DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan

CHIP REPORT | REPORT #20-00067-172 | JULY 1, 2020

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Figure 1. *Oscar G. Johnson VA Medical Center in Iron Mountain, MI (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 Oscar G. Johnson VA Medical Center and multiple outpatient clinics in Michigan and Wisconsin. 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 January 13, 2020, at the Oscar G. Johnson VA Medical Center and Rhinelander 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 Medical Center Director, acting 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 Council overseeing several working groups. The leaders monitor patient safety and care through the Quality Board, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the medical center's executive leadership team included four positions with one permanently filled less than four months, and the chief of staff position had been vacant for three months. Three staff members served as the acting chief of staff during the months preceding the OIG inspection. The Medical Center Director and the ADPCS had worked together at the medical center since 2011.

The OIG noted that selected survey scores related to employees' satisfaction with the medical center's executive leaders were generally better than VHA averages. The scores for the Medical Center Director and ADPCS were markedly higher than VHA averages. Patients appeared generally satisfied with the care provided.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[1]

The VA Office of Operational Analytics and Reporting adapted 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. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[2]

The executive leaders were extremely knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to specific poorly performing SAIL measures. In individual interviews, the executive leadership team members 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.

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[1] 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."

[2] 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.)

The OIG noted areas for improvement in four clinical areas reviewed and issued 11 recommendations that are directed to the Chief of Staff and ADPCS. These are briefly described below.

Medical Staff Privileging

The medical center had processes in place related to provider exit reviews. However, the OIG identified deficiencies with focused and ongoing professional practice evaluation processes.[3]

Medication Management

The OIG observed compliance with several indicators of expected performance, including clinicians conducting pain screening and documenting justification for concurrent therapy with benzodiazepines. However, the OIG found deficiencies with behavior risk assessment, urine drug testing, informed consent, patient follow-up after therapy initiation; and Pain Committee monitoring of quality measures.

Women's Health

The OIG found compliance with many of the requirements for women's health, including care provision, program oversight and performance improvement data monitoring, and most of the reviewed staffing elements. The OIG noted a concern with the Women Veterans Program Manager's collateral duties.

High-Risk Processes

The medical center generally complied with the requirements for quality assurance monitoring and reprocessing and storage area physical inspections. However, the OIG identified deficiencies with administrative processes specific to VISN Sterile Processing Service Board reporting and staff training, competency, and ongoing education.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued 11 recommendations for improvement to the Chief of Staff and ADPCS. The number of recommendations should not be used, however, as a gauge for the

[3] 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."

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 not addressed, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 67–68, and the responses within the body of the report for the full text of the Directors' comments.) The OIG considers recommendations 8 and 9 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

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 Oscar G. Johnson 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]

[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.

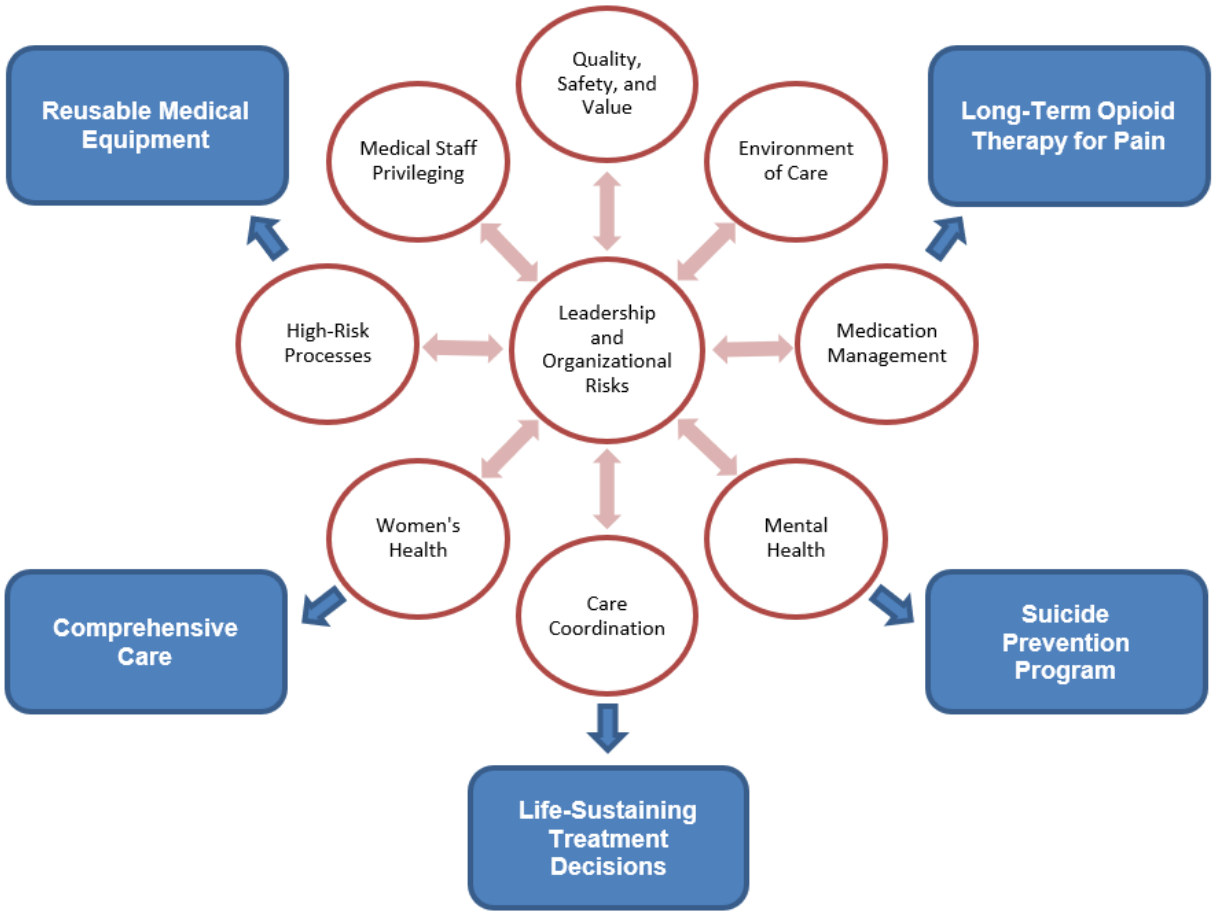

Figure 2. *Fiscal Year (FY) 2020 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

Methodology

The Oscar G. Johnson VA Medical Center includes multiple outpatient clinics in Michigan and Wisconsin. 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 areas of the medical center at the Oscar G. Johnson VA Medical Center and the Rhinelander VA Clinic:

- Oscar G. Johnson VA Medical Center
  - Community Living Center (CLC)[5]
  - Dental clinic
  - Medical/surgical inpatient unit
  - Outpatient clinic
  - Post-anesthesia care unit
  - Sterile Processing Services areas
  - Urgent Care Center

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

The inspection period examined operations from November 10, 2018, through January 16, 2020, 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

[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 January 2020.

