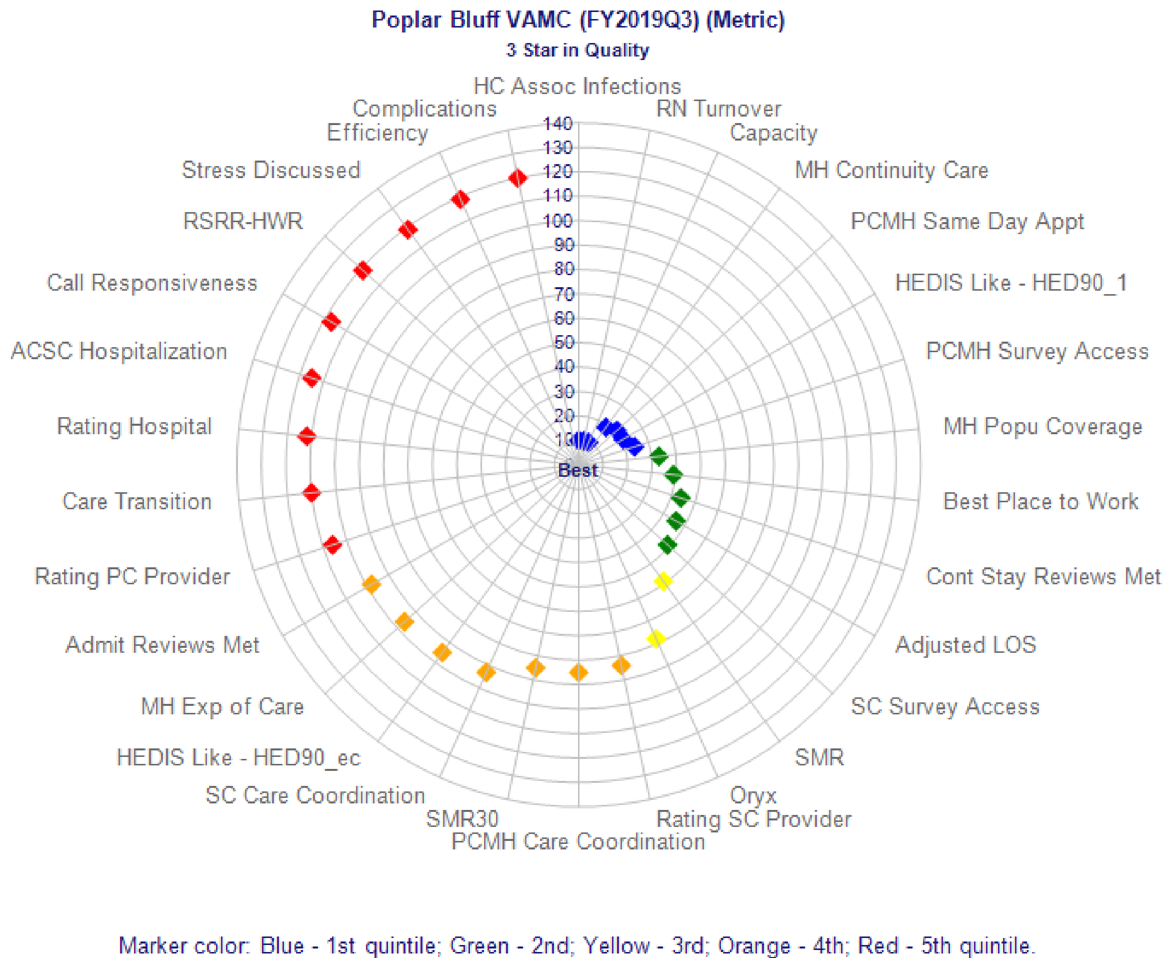

Figure 5. *System Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

Veterans Health Administration Performance Data for Community Living Centers

The "CLC SAIL" Value Model is a tool to summarize and compare the performance of CLCs in the VA. The model leverages much of the same data used in the Centers for Medicare &

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

Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource to review quality measures and health inspection results.[34]

Figure 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2019. Figure 6 uses blue and green data points to indicate high performance for the John J. Pershing VA Medical Center CLC (for example, in the areas of catheter in bladder–long-stay (LS) and urinary tract infections (UTI) (LS)). Metrics that need improvement are denoted in orange and red (for example, falls with major injury (LS), moderate-severe pain (LS), and new or worse pressure ulcers (PU)–short-stay (SS)).[35]

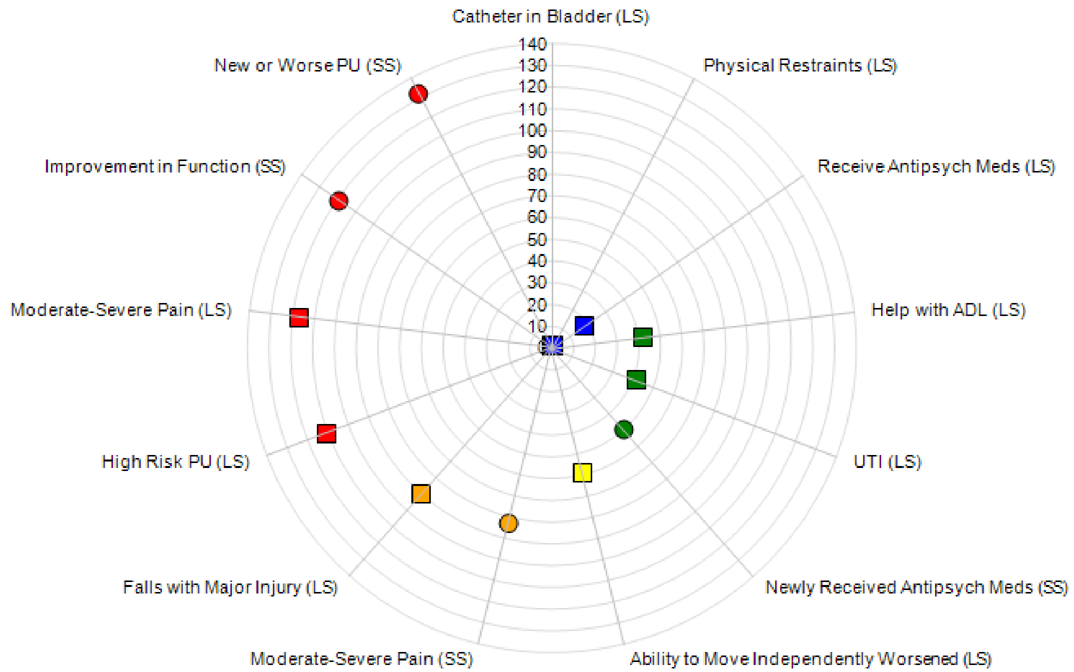

Figure 6. *John J. Pershing VA Medical Center CLC Quality Measure Rankings (as of June 30, 2019)*
LS = Long-Stay Measure *SS = Short-Stay Measure*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

[34] According to the 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."

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

Leadership and Organizational Risks Conclusion

The medical center's executive leadership team appeared relatively stable except for the Interim Medical Center Director, who was detailed into the position a little more than two months prior to the OIG site visit. Survey scores related to employees' satisfaction with the medical center executive leaders revealed opportunities to improve employee satisfaction and for the Associate Director to improve staff feelings of "moral distress" at work. Patient experience survey results were similar or better than VHA averages. Further, the OIG found that survey results for both male and female respondents were generally more favorable than those for VHA patients nationally. The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. In individual interviews, the Interim Medical Center Director and Chief of Staff were able to speak in depth about actions taken during the previous 12 months to maintain or improve employee satisfaction and patient experiences. In addition, the executive leaders were generally knowledgeable within their scope of responsibilities about selected SAIL and the CLC SAIL data and should continue to take action to sustain and improve performance.

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.[36] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and to maintain Joint Commission accreditation.[37] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[38]

To determine whether VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the medical center's committee responsible for quality, safety, and value (QSV) oversight functions; its ability to review data, information, and risk intelligence; and its ability to ensure that key QSV functions are discussed and integrated on a regular basis. Specifically, OIG inspectors examined the following requirements:

- Review of aggregated QSV data
- Recommendation and implementation of improvement actions
- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the medical center's processes for conducting protected peer reviews of clinical care.[39] Protected peer reviews, when conducted systematically and credibly, 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.[40] The OIG team examined the completion of the following elements:

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

[37] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

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

[39] 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. In the context of protected peer reviews, "protected" refers to the designation of review as a confidential quality management activity under 38 U.S.C. 5705 as "a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for improving the quality of medical care or the utilization of health-care resources in VA facilities."

[40] VHA Directive 1190.

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- 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[41]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee
- Quarterly review of Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Next, the inspection team assessed the medical center's utilization management (UM) program, a key component of VHA's framework for quality, safety, and value, which provides vital tools for managing the quality and the efficient use of resources.[42] It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[43] Inspectors reviewed several aspects of the UM program:

- Completion of at least 80 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
- Implementation and monitoring of improvement actions recommended by the interdisciplinary UM group

Finally, the OIG reviewers assessed the medical center's reports of patient safety incidents with related root cause analyses.[44] 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

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[41] The medical center did not have an inpatient mental health unit.

[42] According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019, UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria."

[43] VHA Directive 1117(2).

[44] The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. 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."

communicate potential and actual causes of harm to patients throughout the medical center.[45] The medical center was assessed for its performance on several dimensions:

- Annual completion of a minimum of eight root cause analyses[46]
- Inclusion of required content in root cause analyses
- 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 medical center leaders

The OIG reviewers 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.[47]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions, aggregated data, and the reviewed patient safety elements. However, the OIG identified a concern with the interdisciplinary review of UM data.