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 Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that the medical center 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 had a leadership team consisting of the Director, acting 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.)

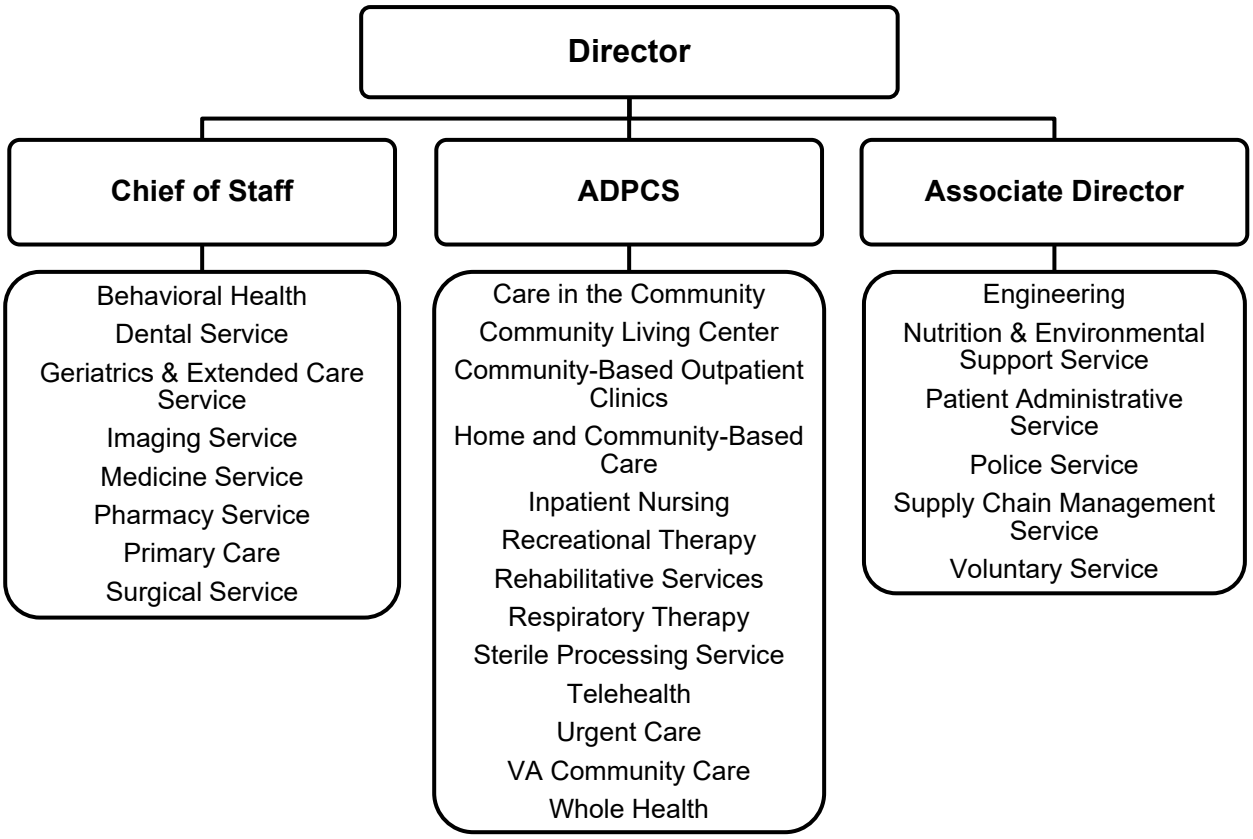

Figure 3. *Medical Center Organizational Chart*
Source: Oscar G. Johnson VA Medical Center (received January 13, 2020)

At the time of the OIG site visit, the medical center's executive leadership team included four positions with one permanently filled in September 2019; the chief of staff position had been vacant since October 2019. Three staff members served as the acting chief of staff during the months preceding the OIG inspection. Interviews for the chief of staff position were scheduled to begin two weeks after the OIG site visit. The Director and ADPCS had worked together at the medical center since 2011 (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	April 10, 2011
Chief of Staff	October 13, 2019 (acting)
Associate Director for Patient Care Services	May 27, 2007
Associate Director	September 3, 2019

Source: Oscar G. Johnson VA Medical Center Human Resources Officer (received January 13, 2020)

To help assess the medical center executive leaders' engagement, the OIG interviewed the Director, ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.[8]

The executive leaders were extremely 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) measures. In individual interviews, the executive leadership team members were able to speak knowledgeably 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 Director serves as the chairperson of the Executive Leadership Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Council oversees the Medical Executive Committee, Administrative Executive Board, Quality Board, and Workforce Development Board.

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

[8] The acting Chief of Staff was on leave during the OIG site visit, and the covering provider was not interviewed.