VHA requires that "UM data are reviewed on an ongoing basis by an interdisciplinary group, including but not limited to representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR [chief business office revenue-utilization review.]"[48] The OIG found that the interdisciplinary committee responsible for reviewing UM data did not have consistent representation from mental health services or social work from January 24, 2019, through October 31, 2019. Lack of consistent representation from all required disciplines may result in inadequate management of patient flow activities.[49] The Quality Manager reported that the mental health representative's lack of participation and attendance was not addressed because the medical center did not have an inpatient mental health program. The Quality Manager also reported that, for two of the four meetings, the social work member was on leave and failed to designate an alternate representative.

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[45] VHA Handbook 1050.01.

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

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

[48] VHA Directive 1117 (2).

[49] VHA Directive 1117 (2).

Recommendation 1

1. The Interim Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures all required representatives consistently participate in interdisciplinary utilization management data reviews.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Utilization Management Committee Charter has been updated to include Mental Health and Social Worker as a regular member. Attendance will be tracked for each Utilization Management Committee meeting. The Medical Center Director or designee will reinforce accountability for member attendance by monitoring compliance of attendance tracking. Data audit of monitoring of required attendance will be reviewed by the Quality Safety and Value Council which the Medical Center Director co-chairs until 90 percent compliance is achieved for two quarters. The numerator will be Quality Safety Value Council minutes where UM data was presented that included all required members and the denominator will be the total number of Quality Safety Value Council minutes where UM data is presented.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[50]

Clinical privileges need to be specific and based on the individual practitioner's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the Medical Center Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[51]

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 process occurs when a provider is hired at the facility and granted initial privileges and before any new clinical privileges are granted. Additionally, VA facilities must continuously monitor the performance of their providers. VHA requirements state that "the on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered."[52] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[53]
  - Clear documentation of the results and time frames
  - Evaluation by another provider with similar training and privileges
- OPPEs
  - Application of criteria specific to the service or section
  - Use of minimum criteria for selected specialty LIPs[54]
  - Evaluation by another provider with similar training and privileges

The OIG also determined whether service chiefs recommended continuing the LIPs' current privileges based in part on the results of OPPE activities and if the medical center's Executive

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[50] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[51] VHA Handbook 1100.19.

[52] VHA Handbook 1100.19.

[53] VHA Acting Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

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

Committee of the Medical Staff decided to recommend continuing privileges based on FPPE and OPPE results.

Further, VA must put processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former licensed practitioner's clinical practice, VA has an obligation to notify state licensing boards (SLBs) and to subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[55] Further, "VA medical facility Directors must designate an individual, and backup, to be responsible for the SLB reporting process. This individual will be the subject matter expert (SME) for the facility…and ensure oversight of the exit review process, including receipt, review, and maintenance of the Provider Exit Review Forms."[56] The OIG reviewers assessed whether the medical center's staff

- Designated an individual and backup responsible for the SLB reporting process,
- Completed forms within the required time frame and with required oversight, and
- Reported results to SLBs when indicated.

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

- Four solo/few practitioners who underwent initial or reprivileging during the previous 12 months[57]
- Three LIPs hired within 18 months before the site visit
- Eleven LIPs privileged within 12 months before the visit
- Nine LIPs who left the medical center in 12 months before the visit

Medical Staff Privileging Findings and Recommendations

The medical center met many of the selected elements of expected performance for OPPE processes. However, until the time of the OIG site visit, the Interim Medical Center Director had not signed a letter designating a responsible individual to ensure completion of exit review forms and SLB reporting; this was corrected prior to the end of the site visit and no recommendation

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[55] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005.

[56] VHA Notice 2018-05, *Amendment to VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards*, February 5, 2018.

[57] 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. The 12-month review period was from November 4, 2018, through November 4, 2019.

was issued. The OIG identified the following deficiencies with FPPE criteria established in advance and provider exit review forms completed within the required time frame.

Specifically, VHA requires criteria for the FPPE process "to be defined in advance, using objective criteria accepted by the practitioner."[58] The OIG found that FPPE process criteria were not defined in advance or accepted by the providers in all four profiles reviewed. This could have resulted in a misunderstanding of expectations by practitioners and the clinical managers performing FPPEs. The Quality Manager acknowledged the requirements and reported that providers received advance notification of FPPE criteria during new employee orientation but could not provide evidence to support this process.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures clinical managers define and document expectations for focused professional practice evaluations in provider profiles prior to assessment.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: FPPE criteria forms have been modified to include a signature line for new providers when they receive their orientation during on boarding. All providers will verify receipt of FPPE criteria and education on the providers' discipline specific evaluation criteria. The Chief of Staff ensures compliance with verification of receipt of the evaluation criteria through Executive Committee of the Medical Staff which the Chief of Staff chairs monthly until 90 percent or greater compliance is demonstrated for two quarters. The numerator will be the number of providers with documented receipt of FPPE criteria during orientation with the denominator being the number of providers who are newly employed by the facility.

VHA requires that provider exit review forms, which document the review of a provider's clinical practice, "must be completed within 7 calendar days of the departure of a licensed health care professional from a VA facility."[59] For three of nine exiting providers, front-line supervisors did not complete a provider exit form within seven calendar days of departure. Failure to complete the form within the required time frame may delay reporting of the exiting provider's potential substandard practice to respective SLBs. The Credentialing Program Specialist acknowledged the requirement and reported that front-line supervisors relied on an electronic notification to complete the form. The specialist reported that the software program failed to send notifications, which delayed completion of the forms.

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[58] VHA Handbook 1100.19.

[59] VHA Notice 2018-05.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and verifies that first- or second-line supervisors complete provider exit review forms within seven calendar days of a provider's departure from the medical center.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff or designee will educate facility service chiefs on the importance of exit reviews and the exit review form has been provided to service chiefs and provided for electronic access. Designated staff will monitor and report compliance with the timely completion of exit reviews monthly to the Executive Committee of the Medical Staff which the Chief of Staff chairs until a 90 percent compliance rate for two quarters has been met. The numerator will be number of exit review forms completed for departing licensed independent practitioners within seven calendar days and include signature of the first- or second-line supervisor and the denominator will be number of licensed independent practitioners that left the medical center.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct Comprehensive Environment of Care Inspection Rounds and to resolve issues in a timely manner. The goal of the Comprehensive 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.[60]

The purpose of this facet of the OIG inspection was to determine whether the medical center maintained a clean and safe healthcare environment in accordance with applicable requirements.[61] The inspection team reviewed relevant documents, interviewed key employees and managers, and examined several aspects of the medical center's environment:

- Medical center
    - General safety
    - Special use spaces
    - Environmental cleanliness and infection prevention
    - Privacy
    - Accommodation and privacy for women veterans
    - Logistics
- Community-based outpatient clinic (CBOC)
    - General safety
    - Special use spaces
    - Environmental cleanliness and infection prevention
    - Privacy
    - Privacy for women veterans
    - Logistics

During its review of the environment of care, the OIG team inspected the Cape Girardeau VA Clinic and the following eight patient care areas at the John J. Pershing VA Medical Center:

- CLC (4 north)
- Dental clinic

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

[61] The medical center did not have an inpatient mental health unit.

- Endoscopy suite
- Medical/surgical inpatient unit
- Primary care clinic
- Specialty care
- Urgent Care Clinic
- Women's health clinic

Environment of Care Findings and Recommendations

The OIG observed general compliance with the above requirements, did not note any issues with the availability of medical equipment or supplies, and made no recommendations.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[62] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[63] Long-term opioid use is of particular concern in the veteran population where there is a high incidence of posttraumatic stress disorder, major depressive disorder, alcohol use, substance abuse, and suicide attempts.[64] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[65]

VHA requires routine assessments of pain and the completion of an opioid risk assessment before initiating patients on long-term opioid therapy and recommends against the therapy for patients with untreated substance use disorders. VHA also recommends avoiding drugs capable of inducing fatal interactions, such as opioids with benzodiazepines.[66] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[67] To achieve VHA's vision of providing patient-driven healthcare, practitioners are also required to obtain informed consent from patients and provide education about the risks, benefits, and alternatives prior to initiating long-term opioid therapy.[68] VHA recommends evaluating patients receiving continued opioid therapy for improvement of pain and opioid-related adverse events at least every three months and more frequently as doses increase.[69]

The OIG reviewers assessed staff's provision of pain management using long-term opioid therapy:

- Completion of initial screening for pain
- Assessment of aberrant behavior risk
- Avoidance of concurrent therapy with benzodiazepines

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[62] World Health Organization. "Information sheet on opioid overdose," August 2018. https://www.who.int/substance_abuse/information-sheet/en/. (This website was accessed on November 6, 2019.)

[63] Centers for Disease Control and Prevention. "Opioid Overdose, Understanding the Epidemic," December 19, 2018. https://www.cdc.gov/drugoverdose/epidemic. (The website was accessed on November 6, 2019.)

[64] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*, Version 3.0. February 2017. https://www.healthquality.va.gov/guidelines/Pain/cot/. (The website was accessed November 6, 2019.)

[65] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

[66] According to the U.S. Department of Justice's Drug Enforcement Administration, benzodiazepines "are a class of drugs that produce central nervous system (CNS) depression and that are most commonly used to treat insomnia and anxiety." https://www.deadiversion.usdoj.gov/drug_chem_info/benzo.pdf. (The website was accessed December 1, 2019.)

[67] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

[68] VHA Directive 1005, *Informed Consent for Long-Term Opioid Therapy for Pain,* May 13, 2020.

[69] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

- Completion of urine drug testing with intervention, when indicated
- Documentation of informed consent
- Timely follow-up with patients included required elements

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures include, but are not limited to, adherence to published clinical practice guidelines, timeliness of treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment, patient satisfaction, and quality of life.[70] The OIG examined the following indicators for program oversight and evaluation:

- Performance of pain management committee activities
- Monitoring of quality measures
- Following the quality improvement process

The OIG interviewed key employees and managers and reviewed relevant documents and the electronic health records of 28 selected outpatients who had newly-dispensed (no VA dispensing in previous six months) long-term opioids for pain, daily or intermittently for 90 or more calendar days through VA from July 1, 2018, through June 30, 2019. The team considered whether providers acted in accordance with guidelines for the provision of pain management and the medical center's oversight process for evaluating pain management outcomes and quality.