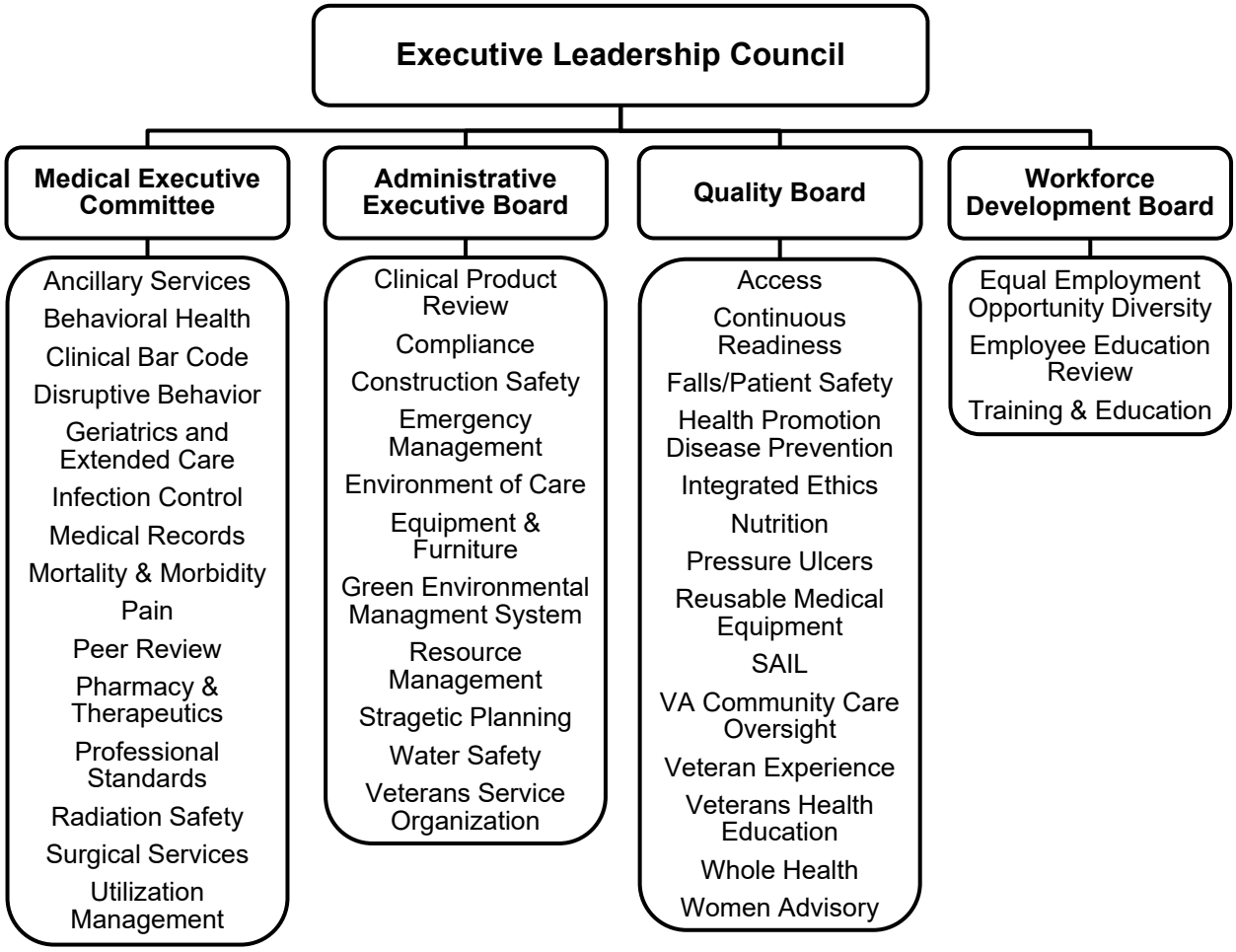

Figure 4. *Medical Center Committee Reporting Structure*
Source: Oscar G. Johnson VA Medical Center (received January 13, 2020)

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 employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2018, through September 30, 2019.[9] Table 2 provides relevant survey results for

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

VHA, the medical center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. Survey results related to employee satisfaction with the medical center executive leaders were generally better than VHA averages.[10] The results for the Director and the ADPCS were markedly higher than the VHA average.[11] The OIG noted that the Director collaborated with a local college to provide leadership development classes and, through quarterly sessions at the medical center, fostered leadership development through book reading sessions for supervisors.

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	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[12]	0–100 where higher scores are more favorable	72.6	78.1	98.0	96.1	91.4	78.8
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	3.6	4.9	4.0	4.6	3.6

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

[11] 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.

[12] 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	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.8	4.9	3.8	4.7	3.5
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.9	4.9	4.1	4.7	3.3

Source: VA All Employee Survey (accessed November 18, 2019, and December 31, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[13] Survey results related to the medical center executive leaders were generally better than VHA averages. Again, the results for the Director and the ADPCS were markedly better than VHA average.

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	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	4.0	5.0	4.4	4.9	4.1

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	4.0	4.9	4.4	4.7	4.3
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	1.1	0.3	1.5	0.7	0.5

Source: VA All Employee Survey (accessed November 18, 2019, and December 31, 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 July 31, 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 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

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

center, the patient survey results reflected higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

Table 4. Survey Results on Patient Experience (October 1, 2018, through July 31, 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	80.4
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	87.8
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	85.8
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	85.3

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 18, 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 experience scores were consistently higher than the corresponding VHA averages for male veterans. For female veterans, the Patient-Centered Medical Home and Specialty Care experience scores were lower than female VHA patients nationally; however, medical center leaders appeared to be actively engaged with male and female patients. For example, the Director, along with the Veteran Experience Officer and the Women Veterans Program Manager, conducts Town Hall Meetings on a regular basis; thirty-nine Town Hall Meetings were held last quarter.

[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 July 31, 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	83.8	85.8	–[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).	84.6	83.4	90.1	–
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).	68.4	62.2	80.7	–

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 18, 2019)

[16] The VHA averages are based on 39,112–39,236 male and 1,858–1,875 female respondents, depending on the question.

[17] The medical center averages are based on 179–185 male respondents, depending on the question.

[18] Data are not available for the low number of female respondents.

Table 6. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2018, through July 31, 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).	50.6	43.1	64.1	30.7
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).	59.7	49.7	71.2	47.9
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).	71.5	65.8	81.3	49.6

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed March 16, 2020)

[19] The VHA averages are based on 66,977–203,592 male and 4,905–10,953 female respondents, depending on the question.

[20] The medical center averages are based on 628–1,792 male and 44–85 female respondents, depending on the question.

Table 7. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2018, through July 31, 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).	48.0	46.0	54.7	–[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	55.4	69.7	–
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).	70.4	70.8	84.0	24.2

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed March 16, 2020)

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 last medical center inspection performed by the OIG.[25] Of note, at the time of the OIG visit, the medical center had closed five of nine recommendations for improvement issued since the previous comprehensive healthcare inspection conducted in November 2018. The Chief

[21] The VHA averages are based on 55,910–175,665 male and 2,905–9,304 female respondents, depending on the question.