Medication Management Findings and Recommendations

The OIG found the medical center addressed the requirement for establishing a pain management committee. However, the OIG found deficiencies with pain management using long-term opioid therapy and quality measure oversight.

VA/DoD clinical practice guidelines recommend that clinicians complete a behavior risk assessment that includes a history of substance abuse psychological factors, and aberrant drug-related behaviors prior to initiating opioid therapy.[71] The OIG determined that providers completed the behavior risk assessment for only seven percent of the patients at the medical center, based on electronic health records reviewed.[72] The lack of consistent evaluation may have

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[70] VHA Directive 2009-053, *Pain Management*, October 28, 2009.

[71] *According to the Pain Management, Opioid Safety, VA Educational Guide (2014)*, July 2014, examples of aberrant drug-related behaviors include "lost prescriptions, multiple requests for early refills, unauthorized dose escalation, apparent intoxication, and frequent accidents"; *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

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

resulted in providers prescribing opioids for patients at high risk for misuse.[73] The Chief of Primary Care and the Associate Chief of Pharmacy acknowledged the requirement but reported that they believed substance abuse and psychological screening completed by licensed practical nurses prior to the primary care provider appointment met requirements.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that providers complete a behavior risk assessment that includes a history of substance abuse, psychological factors, and aberrant drug-related behaviors on all patients prior to initiating long-term opioid therapy.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: A Standard of Work document is being defined which will include the requirements for providers to complete a behavior risk assessment prior to initiating long-term opioid therapy that includes a history of substance abuse, psychological factors, and aberrant drug-related behaviors for patients receiving long-term opiate therapy for non-malignant chronic pain. Monitoring of compliance with documentation of a behavior risk assessment prior to initiating long-term opioid therapy that includes a history of substance abuse, psychological factors, and aberrant drug-related behaviors for patients newly initiated on long-term opiate therapy will be reviewed monthly and results reported quarterly to the Executive Committee of the Medical Staff which the Chief of Staff chairs with a target compliance goal of 90 percent for two quarters. Ten, or 100 percent if less than ten, medical records will be reviewed monthly to ensure documentation of a behavior risk assessment that includes a history of substance abuse, psychological factors, and aberrant drug-related behaviors is completed prior to initiating long term-opioid therapy. The number of patients newly initiated on long-term opioid therapy that have documentation of a behavior risk assessment that includes a history of substance abuse, psychological factors, and aberrant drug-related behaviors at the time of initiation of long-term opioid therapy will be the numerator and the number of patients newly initiated on long-term opioid therapy will be the denominator.

VA/DoD clinical practice guidelines recommend avoiding co-administration of a drug such as an opioid and benzodiazepine that could induce fatal drug-drug interactions.[74] The OIG determined that providers documented justification for patients' concurrent opioid and

[73] Edward Michna, Edgar Ross, Wilfred Hynes, Srdjan Nedeljkovic, Sharonah Soumekh, David Janfaza, Diane Palombi, and Robert Jamison, "Predicting Aberrant Drug Behavior in Patients Treated for Chronic Pain: Importance of Abuse History," *Journal of Pain and Symptom Management,* 28, no. 3 (September 2004). https://doi.org/10.1016/j.jpainsymman.2004.04.007. (The website was accessed on December 4, 2019.)

[74] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

benzodiazepine therapy in two of four electronic health records reviewed. This may have resulted in an increased risk of harm and potentially fatal drug interactions.[75] The Associate Chief of Pharmacy stated that the electronic health record alert should have prompted providers to document justification when a patient was concurrently on an opioid and benzodiazepine; however, when either medication was not dispensed by the VA pharmacy or if both medications were ordered at the same time, the alert did not appear. The Associate Chief of Pharmacy did not provide any other reasons for noncompliance.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers document justification for concurrent opioid and benzodiazepine medication therapy.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: A Standard of Work document is being defined which will include the requirements for providers to document justification for patients' concurrent opioid and benzodiazepine medication therapy. Monitoring of compliance with documentation of justification for patients on long-term opiate therapy with concurrent benzodiazepine medication will be reviewed monthly and results reported quarterly to the Executive Committee of the Medical Staff which the Chief of Staff chairs with a target compliance goal of 90 percent for two quarters. Ten, or 100 percent if less than ten, medical records will be reviewed monthly to ensure documentation of justification is completed prior to initiating long term-opioid and concurrent benzodiazepine medication therapy. The number of patients newly initiated on long-term opioid therapy that have a documentation of justification at the time of initiation of concurrent benzodiazepine and long-term opioid therapy will be the numerator and the number of patients newly initiated on long-term opioid therapy with concurrent benzodiazepine medication will be the denominator.

VA/DoD issued clinical practice guidelines recommending that providers "obtain UDT [urine drug test] prior to initiating or when continuing long-term opioid therapy and in the event of a significant change in the patient's condition or periodically thereafter."[76] The OIG determined that providers conducted initial urine drug screening prior to starting their patients on long-term opioid therapy in 82 percent of the electronic health records reviewed.[77] Lack of screening could have resulted in providers' inability to identify patients who had active substance use disorders,

[75] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

[76] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

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

tested positive for illicit substances, or diverted controlled substances.[78] The Associate Chief of Pharmacy and the Chief of Primary Care were unable to provide a reason for noncompliance.

Recommendation 6

6. The Chief of Staff determines the reason for noncompliance and make certain that healthcare providers consistently conduct urine drug testing as required for patients on long-term opioid therapy.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: A Standard of Work document is being defined which will include the requirements for urine drug testing for patients receiving long-term opiate therapy for non-malignant chronic pain. Monitoring of compliance with urine drug testing for patients on long-term opiate therapy will be reviewed monthly and results reported quarterly to the Executive Committee of the Medical Staff which the Chief of Staff chairs with a target compliance goal of 90 percent for two quarters. Utilization of the Opioid Safety Initiative data report will be monitored monthly to ensure we have at least 90 percent compliance with urine drug screen requirements for all patients on long-term opiate therapy. The number of patients on chronic long-term opiate therapy with a urine drug screen will be the numerator and the number of patients on chronic long-term opiate therapy ordered by Veterans Affairs provider will be the denominator.

VHA requires that opioid prescribers obtain and document informed consent prior to initiating long-term opioid therapy. VHA also recommends that informed consent conversations cover the risks and benefits of opioid therapy as well as alternative therapies.[79] The OIG determined that providers documented informed consent prior to initiating long-term opioid therapy in 57 percent of the patients reviewed.[80] Failure to obtain and document informed consent may impede the "safe and effective use of opioid analgesics for the management of pain, particularly [in] complex chronic pain conditions."[81] The Associate Chief of Pharmacy and Chief of Primary Care did not provide a clear reason for noncompliance with informed consent requirements.

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[78] "Predicting Aberrant Drug Behavior in Patients Treated for Chronic Pain: Importance of Abuse History"; *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain.*

[79] VHA Directive 1005.

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

[81] VHA Directive 1005; *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

Recommendation 7

7. The Chief of Staff determines the reasons for noncompliance and makes certain that healthcare providers obtain and document informed consent consistently for patients prior to initiating long-term opioid therapy.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: A Standard of Work document is being defined which will include the requirements for documented informed consent for patients prior to initiating long-term opioid therapy for chronic non-malignant pain. Monitoring of compliance with document informed consent for patients prior to initiating long-term opioid therapy will be reviewed monthly and results reported quarterly to the Executive Committee of the Medical Staff which the Chief of Staff chairs with a target compliance goal of 90 percent for two quarters. Ten, or 100 percent if less than ten, medical records will be reviewed monthly to ensure informed consent is completed prior to initiating chronic long term-opioid therapy. The number of patients newly initiated on long-term opioid therapy that have a document informed consent prior to initiation long-term opioid therapy will be the numerator and the number of patients newly initiated on long-term opioid therapy by Veterans Affairs provider for chronic non-malignant pain will be the denominator.

VA/DoD clinical practice guidelines recommend that providers follow up with patients within three months after initiating long-term opioid therapy and assess adherence and effectiveness of interventions in the pain management plan.[82] The OIG determined that providers completed follow-up within the required time frame in 68 percent of the patient records reviewed.[83] In addition, the OIG identified that follow-up included assessment of adherence to the pain management care plan in 84 percent of records and intervention effectiveness in 79 percent of electronic health records reviewed.[84] This may have resulted in missed opportunities to assess patients' adherence, effectiveness of treatment, and risks associated with continued opioid therapy.[85] The Chief of Primary Care and Associate Chief of Pharmacy stated that follow-up occurred but providers were unaware of the time frame differences between short- and long-term opioid therapy follow-up requirements. For the cases when follow-up lacked the appropriate assessment, the Chief of Primary Care and Associate Chief of Pharmacy reported that providers believed screening completed by licensed practical nurses prior to the provider appointment met requirements.

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[82] VHA Directive 2009-053; *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*

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

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

[85] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*; VHA Directive 2009-053.

Recommendation 8

8. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures providers follow up with patients within the required time frame after initiating long-term opioid therapy.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: A Standard of Work document is being defined which will include the requirements for follow up appointments for patients receiving long-term opiate therapy for chronic non-malignant pain. Monitoring of compliance with follow up appointments for patients on long-term opiate therapy will be reviewed monthly and results reported quarterly to the Executive Committee of the Medical Staff which the Chief of Staff chairs with a target compliance goal of 90 percent for two quarters. Ten, or 100 percent if less than ten, medical records will be reviewed monthly to ensure a timely follow up visit is ordered when initiating chronic long term-opioid therapy. The number of patients on chronic long-term opioid therapy that have a follow up appointment completed will be the numerator and the number of patients newly initiated on long-term opioid therapy will be the denominator.