[22] The medical center averages are based on 291–941 male and 32 female respondents, depending on the question.

[23] Data are not available for the low number of female respondents.

[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] A Joint Commission survey had not been performed since the previous OIG comprehensive healthcare inspection conducted in November 2018.

of Quality Management reported continuing to work with medical center managers to address the four open recommendations.[26]

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.

Table 8. Office of Inspector General Inspection

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan,* Report No. 18-04669-125, May 28, 2019)	November 2018	9	4[27]

Source: OIG (inspection/survey results verified with the Chief of Quality Management on January 14, 2020)

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. The OIG identified the lack of a permanent chief of staff as a vulnerable area for the medical center.

Table 9 lists the reported patient safety events from November 10, 2018 (the prior OIG comprehensive healthcare inspection), through January 13, 2020.[28]

[26] VA Office of Inspector General, *Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center Iron Mountain, Michigan,* Report No. 18-04669-125, May 28, 2019.

[27] At the time of publication, the medical center had closed eight of nine recommendations for improvement.

[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 Oscar G. Johnson VA Medical Center is a low complexity (3) system as described in Appendix B.)

Table 9. Summary of Selected Organizational Risk Factors (November 10, 2018, through January 13, 2020)

Factor	Number of Occurrences
Sentinel Events[29]	1
Institutional Disclosures[30]	2
Large-Scale Disclosures[31]	0

Source: Oscar G. Johnson VA Medical Center Chief of Quality Management (received January 13, 2020)

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[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 medical center (for example, in the areas of best place to work, care transition, and capacity). Metrics that need improvement are denoted in orange and red (for example, adjusted length of stay (LOS) and ambulatory care sensitive condition (ACSC) hospitalization).[33]

[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.)

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

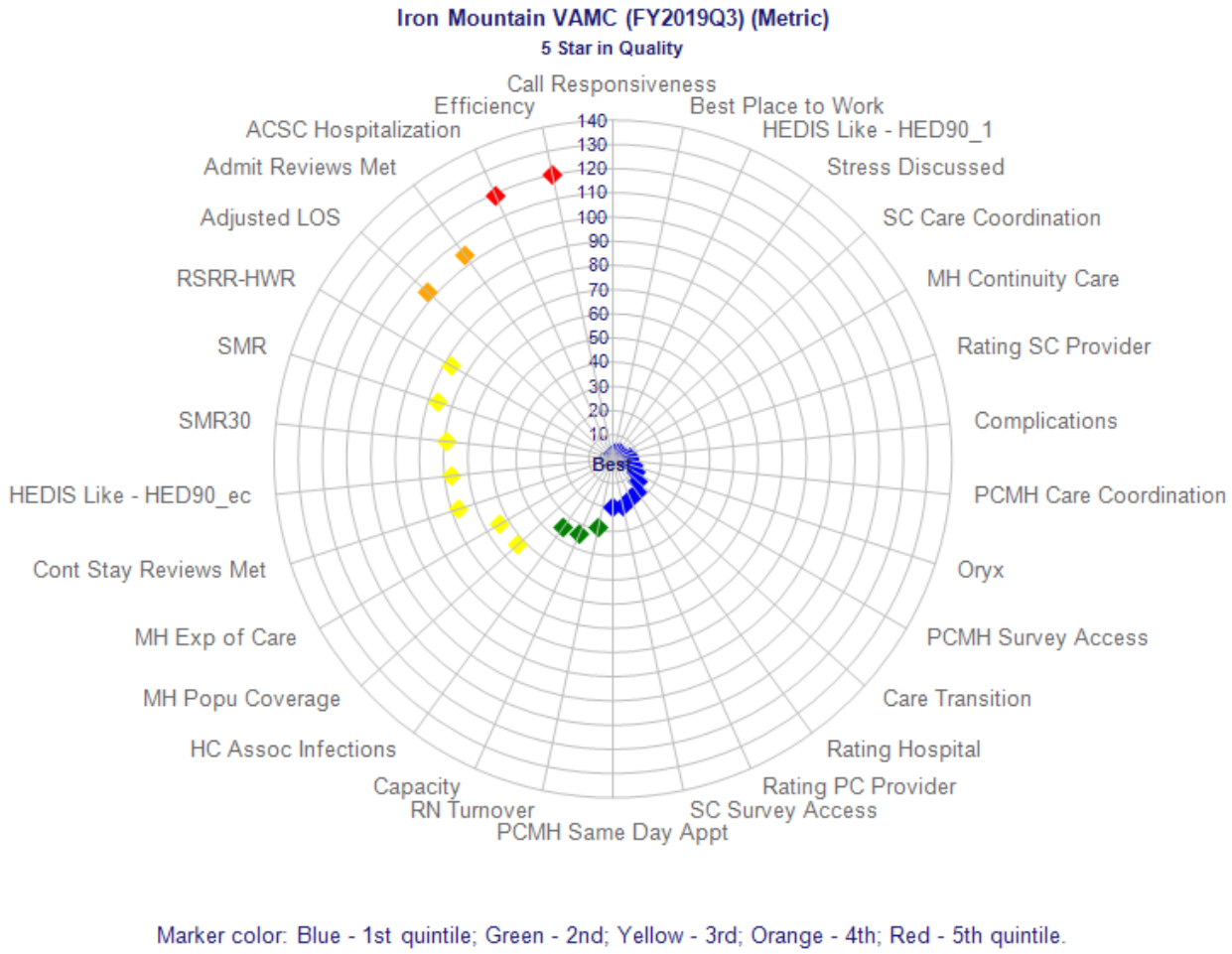

Figure 5. *System Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

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 &

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 CLC (for example, in the areas of improvement in function–short-stay (SS), high risk pressure ulcer (PU)–long-stay (LS), and ability to move independently worsened–LS). Metrics that need improvement are denoted in orange and red (for example, new or worse pressure ulcers (PU)–SS, moderate-severe pain–LS, and falls with major injury–LS.[35]

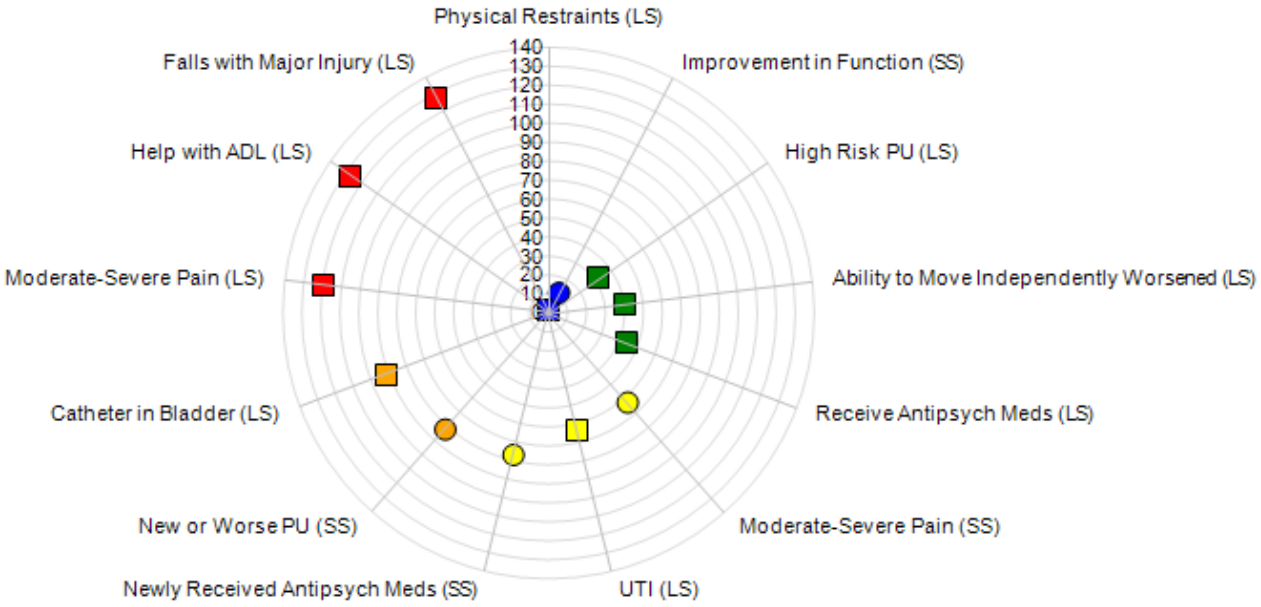

Figure 6. *Oscar G. Johnson VA Medical Center CLC Quality Measure Rankings (as of June 30, 2019)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

Leadership and Organizational Risks Conclusion

The medical center's executive leadership team included four positions with one permanently filled less than four months, and the chief of staff position had been vacant for three months prior to the OIG site visit. Three staff members had served as the acting chief of staff while the

[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.

position remained vacant. Interviews for the chief of staff position were scheduled to begin approximately two weeks after the OIG visit. The Director and ADPCS had worked together at the medical center since 2011. Survey results related to employees' satisfaction with the medical center executive leaders were generally better than VHA averages. The results for the Director and ADPCS were markedly higher than the VHA average. Patient experience survey data noted that patients appeared satisfied with the care provided. Although, the OIG found that selected survey results for female respondents were less favorable than those for female VHA patients nationally, the medical center leaders appeared actively engaged with employees and patients and were working to sustain and further improve engagement and satisfaction. The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to maintain positive perceptions of the medical center through active stakeholder engagement). The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. The leadership team was extremely knowledgeable within their scope of responsibility about SAIL data and should continue to take actions 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:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)

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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.

- 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

[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." This directive expired July 31, 2019.

[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. (This VHA handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

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

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

[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.

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).[48]

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 Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[49]

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."[50] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[51]
  - 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[52]
  - Evaluation by another provider with similar training and privileges

[48] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

[49] VHA Handbook 1100.19.

[50] VHA Handbook 1100.19.

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

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

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 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.[53] 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."[54] 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:

- Three solo/few practitioners who underwent initial or reprivileging during the previous 12 months[55]
- Ten LIPs hired within 18 months before the site visit
- Eight LIPs privileged within 12 months before the visit
- Eighteen LIPs who left the medical center in 12 months before the visit

Medical Staff Privileging Findings and Recommendations

The OIG identified deficiencies with FPPE and OPPE processes:

- OPPEs involved criteria specific to the service or section

[53] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005. (This handbook was scheduled for recertification on or before the last working day of December 2010 and has not been recertified.)

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

[55] 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 January 13, 2019, through January 13, 2020.

- The Executive Committee of the Medical Staff recommended continuing privileges based on FPPE results

VHA requires that reprivileging decisions are based on OPPE data specific to the service and practitioner.[56] For 5 of 11 practitioners reprivileged within the last 12 months—one of whom was a solo provider—the OIG found that the OPPE criteria were not service specific. This resulted in inadequate data to support decisions to continue practitioners' clinical privileges. The credentialing coordinator reported that the forms used for the reviews were initiated by the former Chief of Staff who left in August 2019 and that current forms are being evaluated by the acting Chief of Staff.

Recommendation 1

1. The Chief of Staff determines the reason(s) for noncompliance and ensures that ongoing professional practice evaluations include service-specific criteria.

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Chief of Staff will develop and implement new ongoing professional practice evaluations which will include service specific criteria. Compliance will be measured by the number of ongoing professional practice evaluations reviewed by the Medical Executive Committee with the service specific criteria as the numerator and the number of total ongoing professional practice evaluations reviewed by the Medical Executive Committee as the denominator. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90% or greater compliance with use of the service specific ongoing professional practice evaluations forms and/or data showing no ongoing professional practice evaluations required that month. Compliance will be reported to Quality Board at least quarterly.

VHA requires the results of FPPEs to be reported to the Executive Committee of the Medical Staff for consideration when deciding to continue initially granted privileges.[57] For 7 of the 10 practitioners who had initial privileges granted, the OIG found that the results of the FPPE were not reported to the Medical Executive Committee, the medical center's Executive Committee of the Medical Staff. Failure to report FPPE results to the Executive Committee of the Medical Staff impacts the medical staff leaders' ability to identify professional practice trends that may impact quality of care and patient safety. The Credentialing Coordinator provided details as to why each case was not reviewed by the Medical Executive Committee: One case was not reported to the committee due to an error, one could not be located, one was not completed by the prior Chief of Staff, one was not completed because the provider was placed on summary

[56] VHA Handbook 1100.19.