Recommendation 9

9. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers' follow-up of patients receiving long-term opioid therapy includes an assessment of pain management care plan adherence and intervention effectiveness.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: A Standard of Work document is being defined which will include the requirements for an assessment of pain management care plan adherence and intervention effectiveness for patients receiving long-term opiate therapy for chronic non-malignant pain. The Chief of Staff or designee will ensure monitoring of compliance with an assessment of pain management care plan adherence and intervention effectiveness for patients on long-term opiate therapy with data being compiled monthly and reported to the Executive Committee of the Medical Staff which the Chief of Staff chairs quarterly with a target compliance goal of 90 percent for two quarters. Ten, or 100 percent if less than ten, medical records will be reviewed monthly to ensure an assessment of pain management care plan adherence and intervention effectiveness is completed for patients receiving long term-opioid therapy for chronic non-malignant pain. The number of patients initiated on chronic long-term opioid therapy for non-malignant pain that have an assessment of pain management care plan adherence and intervention effectiveness completed will be the numerator and the number of patients initiated on long-term opioid therapy will be the denominator.

VHA requires the medical center to have a multidisciplinary pain management committee to provide oversight of pain management activities and processes, including monitoring quality of pain assessment and the effectiveness of pain management interventions.[86] TJC also requires the medical center to ensure that deficiencies or opportunities for improvement are identified and action plans are implemented.[87] The OIG reviewed the Pain Management Sub-Committee minutes for April 8, 2019, through September 9, 2019, and found no evidence that the subcommittee monitored the quality of pain assessment and the effectiveness of pain management interventions.[88] This resulted in the subcommittee's inability to report patterns and trends to medical center leaders so that action plans could be developed to improve pain management outcomes.[89] The Associate Chief of Pharmacy reported the committee reviewed multiple aspects of their long-term opioid therapy program but did not monitor pain assessment quality or pain management intervention effectiveness.

Recommendation 10

10. The Interim Medical Center Director determines the reasons for noncompliance and ensures that the Pain Management Sub-Committee monitors the quality of pain assessment and the effectiveness of pain management interventions.

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[86] VHA Directive 2009-053.

[87] TJC. Leadership standards LD.03.02.01, LD.03.05.01; Performance Improvement standard PI.03.01.01.

[88] The Pain Management Sub-Committee recommendations are reviewed and approved by the Clinical Practice Committee.

[89] TJC. Leadership standard LD.03.02.01.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Pain Management Sub-Committee charter has been updated to include the requirement to monitor the quality of pain assessment and the effectiveness of pain management interventions. The Pain Management Sub-Committee will monitor the reduction in pain scores on an alternative pain therapy modality offered by the facility. The Pain Management Sub-Committee meetings will be held every other month. The quality of pain assessment and the effectiveness of pain management data will be reported to Executive Leadership Council which the Medical Center Director chairs at least quarterly until 90 percent or greater compliance is achieved for two quarters. The numerator will be the number of meetings where the Pain Management Sub-Committee includes data regarding evaluation of the quality of pain assessment and effectiveness of pain management interventions and the denominator will be the number of meetings the Pain Management Sub-Committee.

Mental Health: Suicide Prevention Program

In 2017, suicide was the 10th leading cause of death, with approximately 47,000 lives lost across the United States.[90] The suicide rate was 1.5 times greater for veterans than for non-veteran adults and estimated to represent approximately 22 percent of all suicide deaths in the United States.[91] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[92]

VHA has identified suicide prevention as a top priority and implemented various evidence-based approaches to reduce the veteran suicide rate. In addition to expanded mental health services and community outreach, VHA has developed comprehensive screening and assessment processes to identify at-risk patients.[93]

VHA requires that each medical center and very large CBOC have a full-time suicide prevention coordinator (SPC) to track and follow up with high-risk veterans, develop a process for responding to referrals from hotlines such as the Veteran Crisis Line, and conduct community outreach activities.[94] The OIG examined various requirements related to SPCs:

- Assignment of a full-time SPC
- Tracking and follow-up of high-risk veterans
  - Patients' completion of four appointments within the required time frame
  - Safety plan completion within the required time frame
  - Mental health teams' contacts with patients for missed appointments
- Provision of suicide prevention training for nonclinical employees at new employee orientation
- Completion of at least five outreach activities per month

VHA also requires that any patient determined to be at high risk for suicide be added to the facility high-risk list and have a High Risk for Suicide (HRS) Patient Record Flag (PRF) placed

[90] Centers for Disease Control and Prevention. *Preventing Suicide*. https://www.cdc.gov/violenceprevention/suicide/fastfact.html. (The website was accessed on March 4, 2020.)

[91] Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016*, September 2018; Department of Veterans Affairs, *National Strategy for Preventing Veteran Suicide 2018-2028*.

[92] Veterans who recently used VHA services are defined as having an encounter in the calendar year of death or in the previous year; Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016.*

[93] *VA Office of Mental Health and Suicide Prevention Guidebook*, June 2018.

[94] According to VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015, very large CBOCs are those that serve more than 10,000 unique veterans each year. The Veterans Crisis Line connects veterans with qualified responders through a confidential toll-free hotline, online chat, and text-messaging service to receive confidential support 24 hours a day. Community outreach activities are described in VHA Handbook 1160.01.

in his or her electronic health record "as soon as possible but no later than 1 business day after such determination by the SPC."[95] According to VHA, "Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death…The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions."[96] The HRS PRF is reviewed at least every 90 days and depending on changes to the suicide risk status, will remain active or be removed.[97] Additionally, VHA requires designated high-risk patients to have a completed suicide safety plan and four face-to-face visits with an acceptable provider within the first 30 days of designation.[98]

The OIG noted that from July 1, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA required that "Any patient determined to be High Risk for Suicide [by the licensed independent provider] must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination."[99] However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management changed the requirement for the HRS PRF placement to be "as soon as possible but no later than 1 business day after determination by the SPC."[100] VHA further provided additional clarifying information:

- The "SPC exclusively controls the HRS-PRF and must limit their use to patients who meet the criteria of being placed on the facility high-risk suicide list."
- "The time frame of placing the flag begins once the SPC makes the determination that an HRS-PRF is warranted."
- The SPC's determination process "may be beyond 24 hours after a referral, due to case consultation and review."[101]

The OIG is concerned that the updated requirement may result in delayed placement of HRS PRFs for at-risk patients. Without defined time frames for SPC determination that the HRS PRF

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[95] VHA DUSHOM Memorandum, *Update to High Risk for Suicide Patient Record Flag Changes*, January 16, 2020.

[96] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

[97] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care*, Suicide Prevention Coordinator Guide, January 5, 2018; VHA DUSHOM Memorandum, *High Risk for Suicide Patient Record Flag Changes*, October 3, 2017.

[98] A safety plan is a written list of coping strategies and support sources for use during or preceding suicidal crises. Face-to-face visits may be performed as telephone visits if requested by the patient. The requirement for four face-to-face visits within 30 days of designation can be found in *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide*.

[99] VHA DUSHOM Memorandum, *High Risk for Suicide Patient Record Flag Changes*, October 3, 2017.

[100] VHA DUSHOM Memorandum, *Update to High Risk for Suicide Patient Record Flag Changes*, January 16, 2020.

[101] VHA, *Response to Questions by VA OIG Office of Healthcare Inspections from February 12, 2020*, received February 19, 2020.

is warranted, patients identified as at-risk for suicide could have flags placed in his or her chart several days after referral. For example, the current requirement would allow for a patient to be identified as high risk for suicide and referred to the SPC on Monday, the SPC to assess the patient for risk and determine the need for an HRS PRF on the following Friday, and the SPC to place an HRS PRF on the subsequent Monday (a week after referral).

On March 27, 2020, VHA also updated existing policy requirements to allow the review of an HRS PRF to "occur no earlier than 10 days before and no later than 10 days after the 90-day due date."[102]

Inspectors examined the completion of several requirements:

- Review of HRS PRFs within the required time frame
- Completion of at least four mental health visits within 30 days of HRS PRF placement
- Appropriate follow-up for no-show high-risk appointments
- Completion of suicide safety plans with the required elements within the required time frame

All VHA employees must complete suicide risk and intervention training within 90 days of entering their position. Clinical staff (including physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and Vet Center counselors) must complete Suicide Risk Management Training for Clinicians, and nonclinical staff must complete Operation S.A.V.E. training.[103] VHA also requires that all staff receive annual refresher training.[104] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[105]

To determine whether the medical center complied with OIG-selected suicide prevention program requirements, the inspection team interviewed key employees and reviewed

- Relevant documents;

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[102] VHA Notice 2020-13, *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*, March 27, 2020.

[103] Operation S.A.V.E. is a VA gatekeeper training program provided by suicide prevention coordinators to veterans and those who serve veterans. The acronym "S.A.V.E" summarizes the steps needed to take in recognizing and responding to a veteran in suicidal crisis. The training was designed for non-clinical employees and includes food service workers, registration clerks, volunteers, and police. It should also be viewed by ancillary/support staff or any other category not covered by the clinical training.

[104] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017.

[105] The training was designed for nonclinical employees and includes food service workers, registration clerks, volunteers, and police. It should also be viewed by ancillary/support staff or any other category not covered by the clinical training. VHA DUSHOM Memorandum, *Suicide Awareness Training*, April 11, 2017.

- The electronic health records of 45 randomly selected outpatients whose electronic health records were flagged as high risk for suicide from July 1, 2018, to June 30, 2019; and
- Staff training records.