[57] VHA Handbook 1100.19.

suspension, and the remaining three were reported through the Professional Standards Board; however, the Medical Executive Committee deferred and never rescheduled the reviews.

The credentialing coordinator was a full-time position and had collateral duties. In addition, the former Chief of Staff left the medical center in August 2019, and the position had been covered by multiple in-house staff until an acting Chief of Staff assumed the role in October 2019.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and makes certain that Medical Executive Committee minutes consistently reflect the review of professional practice evaluation results.

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Chief of Staff or designee will ensure that the Medical Executive Committee minutes consistently reflect the review of professional practice evaluation results. Monthly the Credentialing Coordinator and the Chief of Staff will review the number of professional practice evaluations presented to Medical Executive Committee (numerator) with total number of professional practice evaluation due for review (denominator). This recommendation will be considered compliant when 90% or greater of the focused professional practice evaluations which were completed were reported to the Medical Executive Committee for six consecutive months. Compliance will be reported to Quality Board at least quarterly.

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.[58]

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.[59] 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 seven patient care areas:

- Community Living Center
- Dental Clinic
- Medical/Surgical Unit

[58] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
[59] The medical center did not have an inpatient mental health unit.

- Post-Anesthesia Care Unit
- Primary Care Clinic
- Rhinelander VA Clinic
- Urgent Care Clinic

Environment of Care Findings and Recommendations

Generally, the medical center met the requirements listed above. The OIG did not note any issues with the availability of medical equipment and supplies. During the OIG inspection, two wheelchairs at the medical center were found with damage to the arm cushions, and staff removed them from service for repair. The OIG also noted that despite Safety Data Sheets being available, some staff at the Rhinelander VA Clinic were unable to discuss the process to access the information. Upon learning of the knowledge deficit, the Lead Nurse provided training to remind all staff how to access the information. The OIG made no recommendations.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[60] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[61] 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.[62] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[63]

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.[64] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[65] To achieve VHA's vision of providing patient-driven healthcare, practitioners are also required to obtain informed consent from patients and to provide education about the risks, benefits, and alternatives prior to initiating long-term opioid therapy.[66] 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.[67]

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
- Completion of urine drug testing with intervention, when indicated

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[60] 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.)

[61] 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.)

[62] *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.)

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

[64] 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.)

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

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

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

- 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.[68] 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 29 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 several of the indicators of expected performance, including clinicians conducting pain screening and documenting justification for concurrent therapy with benzodiazepines. However, the OIG found deficiencies with aberrant behavior risk assessment, urine drug testing, informed consent, and patient follow-up after therapy initiation.

Additionally, the OIG identified a concern with the multidisciplinary pain committee monitoring of quality measures.

VA/DoD clinical practice guidelines recommend that clinicians complete a behavioral risk assessment, including history of substance abuse,[69] psychological factors, and aberrant drug-related behaviors[70] prior to initiating opioid therapy.[71] The OIG determined that clinicians completed an aberrant behavior risk assessment in 66 percent of the patients reviewed.[72] This may have resulted in providers prescribing opioids for patients at high risk for misuse. The acting Associate Chief of Staff for Primary Care reported that, since 2014, there had been multiple

[68] VHA Directive 2009-053, *Pain Management*, October 28, 2009. (This directive expired on October 31, 2014.)

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

[70] Examples of aberrant drug related behaviors include lost prescriptions, multiple requests for early refills, unauthorized dose escalation, apparent intoxication, and frequent accidents.

[71] *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.

updates to guidelines regarding opioid prescriptions, resulting in multiple changes to documentation requirements. The Director reported that it is difficult to fill positions due to the facility's rural setting, the associate chief of staff for primary care position had been vacant for two years, and Primary Care Services had experienced turnover in multiple providers during the previous year.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures that clinicians complete a behavioral risk assessment that includes a history of substance abuse, psychological disease, 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: The Chief of Staff will ensure that clinicians complete a behavioral risk assessment that includes a history of substance abuse, psychological disease, and aberrant drug related behaviors on patients prior to initiating long-term opioid therapy. Thirty records will be reviewed monthly to ensure a behavioral risk assessment is completed prior to initiating long-term opioid therapy. If less than thirty records are available, a 100% review will be completed. The number of patients newly started on long-term opioid therapy that have behavioral risk assessment will be the numerator and the number of patients newly started on long-term opioid therapy will be the denominator. This recommendation will be considered compliant when 90% or greater of records reviewed include a behavioral risk assessment for six consecutive months. Compliance will be reported to Quality Board at least quarterly.

VA/DoD clinical practice guidelines recommend that providers "obtain UDT [urine drug testing] prior to initiating or continuing LOT [long-term opioid therapy] and periodically thereafter."[73] The OIG found that clinicians conducted initial urine drug testing in 41 percent of the patients reviewed.[74] This resulted in providers' inability to identify whether the remaining 59 percent of patients had substance use disorders, determine potential diversion, or ensure patients adhered to the prescribed medication regimen. The acting Associate Chief of Staff for Primary Care reported that providers were trained on conducting urine drug screens at long-term opioid therapy initiation, however, identified this as a performance issue that will need additional follow-up. The Director reported that it is difficult to fill positions due to the facility's rural setting, the associate chief of staff for primary care position has been vacant for two years, and Primary Care Services had experienced turnover in multiple providers during the previous year.

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

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

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and makes certain that healthcare providers consistently conduct urine drug testing for patients prior to initiating or continuing long-term opioid therapy and periodically thereafter.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff will ensure that health care providers consistently conduct urine drug testing for patients prior to initiating or continuing long-term opioid therapy, and periodically thereafter. Thirty records will be reviewed monthly to ensure urine drug screen testing is completed prior to initiating or when continuing long term-opioid therapy. If less than thirty records are available, a 100% review will be completed. The number of patients newly started on long-term opioid therapy that have a urine drug screen completed prior to initiation of long-term opioid therapy will be the numerator and the number of patients newly started on long-term opioid therapy will be the denominator. This recommendation will be considered compliant when 90% or greater of records reviewed included a urine drug screen prior to or when continuing long-term opioid therapy. Compliance will be reported to Quality Board at least quarterly.

VHA requires providers to obtain and document informed consent for treatments that have a significant risk of complication or morbidity, including long-term opioid therapy, prior to initiation. VHA also recommends that the informed consent conversation cover the risks and benefits of opioid therapy, as well as alternative therapies.[75] The OIG determined that clinicians documented informed consent prior to initiating long-term opioid therapy in 45 percent of the patients reviewed.[76] The remaining patients, therefore, were potentially receiving treatment without documented knowledge of the risks associated with long-term opioid therapy, including opioid dependence, tolerance, addiction, and intentional or unintentional fatal overdose. The Director reported that providers did not obtain a new consent when therapy was restarted if there was already a consent in the medical record from prior long-term opioid therapy. Again, the Director reported that it is difficult to fill positions due to the facility's rural setting, the associate chief of staff for primary care position has been vacant for two years, and Primary Care Services had experienced turnover in multiple providers during the previous year.

[75] VHA Directive 1005.

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

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and makes certain that healthcare providers consistently obtain and document informed consent for patients prior to initiating long-term opioid therapy.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff will ensure that healthcare providers consistently obtain and document informed consent prior to initiating long-term opioid therapy. Thirty records will be reviewed monthly to ensure healthcare providers obtain and document informed consent for patients prior to initiating long-term opioid therapy. If less than thirty records are available, a 100% review will be completed. The number of patients newly started on long-term opioid therapy that have documented informed consent will be the numerator and the number of patients newly started on long-term opioid therapy will be the denominator. This recommendation will be considered compliant when 90% or greater of records reviewed include an informed consent prior to initiating long-term opioid therapy for six consecutive months. Compliance will be reported to Quality Board at least quarterly.

VA/DoD clinical practice guidelines recommend providers follow up with patients within three months after initiating long-term opioid therapy.[77] The OIG found that clinicians provided patient follow-up visits within three months after initiating long-term opioid therapy in 79 percent of the patients reviewed.[78] For the remaining patients, failure to conduct follow-up visits can result in missed opportunities to assess those patients' adherence to the therapy plan, effectiveness of treatment, and risks of continued opioid therapy. Again, the Director reported that it is difficult to fill positions due to the facility's rural setting, the associate chief of staff for primary care position has been vacant for two years, and Primary Care Services had experienced turnover in multiple providers during the previous year.

Recommendation 6

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

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

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

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff will ensure health care providers follow up with patients within the required three-month time frame after initiating long-term opioid-therapy. Thirty records will be reviewed monthly to ensure follow up is completed after initiating long-term opioid therapy. If less than thirty records are available, a 100% review will be completed. The number of patients newly started on long-term opioid therapy that have documented health care provider follow up with patients within the required three-month time frame will be the numerator and the number of patients newly started on long-term opioid therapy will be the denominator. This recommendation will be considered compliant when 90% or greater of records reviewed include follow-up after initiating long-term opioid therapy (records will be considered compliant if the appointment is cancelled and rescheduled by the patient or the cancellation would be considered unavoidable). Compliance will be reported to Quality Board at least quarterly.

VHA requires that a multidisciplinary pain management committee be established to "provide oversight, coordination, and monitoring of pain management activities and processes" to enable the facility to be compliant with evidence-based standards for pain care and external accrediting bodies.[79] Additionally, TJC expects facilities to use data to make decisions on opportunities for improvements and to take actions on those opportunities toward sustained improvement.[80] Although the medical center had an established Pain Committee that met on a monthly basis, there were no measures in place to evaluate quality or effectiveness, such as adherence to published clinical practice guidelines, timeliness of pain treatment, adequacy of pain control, and/or patient satisfaction. This resulted in the inability to identify deficiencies and provide recommendations to medical center leaders, which could assist in creating action plans to improve pain management outcomes. The Chair of the Pain Committee and the acting Associate Chief of Staff for Primary Care reported the Pain Committee met under the leadership of the former permanent Chief of Staff. The committee reconvened in September 2019 and documented work on the charter but had not started monitoring the quality of pain assessments or effectiveness of pain management.

Recommendation 7

7. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and makes certain that the Pain Committee monitors the quality of pain assessment and the effectiveness of pain management interventions.

[79] VHA Directive 2009-053.

[80] TJC. Leadership Standard (LD).03.02.01, LD.03.05.01, and Performance Improvement (PI).03.01.01.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff will make certain that the Pain Committee monitors the quality of pain assessments and the effectiveness of pain management interventions. The Pain Committee monthly meeting minutes will be reviewed by the Chief of Staff to ensure they are monitoring each of the above elements. The Pain Committee monitoring the quality of pain assessments and the effectiveness of pain management interventions documented will be the numerator and the number of Pain Committee meetings will be the denominator. This recommendation will be considered compliant when Pain Committee minutes have 90% or greater documentation of the quality of pain assessments and effectiveness of pain management for two consecutive quarters. Compliance will be reported to Quality Board at least quarterly.

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.[81] 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.[82] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[83]

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.[84]

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.[85] 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

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

[82] 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*.

[83] 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.*

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

[85] 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."[86] 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."[87] 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.[88] 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.[89]

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."[90] However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management (DUSHOM) 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."[91] 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."[92]

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 is warranted, patients identified as at-risk for suicide could have flags placed in his or her chart

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

[87] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. (This directive expired on July 31, 2013 and has not been updated.)

[88] *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.

[89] 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*.

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

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

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

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 a 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 HRS PRFs to "occur no earlier than 10 days before and no later than 10 days after the 90-day due date."[93]

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 flag 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.[94] VHA also requires that all staff receive annual refresher training.[95] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[96]

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

- Relevant documents;

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

[94] 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.

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

[96] 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 47 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 had complied with requirements associated with a designated SPC, tracking of patients' appointment completion within the required time frame, timely completion of safety plans, and patient missed appointment contact; suicide prevention training; and completion at least five community outreach events per month.