Mental Health Findings and Recommendations

The OIG found the medical center complied with requirements associated with a designated SPC and timely suicide safety plans.

However, the OIG found deficiencies. With VHA's original requirement that was in place when these patients received care—that "Any patient determined to be High Risk for Suicide must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"[106]—the OIG determined that 20 percent of HRS PRFs were placed within one business day of referral to the SPC.[107] Based on the current updated requirement that the SPC be responsible for determining placement of the HRS PRF (without a defined timeframe for doing so), the OIG further calculated that the average time from referral to HRS PRF placement for the patients reviewed was seven days (observed range was 0-30 days).

Further, the OIG noted concerns with reviewing HRS PRFs within the required time frame. VHA required that all patients with an HRS PRF be reevaluated at least every 90 days and there is documented justification for continuing or discontinuing the flag.[108] The OIG estimated that none of the patients with an HRS PRF were reevaluated at least every 90 days.[109] However, based upon the updated requirement that an HRS PRF be reviewed up to 10 days prior to or after the due date for reevaluation, the OIG found that three patients were not reviewed within the expected time frame (observed range was 91–119 days).

Additionally, the OIG noted concerns with the completion of mental health visits within 30 days of HRS PRF placement and suicide prevention training.

VHA requires a veteran to have four follow-up visits with a qualified provider within 30 days of the HRS PRF placement. The follow-up visits must be face-to-face unless the veteran requests a telephonic visit, and there must be documentation identifying the patient's preference for a

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[106] VHA DUSHOM Memorandum, *High Risk for Suicide Patient Record Flag Changes*, October 3, 2017.

[107] The OIG estimated that 95 percent of the time, the true compliance rate is between 8.9 and 32.6 percent, which is statistically significantly below the 90 percent benchmark.

[108] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide*.

[109] The OIG estimated that 95 percent of the time, the true compliance rate is zero percent, which is statistically significantly below the 90 percent benchmark.

telephone call.[110] The OIG estimated that in 69 percent of electronic health records reviewed, patients had four follow-up mental health visits within the required time frame.[111] Failure to complete the follow-up visits is a missed opportunity to "make sure the safety plan is still working for them" and "to assess for suicidality."[112] The Suicide Prevention Coordinator stated that clinical staff conducted telephone visits because in-person appointments were challenging to complete for the patient population. Reported barriers included their rural location, economics of the area, and patients' personal preferences. The SPC and Mental Health Case Manager were also unaware of the requirement to document patients' preferences for a telephone encounter.

Recommendation 11

11. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that clinicians conduct four follow-up appointments, either face-to-face or telephonic with documented consent, within the required time frame.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff and the SPC determined that patient missed appointments was the reason for non-compliance. The Chief of Staff or designee ensures routine review of the High-Risk Flag Dashboard to ensure timely completion of follow up appointments and mental health appointments. The suicide prevention staff will monitor compliance with documented efforts to contact patients flagged as high risk for suicide who miss mental health or substance abuse appointments with a target of 90 percent compliance rate for two quarters. Results will be reported to the Executive Committee of the Medical Staff which the Chief of Staff chairs on a quarterly basis. Ten, or 100 percent if less than ten, medical records will be reviewed monthly to ensure compliance with documented appointment attempts. The numerator will be the number of patients that either had follow visit completed or that have properly documented contact attempt for follow up which meets VHA guidance for suicide who miss mental health or substance abuse appointments and properly document those efforts, and the denominator will be total number of patients flagged as high risk for suicide who are due a mental health or substance abuse appointment.

[110] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care Suicide Prevention Coordinator Guide*.

[111] The OIG estimated that 95 percent of the time, the true compliance rate is between 54.8 and 82.2 percent, which is statistically significantly below the 90 percent benchmark.

[112] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care Suicide Prevention Coordinator Guide*.

VHA requires that all employees complete suicide risk and intervention training within 90 days of entering their position. VHA also requires that all staff, regardless of hire date, complete annual refresher training thereafter.[113] The OIG found that of the 20 staff records reviewed, 4 had no evidence of annual refresher training. Lack of training could prevent staff from providing optimal treatment for patients with suicidal ideations.[114] The Chief of Mental Health stated that each service chief was responsible for monitoring their respective staff's compliance, and the Chief of Quality acknowledged the need to improve in this area.

Recommendation 12

12. The Interim Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain staff receive annual suicide prevention refresher training.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: Suicide prevention training is assigned to each staff member utilizing the Talent Management System (TMS) according to clinical and non-clinical role of their employment. The Medical Center Director or designee ensures that staff have completed the training appropriate to their assigned role. The facility has evaluated the training compliance and the facility currently has a compliance rate of 98.9 percent with the SAVE training including the clinical, non-clinical, and refresher training. The data related to staff training completion will be reviewed by Executive Leadership Board which the Medical Center Director chairs until 90 percent or greater compliance is demonstrated for minimum period of two quarters. Data will include the number of staff with completed training as the numerator and the number of staff required to complete training as the denominator.

[113] VHA Directive 1071.

[114] VHA Directive 1071

Care Coordination: Life-Sustaining Treatment Decisions

Life-sustaining treatments (LSTs) are intended to extend the life of a patient expected to die soon without medical intervention. LSTs may include artificial nutrition, hydration, and mechanical ventilation. VHA issued the Life-Sustaining Treatment Decisions (LSTD) handbook to standardize practices related to discussing and documenting goals of care and LSTD. Per VHA, the goal is to encourage personalized, proactive, patient-driven treatment plans for veterans with serious illness by "…eliciting, documenting, and honoring patients' values, goals, and preferences."[115]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.[116] Implementation requirements included initiating conversations about the goals of care. A goals of care conversation is a discussion between a healthcare provider and a patient or surrogate to help define the patient's values, goals, and preferences for care and, based on the discussion, make choices about starting, limiting, or ceasing LSTs.[117] VHA requires practitioners to initiate goals of care conversations with high-risk patients—including hospice patients or their surrogates—within a time frame that meets the medical needs of the patient or at the time of a triggering event.[118]

The OIG noted that from July 12, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA policy defined the elements of a goals of care conversation to be documented in an LST progress note in the electronic health record, which included

- Decision-making capacity,
- Identification of a surrogate if the patient loses decision-making capacity,
- Patient or surrogate understanding of the patient's condition,
- Goals of care,
- Plan of care for the use of LST, including whether cardiopulmonary resuscitation will be attempted in the event of cardiac arrest, and
- Informed consent for the LST plan.

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[115] VHA Handbook 1004.03(1), *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017, amended March 19, 2020.

[116] According to VHA Handbook 1004.03(1), the medical facility must fully implement handbook requirements within 18 months of publication.

[117] According to VHA Handbook 1004.03(1), a surrogate is legally authorized under VA policy to serve as the decision maker on behalf of the patient should the patient lose decision-making capacity.

[118] VHA Directive 1139, *Palliative Care Consult Teams (PCCT) And VISN Leads*, June 14, 2017, defines hospice patients as individuals diagnosed with a terminal condition with a life expectancy of six months or less if the disease runs its projected course. According to VHA Handbook 1004.03(1), triggering events requiring goals of care conversations include those "prior to referral or following admission (e.g., within 24 hours) to VA or non-VA hospice."

However, on March 19, 2020, VHA amended the requirements related to documenting patients' goals of care. Although the elements of the goals of care conversation are still required, the LST progress note must document at a minimum

- Decision-making capacity,
- Goal(s) of care,
- Plan of care for the use of LST, and
- Informed consent for the LST plan.

The OIG is concerned that VHA's updated requirement could mislead practitioners to only address those goals of care conversation elements that are required to be documented in the LST progress note.

The medical center was assessed for its adherence to requirements for goals of care conversations:

- Completion of LSTD notes
- Timely documentation of LSTD
- Inclusion of required elements in LSTD documentation
- Completion of LSTD note/orders by an authorized provider or delegation to a designee met all requirements

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[119] Inspectors examined if the medical center established an LSTD committee that was comprised of a multidisciplinary membership, which included representation from Ethics Consultation Service, and reviewed proposed LST plans.

To determine whether the medical center complied with the OIG-selected requirements related to LSTD for hospice patients, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 48 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

Care Coordination Findings and Recommendations

Generally, the medical center met the above requirements. The OIG made no recommendations.

[119] VHA Handbook 1004.03(1).

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[120] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans are anticipated to increase.[121] To help the VA better understand the needs of the growing women's veteran population, efforts have been made by VHA to identify and address the urgent needs "by examining health care use, preferences, and the barriers Women Veterans face in access to VA care."[122] Additionally, a VA report in 2016 on suicide among veterans pointed out concerning trends in suicide among women veterans and discussed "the importance of understanding suicide risk among women veterans and developing gender-tailored suicide prevention strategies."[123]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment. Facilities must, therefore, ensure availability of appropriate resources, services, and staffing ratios.[124] VHA also requires delivery of quality care to all women veterans accessing VA emergency services. In addition, VHA requires facilities to establish a multidisciplinary women veteran health committee "that develops and implements a Women's Health Program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans."[125]

To determine whether the medical center complied with OIG-selected VHA requirements to provide comprehensive healthcare services to women veterans, the inspection team reviewed relevant documents and interviewed selected managers and staff on the following requirements:

- Provision of care requirements

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[120] National Center for Veterans Analysis and Statistics, "VETPOP2016 LIVING VETERANS BY AGE GROUP, GENDER, 2015-2045," Table 1L. https://www.va.gov/vetdata/Veteran_Population.asp. (The website was accessed on November 14, 2019.)

[121] National Center for Veterans Analysis and Statistics, "Veteran Population," May 3, 2019. https://www.va.gov/vetdata/docs/Demographics/VetPop_Infographic_2019.pdf. (The website was accessed on September 16, 2019.)

[122] U.S. Department of Veterans Affairs, "Study of Barriers for Women Veterans to VA Health Care," Final Report, April 2015. https://www.womenshealth.va.gov/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf. (The website was accessed on September 16, 2019.)

[123] U.S. Department of Veterans Affairs, Health Services Research & Development, Forum, *Concerning Trends in Suicide Among Women Veterans Point to Need for More Research on Tailored Interventions*, Suicide Prevention, Spring 2018. https://www.hsrd.research.va.gov/publications/forum/spring18/default.cfm?ForumMenu=Spring18-5. (The website was accessed on September 16, 2019.)

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

[125] VHA Directive 1330.01(2).

  - Designated Women's Health Patient Aligned Care Team established
  - Primary Care Mental Health Integration services available
  - Gynecologic care coverage available 24/7
  - Gynecology care accessible
  - Facility women health primary care providers designated
  - CBOC women's health primary care providers designated
  - Emergency contraception accessible
- Oversight of program and monitoring of performance improvement data
  - Women Veterans Health Committee established
    - Quarterly meetings held
    - Core members attend
    - Quality assurance data collected and tracked
    - Reports made to clinical executive leaders
- Assignment of required staffing
  - Women Veterans Program Manager
  - Women's Health Medical Director or clinical champion
  - Maternity Care Coordinator
  - Women's health clinical liaison is assigned at each CBOC

Women's Health Findings and Recommendations

The medical center complied with requirements for most of the provision of care indicators and some of the staffing elements reviewed. However, the OIG identified weaknesses with CBOC-designated women's health primary care providers and the Women Veterans Health Committee.

Specifically, VHA requires that each CBOC have at least two designated women's health primary care providers (WH-PCPs) or ensures arrangements for leave coverage are in place when CBOCs have only one designated WH-PCP.[126] The OIG identified two CBOCs (Salem and Pocahontas) that did not have designated WH-PCPs. Four additional CBOCs (West Plains, Paragould, Farmington, and Sikeston) lacked appropriate arrangements for coverage when the sole designated WH-PCP was on leave. Lack of WH-PCPs at CBOCs may prevent continuity of comprehensive gender-specific care. The Women Veterans Program Manager reported that a

[126] VHA Directive 1330.01(2).

provider vacancy and one provider's lack of required training prevented appropriate arrangements for coverage.

Recommendation 13

13. The Interim Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that each community-based outpatient clinic has at least two designated women's health primary care providers or arrangements for leave coverage when CBOCs have only one designated provider.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Women's Health Program Manager has developed a coverage plan contingency plan for staffing in the case of scheduled absences to ensure equity of access to care for each Community Outpatient Based Clinic location which includes coverage and a backup women's health primary care provider for each location. The Medical Center Director or designated staff will review the coverage plan with report to the Women's Health Committee until 90 percent or greater compliance is demonstrated for two quarters. The numerator will be the number of Community Outpatient Based Clinic locations with a women's health provider and back up assigned and the denominator will the number of Community Outpatient Based Clinic locations operating within the medical center.

VHA requires that the Women Veterans Health Committee meet quarterly, report to executive leaders, and include all required members. That membership includes a women veterans program manager; women's health medical director; and "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership."[127]

The OIG team reviewed the Women Veterans Health Committee charter and meeting minutes from April 24, 2019 through August 28, 2019, and noted the committee lacked consistent core membership representation from Primary Care, Medical and/or Surgical Subspecialties, Pharmacy, Social Work, Nursing, Urgent Care, Radiology, Laboratory, Business Office, Quality Management, and Executive Leadership. Furthermore, the committee charter did not include all core representatives, was not signed by the Interim Medical Center Director, and was still under review at the time of the OIG site visit. This resulted in a lack of expertise and oversight in the review and analysis of data, as the committee planned and carried out improvements for quality and equitable care for women veterans.[128] The Women Veterans Program Manager acknowledged the requirements and stated the following factors contributed to noncompliance:

[127] VHA Directive 1330.01(2).

[128] VHA Directive 1330.01(2).

staff vacancies of core members, a cultural belief within the medical center that the committee should be solely comprised of women, inability to hold assigned disciplines accountable for poor attendance, and lack of participation by executive leaders.

Recommendation 14

14. The Interim Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that the Women Veterans Health Committee is comprised of the required core members.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Women Veterans Health Committee charter and attendance tracker has been updated to identify all required representatives. Starting June 2020, a monthly attendance sign-in sheet will be used to document attendance. The Women Veterans Program Manager will track attendance rates until a target compliance of 90 percent is achieved for the required members. The Women Veteran Program Manager will monitor committee attendance monthly for two quarters to ensure sustainment and report results to the Medical Executive Committee which the Chief of Staff chairs quarterly. The numerator will be the number of meetings where required members (or alternates) attended and the denominator will be total number of meetings held.

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have a Sterile Processing Services (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment…"[129] The goal of SPS is to "...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[130] To ensure this, VHA requires facilities to conduct the following activities:

- Maintain a current inventory list of all RME
- Have standard operating procedures (SOPs) that are based on current manufacturer's guidelines and reviewed at least triennially
- Use CensiTrac® Instrument Tracking System for tracking reprocessed instruments[131]
- Perform annual risk analysis and report results to the VISN SPS Management Board
- Monitor data for reprocessing and storing RME
- Conduct annual airflow/ventilation system inspections[132]

VHA requires strict controls that closely monitor climate, storage, and sterilization parameters and additionally requires that quality assurance documentation of this monitoring be maintained for a minimum of three years.[133] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[134]

In addition, RME reprocessing areas must be clean, restricted, and airflow-controlled. All areas where RME reprocessing occurs must have safety data sheets, an unobstructed eyewash station,

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[129] VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.

[130] Association for Professionals in Infection Control and Epidemiology, *APIC Text of Infection Control and Epidemiology,* Chapter 107: Sterile Processing, April 26, 2019. https://text.apic.org/toc/infection-prevention-for-support-services-and-the-care-environment/sterile-processing#book_section_17348. (The website was accessed on May 14, 2019.)

[131] VHA DUSHOM Memorandum, *Instrument Tracking Systems for Sterile Processing Services*, January 1, 2019.

[132] VHA Directive 1116(2).

[133] VHA Directive 1116(2); VHA DUSHOM Memorandum*, Interim Guidance for Heating, Ventilation and Air Conditioning (HVAC) Requirements Related to Reusable Medical Equipment (RME) Reprocessing and Storage*, September 5, 2017.

[134] VHA Directive 7704(1), *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, February 16, 2016.

personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[135]

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued annual and essential staff competency assessments, and monthly continuing education. This ensures that staff have sufficient aptitude, knowledge, and skills to effectively and safely reprocess and sterilize RME.[136]

To determine whether the medical center complied with OIG-selected requirements, the inspection team examined relevant documents and training records; conducted physical inspections of the SPS, Gastroenterology SPS, and sterile storage areas; and interviewed key managers and staff on the following:

- Requirements for administrative processes
  - RME inventory file is current
  - SOPs are based on current manufacturer's guidelines and reviewed at least triennially
  - CensiTrac® System used
  - Risk analysis performed and results reported to the VISN SPS Management Board
  - Airflow checks made
  - Eyewash station checked
  - Daily cleaning schedule maintained
- Monitoring of quality assurance
  - High-level disinfectant solution tested
  - Bioburden tested
- Physical inspections of reprocessing and storage areas
  - Traffic restricted
  - Airflow monitored
  - Personal protective equipment available
  - Area is clean
  - Eating or drinking in the area prohibited

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[135] VHA Directive 1116(2).
[136] VHA Directive 1116(2).

  - Equipment properly stored
  - Required temperature and humidity maintained
- Completion of staff training, competency, and continuing education
  - Required training completed in a timely manner
  - Competency assessments performed
  - Monthly continuing education received

High-Risk Processes Findings and Recommendations

The medical center complied with most elements of expected performance for reprocessing reusable medical equipment. However, the OIG identified deficiencies with SOPs, the annual risk analysis, and competency assessments.

As previously mentioned, VHA requires that facilities "must have standard operating procedures (SOPs) based on manufacturer's guidelines that establishes a documented and systematic approach to critical and semi-critical RME processes."[137] VHA also requires that "all SOPs are kept up-to-date, reviewed at least every 3 years and updated when there is a change in process or a change in manufacturer's IFU [instructions for use]."[138] The OIG found that the SOP for a particular colonoscope did not align with the manufacturer's instructions for use. Failure to follow the manufacturer's instructions could result in inadequate reprocessing, damage to the scope, and significant patient safety risks.[139] The Chief of SPS, who was new to the position, was unaware of the discrepancy and unable to provide a reason for noncompliance but believed two different SOPs may have been merged into one to reduce redundancy.

Recommendation 15

15. The Associate Director for Patient Care Services determines the reasons for noncompliance and makes certain that standard operating procedures align with manufacturers' guidelines and instructions for use.

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[137] VHA Directive 1116(2).

[138] VHA Directive 1116(2).

[139] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: September 30, 2020

Medical center response: The standard operating procedure has been revised with validation of education and competencies for 100 percent (6/6) of sterile processing staff on December 2, 2019. Competency is validated annually for all sterile processing staff that reprocess gastrointestinal scopes. The competency log is reviewed on a monthly basis in the Reusable Medical Equipment Committee of which the Associate Director of Patient Care Services is a member. The Associate Director of Patient Care Services will ensure compliance through verification of documentation that the competency review log is reviewed. The number of months of competency log review completion will be the numerator and the denominator will be the number of competency logs reviews anticipated. Review of the Reusable Medical Equipment Committee Minutes for six months (December 1, 2019 through May 30, 2020) demonstrated facility 100 percent compliance with the review of critical and semi-critical standard operating procedures and competency compliance review.

VHA requires the Chief of SPS to perform an annual risk analysis and report the results to the VISN SPS Management Board.[140] The OIG found that an annual risk analysis was performed; however, the medical center lacked evidence that the results were reported to the VISN SPS Management Board. This may have impeded the identification of potential process failures and the medical center's preparedness for managing those risks.[141] The Chief of SPS reported the risk analysis was sent to the VISN SPS Management Board but due to a change in VISN leadership, could not provide evidence of the submission.

Recommendation 16

16. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that the Chief of Sterile Processing Services reports the annual risk analysis results to the Veterans Integrated Service Network Sterile Processing Services Management Board.

[140] VHA Directive 1116(2).

[141] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: September 30, 2020

Medical center response: The Associate Director for Patient Care Services or designee recognized that change in staffing including at the VISN may have contributed to the lack of documentation of the review of the risk assessment by the VISN Sterile Processing Services (SPS) Management Board. A facility Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis related to sterile processing was completed in February 2020. The SWOT analysis was submitted to the VISN Sterile Processing Service Management Board for their review at the March 2020 meeting.

VHA requires that competencies for RME staff are completed prior to performing reprocessing duties.[142] The OIG found that all six selected SPS staff had a competency assessment for reprocessing a colonoscope. However, the colonoscope SOP did not align with manufacturer's IFU; therefore, the competency was invalid. This could result in improper cleaning of the RME and compromise patient safety. The Chief of SPS, who was new to the position, was unaware of the SOP discrepancy.

Recommendation 17

17. The Associate Director for Patient Care Services determines the reasons for noncompliance and ensures that Sterile Processing Services staff properly complete competency assessments for reprocessing reusable medical equipment.

Medical center concurred.

Target date for completion: September 30, 2020

Medical center response: The standard operating procedure has been revised with validation of education and competencies for 100 percent (6/6) of sterile processing staff on December 2, 2019. Competency is validated annually for all sterile processing staff that reprocess gastrointestinal scopes. The competency log is reviewed on a monthly basis in the Reusable Medical Equipment Committee of which the Associate Director of Patient Care Services is a member. The Associate Director of Patient Care Services will ensure compliance through verification of documentation that the competency review log is reviewed. The number of months of competency log review completion will be the numerator and the denominator will be the number of competency logs reviews anticipated. Review of the Reusable Medical Equipment Committee Minutes for six months (December 1, 2019 through May 30, 2020) demonstrated facility compliance with the review of critical and semi-critical standard operating procedures and competency compliance review. The cumulative compliance rate is 100 percent.

[142] VHA Directive 1116(2).

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

The intent is for system 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	Requirements	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Factors related to possible lapses in care and medical center response • VHA performance data (facility or system) • VHA performance data for CLCs	Seventeen OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the Interim Medical Center Director, Chief of Staff, and ADPCS. See details below.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• None	• All required representatives participate in interdisciplinary UM data reviews.
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• None	• FPPE criteria are defined and documented in advance in provider profiles. • Provider exit review forms are completed within the required time frame.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	• Medical center ○ General safety ○ Special use spaces ○ Environmental cleanliness and infection prevention ○ Privacy ○ Accommodation and privacy for women veterans ○ Logistics • Inpatient mental health unit ○ General safety ○ Special use spaces ○ Environmental cleanliness and infection prevention ○ Privacy ○ Accommodation for women veterans ○ Logistics • Community-based outpatient clinic ○ General safety ○ Special use spaces ○ Environmental cleanliness and infection prevention ○ Privacy ○ Privacy for women veterans ○ Logistics	• None	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• Providers complete behavior risk assessments prior to initiating long-term opioid therapy. • Providers document justification for prescribing opioids and benzodiazepines concurrently. • Providers conduct urine drug testing within the required time frame for patients on long-term opioid therapy. • Providers obtain and document informed consent for patients prior to initiating long-term opioid therapy. • Providers follow up with patients within the required time frame after initiating long-term opioid therapy. • Provider follow-up includes assessment of adherence to care plan and intervention effectiveness.	• The Pain Management Sub-Committee monitors quality of pain assessment and the effectiveness of pain management interventions.
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements	• Clinicians conduct four follow-up appointments within the required time frame.	• Staff complete mandatory annual suicide prevention refresher training.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• None	• None
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• None	• CBOCs have at least two designated WH-PCPs or arrangements for leave coverage. • The Women Veterans Health Committee is comprised of the required core members.
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Data monitoring • Physical inspection • Staff training	• None	• SPS SOPs align with manufacturers' guidelines and instructions for use. • The SPS Chief reports the annual risk analysis to the VISN SPS Management Board. • SPS staff properly complete competency assessments.

Appendix B: Medical Center Profile

The table below provides general background information for this low complexity (3) medical center reporting to VISN 15.[1]

Table B.1. Profile for the John J. Pershing VA Medical Center (657/A4) (October 1, 2016, through September 30, 2019)

Profile Element	Medical Center Data FY 2017[2]	Medical Center Data FY 2018[3]	Medical Center Data FY 2019[4]
Total medical care budget	$125,688,427	$143,821,721	$158,345,493
Number of:			
• Unique patients	21,626	21,993	22,133
• Outpatient visits	224,215	224,941	228,622
• Unique employees[5]	436	487	554
Type and number of operating beds:			
• Community living center	40	40	40
• Domiciliary	—	12	12
• Medicine	13	10	10
Average daily census:			
• Community living center	25	28	24
• Medicine	4	3	3

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.

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

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

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

[4] October 1, 2018, through September 30, 2019.

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

Appendix C: VA Outpatient Clinic Profiles[1]

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

Table C.1. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2018, through September 30, 2019)[2]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
West Plains, MO	657GF	8,440	2,662	Dermatology Endocrinology Eye Hematology/ Oncology Poly-trauma	Radiology	Nutrition Pharmacy Social work Weight management
Paragould, AR	657GG	4,770	2,302	Dermatology Endocrinology Eye	n/a	Nutrition Pharmacy Weight management

[1] Includes all outpatient clinics in the community that were in operation as of August 27, 2019.

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

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

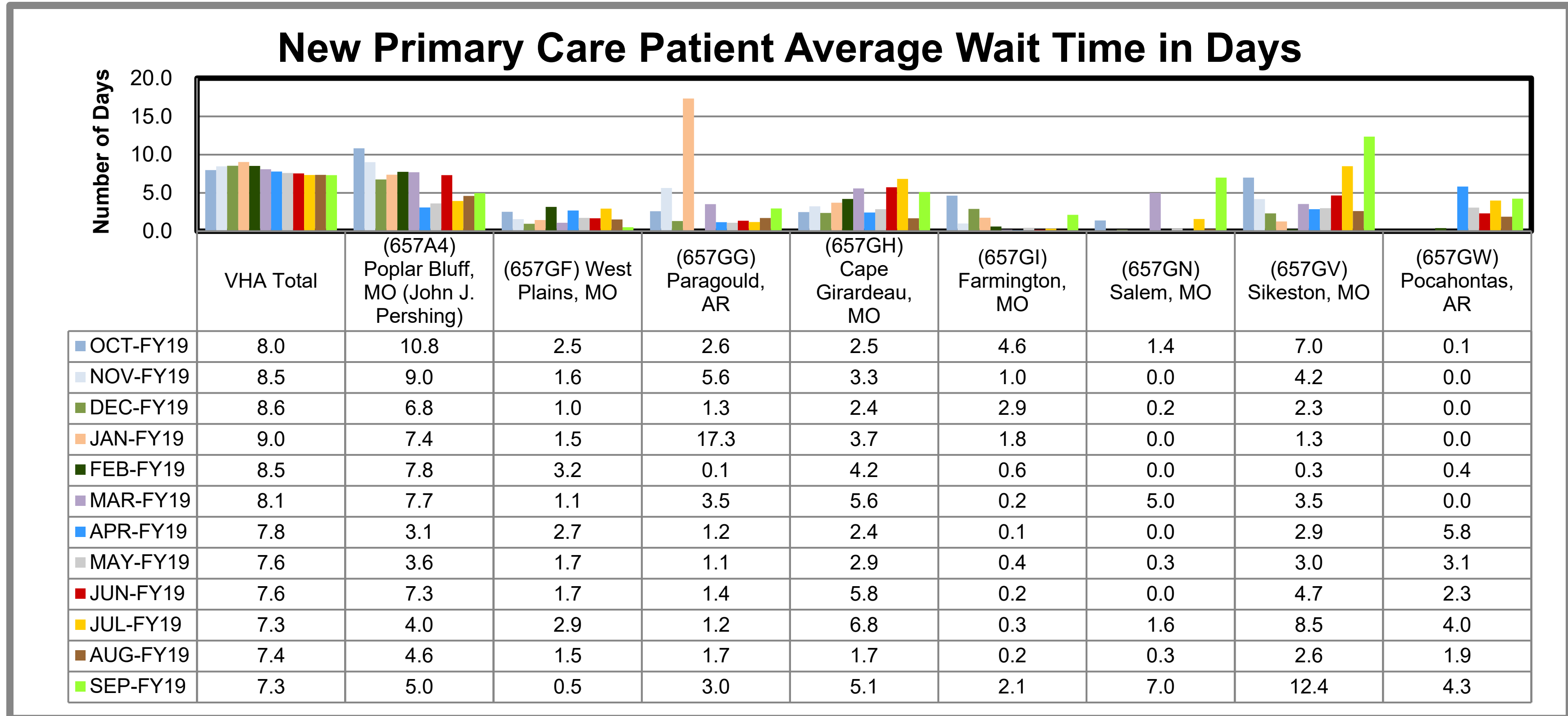
[4] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

[5] 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[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Cape Girardeau, MO	657GH	8,307	7,050	Dermatology Endocrinology Eye	n/a	Nutrition Pharmacy Weight management
Farmington, MO	657GI	8,431	4,307	Dermatology Endocrinology Eye	n/a	Nutrition Pharmacy Weight management
Salem, MO	657GN	798	n/a	n/a	n/a	Nutrition Weight management
Sikeston, MO	657GV	3,997	1,443	Dermatology Endocrinology Eye	n/a	Nutrition Weight management
Pocahontas, AR	657GW	1,999	320	n/a	n/a	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

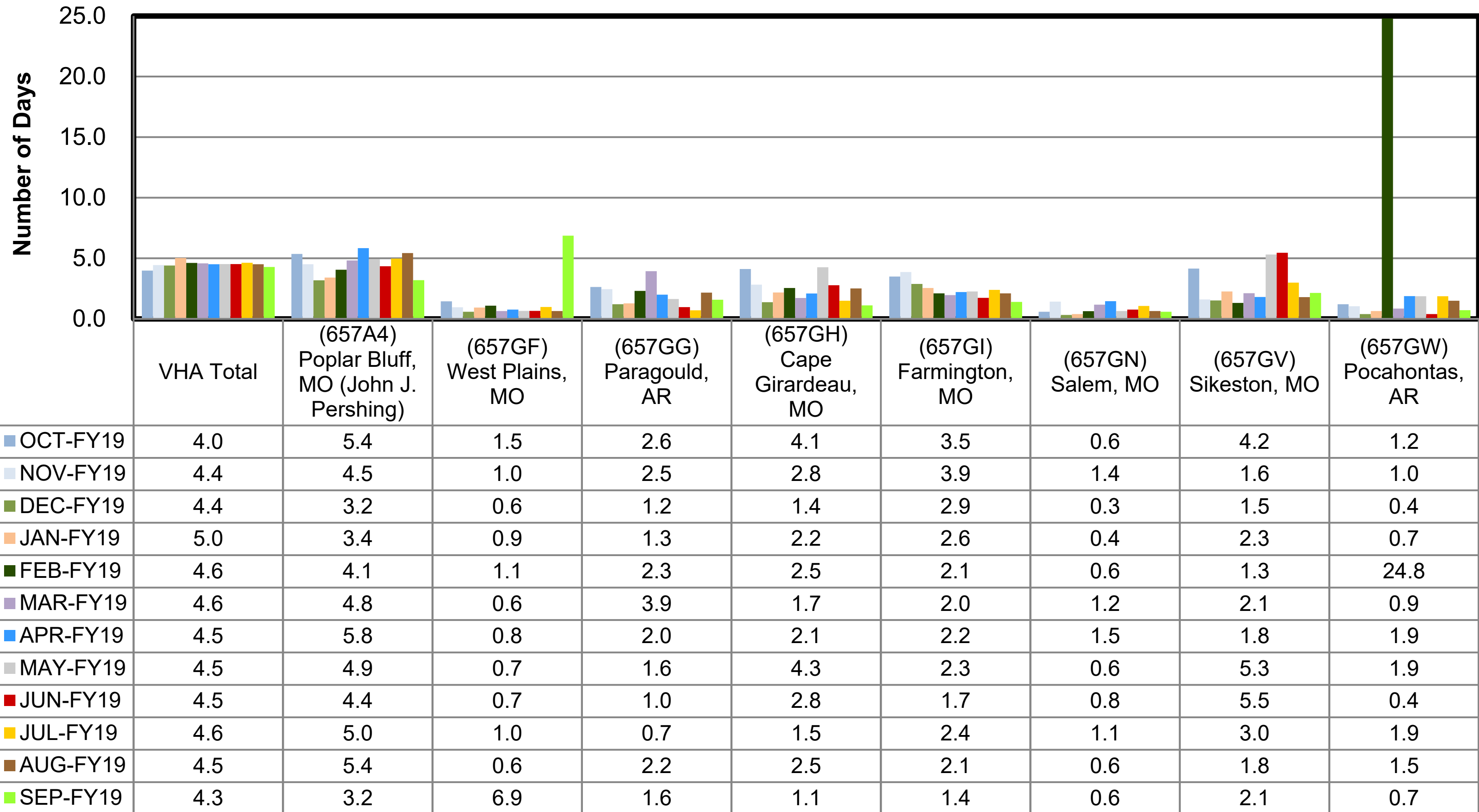
Appendix D: Patient Aligned Care Team Compass Metrics[1]



	VHA Total	(657A4) Poplar Bluff, MO (John J. Pershing)	(657GF) West Plains, MO	(657GG) Paragould, AR	(657GH) Cape Girardeau, MO	(657GI) Farmington, MO	(657GN) Salem, MO	(657GV) Sikeston, MO	(657GW) Pocahontas, AR
OCT-FY19	8.0	10.8	2.5	2.6	2.5	4.6	1.4	7.0	0.1
NOV-FY19	8.5	9.0	1.6	5.6	3.3	1.0	0.0	4.2	0.0
DEC-FY19	8.6	6.8	1.0	1.3	2.4	2.9	0.2	2.3	0.0
JAN-FY19	9.0	7.4	1.5	17.3	3.7	1.8	0.0	1.3	0.0
FEB-FY19	8.5	7.8	3.2	0.1	4.2	0.6	0.0	0.3	0.4
MAR-FY19	8.1	7.7	1.1	3.5	5.6	0.2	5.0	3.5	0.0
APR-FY19	7.8	3.1	2.7	1.2	2.4	0.1	0.0	2.9	5.8
MAY-FY19	7.6	3.6	1.7	1.1	2.9	0.4	0.3	3.0	3.1
JUN-FY19	7.6	7.3	1.7	1.4	5.8	0.2	0.0	4.7	2.3
JUL-FY19	7.3	4.0	2.9	1.2	6.8	0.3	1.6	8.5	4.0
AUG-FY19	7.4	4.6	1.5	1.7	1.7	0.2	0.3	2.6	1.9
SEP-FY19	7.3	5.0	0.5	3.0	5.1	2.1	7.0	12.4	4.3

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

[1] Department of Veterans Affairs, *Patient Aligned Care Teams Compass Data Definitions*, accessed October 21, 2019.



	VHA Total	(657A4) Poplar Bluff, MO (John J. Pershing)	(657GF) West Plains, MO	(657GG) Paragould, AR	(657GH) Cape Girardeau, MO	(657GI) Farmington, MO	(657GN) Salem, MO	(657GV) Sikeston, MO	(657GW) Pocahontas, AR
OCT-FY19	4.0	5.4	1.5	2.6	4.1	3.5	0.6	4.2	1.2
NOV-FY19	4.4	4.5	1.0	2.5	2.8	3.9	1.4	1.6	1.0
DEC-FY19	4.4	3.2	0.6	1.2	1.4	2.9	0.3	1.5	0.4
JAN-FY19	5.0	3.4	0.9	1.3	2.2	2.6	0.4	2.3	0.7
FEB-FY19	4.6	4.1	1.1	2.3	2.5	2.1	0.6	1.3	24.8
MAR-FY19	4.6	4.8	0.6	3.9	1.7	2.0	1.2	2.1	0.9
APR-FY19	4.5	5.8	0.8	2.0	2.1	2.2	1.5	1.8	1.9
MAY-FY19	4.5	4.9	0.7	1.6	4.3	2.3	0.6	5.3	1.9
JUN-FY19	4.5	4.4	0.7	1.0	2.8	1.7	0.8	5.5	0.4
JUL-FY19	4.6	5.0	1.0	0.7	1.5	2.4	1.1	3.0	1.9
AUG-FY19	4.5	5.4	0.6	2.2	2.5	2.1	0.6	1.8	1.5
SEP-FY19	4.3	3.2	6.9	1.6	1.1	1.4	0.6	2.1	0.7

Source: VHA Support Service Center

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

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

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[1]

Measure	Definition	Desired Direction
ACSC hospitalization	Ambulatory care sensitive conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit reviews met	Percent acute admission reviews that meet interqual criteria	A higher value is better than a lower value
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
Cont stay reviews met	Percent acute continued stay reviews that meet interqual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
HC assoc infections	Health care associated infections	A lower value is better than a higher 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 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

[1] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated September 30, 2019). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=9428. (The website was accessed on March 6, 2020, but is not accessible by the public.)

Measure	Definition	Desired Direction
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
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
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
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
SC care coordination	SC (specialty care) care coordination	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
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
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

Appendix F: Community Living Center (CLC) Strategic Analytics for Improvement and Learning (SAIL) Measure Definitions[1]

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.

[1] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated December 12, 2019). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on January 13, 2020, but is not accessible by the public.)

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 8, 2020

From: Director, VA Heartland Network (10N15)

Subj: Comprehensive Healthcare Inspection of the John J. Pershing VA Medical Center in Poplar Bluff, Missouri

To: Director, Office of Healthcare Inspections (54CH02)

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

Attached is the facilities response to the Comprehensive Healthcare Inspection of the John J. Pershing VA Medical Center, Poplar Bluff, Missouri draft report.

I have reviewed and concur with the facility's response to the findings, recommendations, and submitted action plans.

(Original signed by:)

William P. Patterson
Network Director
VA Heartland Network (VISN15)

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: June 3, 2020

From: Director, John J. Pershing VA Medical Center (657/A4)

Subj: Comprehensive Healthcare Inspection of the John J. Pershing VA Medical Center in Poplar Bluff, Missouri

To: Director, VA Heartland Network (10N15)

1. Thank you for the opportunity to review the VA Office of Inspector General's Comprehensive Healthcare Inspection Program report of the John J. Pershing Veterans Affairs Medical Center. I concur with the assessment and findings and appreciate the review team's thoroughness and dedication to quality improvement across the VA.
2. A corrective action plan remedying identified deficiencies is provided. The John J. Pershing Veterans Affairs Medical Center will continue to monitor performance to ensure all recommendations are addressed and action plans successfully implemented.

(Original signed by:)

Paul Hopkins, MBA
Interim Medical Center Director

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