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 HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"[97]—the OIG determined that 55 percent of HRS PRFs were placed within one business day of referral to the SPC.[98] Based on the current updated requirement that the SPC be responsible for determining placement of the HRS PRF (without a defined time frame for doing so), the OIG calculated that the average time from referral to HRS PRF placement for the patients reviewed was 2 days (observed range was 0–8 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.[99] The OIG estimated that 49 percent of patients with an HRS flag were reevaluated at least every 90 days.[100] However, based upon the updated requirement that HRS PRFs be reviewed up to 10 days prior to or after the due date for reevaluation, the OIG found that all patients were reviewed within the expected time frame (observed range was 90–98 days).[101]

The OIG made no recommendations.

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

[98] The OIG estimated that 95 percent of the time, the true compliance rate is between 41.3 and 69.0 percent, which is statistically significantly below the 90 percent benchmark.

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

[100] The OIG estimated that 95 percent of the time, the true compliance rate is between 34.8 and 63.3 percent, which is statistically significantly below the 90 percent benchmark.

[101] VHA Notice 2020-13.

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. Life-sustaining treatments 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."[102]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.[103] 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.[104] 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.[105]

The OIG noted that from July 1, 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.

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

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

[104] According to VHA Handbook 1004.03, 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.

[105] 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, triggering events requiring goals of care conversations include those "prior to referral to VA or non-VA hospice; after admission to VA hospice for patients referred from outside VA (for example within 24 hours)."

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.[106] 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 43 randomly selected hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

[106] VHA Handbook 1004.03.

Care Coordination Findings and Recommendations

The OIG found the medical center generally complied with requirements for the LSTD committee and supervision of designees. Additionally, with VHA's original requirements that were in place when these patients received care, the OIG estimated that

- 73 percent of patients' LST progress notes addressed identification of a surrogate if the patient loses decision-making capacity,[107]
- 60 percent of patients' LST progress notes addressed previous advance directive(s), state-authorized portable orders, and/or LST notes, and[108]
- 75 percent of patients' LST progress notes addressed the patient's or surrogate's understanding of the patient's condition.[109]

However, VHA no longer requires these elements to be documented in the LST progress note. The OIG remains concerned that this change could result in practitioners not addressing these important goals of care conversation elements.

[107] The OIG estimated that 95 percent of the time, the true compliance rate is between 57.9 and 85.4 percent, which is statistically significantly below the 90 percent benchmark.

[108] The OIG estimated that 95 percent of the time, the true compliance rate is between 44.7 and 75.0 percent, which is statistically significantly below the 90 percent benchmark.

[109] The OIG estimated that 95 percent of the time, the true compliance rate is between 60.6 and 87.5 percent, which is statistically significantly below the 90 percent benchmark.

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[110] 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.[111] 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."[112] 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."[113]

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.[114] 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."[115]

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
    - Designated Women's Health Patient Aligned Care Team established

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[110] 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.)

[111] 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.)

[112] 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.)

[113] 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.

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

[115] VHA Directive 1330.01(2).

  - 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 system complied with requirements for the provision of care indicators, program oversight and performance improvement data monitoring, and most of the selected staffing elements reviewed. However, the OIG identified a concern with the Women Veterans Program Manager position.

VHA requires facility's to have a Women Veterans Program Manager who is full-time and free of collateral duties.[116] Further, VHA states that maternity "care coordination needs to be done within a Patient Aligned Care Team as much as possible with close collaboration with the Women Veterans Program Manager or a Maternity Care Coordinator designee."[117] The OIG found the medical center's designated Women Veterans Program Manager was also serving as the Maternity Care Coordinator. This could negatively impact the medical center's ability to deliver the best health care services to their women veterans. The Women Veterans Program Manager stated optimal health care services were being delivered to women veterans in need of

[116] VHA Directive 1330.01(2).
[117] VHA Directive 1330.03, *Maternity Health Care and Coordination,* October 5, 2012.

obstetric care, while maintaining fiscal responsibility by having the Women Veterans Program Manager function in this dual role. The Women Veterans Program Manager coordinated care for a total of 26 pregnancies and eight deliveries in 2019 and believed holding this dual role was fiscally prudent as the low volume did not necessitate assigning an additional staff member.

Recommendation 8

8. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures the Women Veterans Program Manager is full-time and free of collateral duties.[118]

Medical center concurred. Target date for completion: Completed Medical center response: Facility leadership has reassigned the duties of Maternity Care Coordinator as of 4/23/2020 as collateral duty to a Patient Aligned Care Team Registered Nurse.

[118] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

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…"[119] The goal of SPS is to "...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[120] 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[121]
- 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[122]

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.[123] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[124]

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, personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[125]

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

[120] 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.)

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

[122] VHA Directive 1116(2).

[123] 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.

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

[125] VHA Directive 1116(2).

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.[126]

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 clinic 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 inspection of reprocessing and storage areas
  - Traffic restricted
  - Airflow monitored
  - Personal protective equipment available
  - Area is clean
  - Eating or drinking in the area prohibited
  - Equipment properly stored
  - Required temperature and humidity maintained
- Completion of staff training, competency, and continuing education
  - Required training completed in a timely manner

[126] VHA Directive 1116(2).

- Competency assessments performed
- Monthly continuing education received

High-Risk Processes Findings and Recommendations

The medical center generally complied with the requirements for quality assurance monitoring, and reprocessing area physical inspections. However, the OIG identified the following deficiencies:

- Risk analysis results reported to the VISN SPS Management Board
- Staff training, competency, and continuing education
  - Required training completed in a timely manner
  - Competency assessments performed
  - Monthly continuing education received

VHA requires that the Chief of SPS performs an annual risk analysis and reports the results to the VISN SPS Management Board.[127] The OIG found no evidence that the FY 2019 risk analysis, which was completed on January 18, 2019, was reported to the VISN SPS Management Board. Failure to report the risk analysis results could delay or prevent the identification of problems or process failures and missed opportunities for awareness and assistance at the VISN level. The ADPCS stated that the prior Chief of SPS departed in November 2019 with minimal time for handoff of the position duties or status of work. The ADPCS reported that the prior Chief of SPS maintained oversight of SPS at this medical center while also performing VISN SPS duties, including inspections at the other facilities in the VISN, and was the chair of the VISN SPS Management Board. The ADPCS and Associate Chief Nurse, who had been the acting Chief of SPS for six weeks at the time of the site visit, were unable to provide evidence that the risk analysis had been submitted to the VISN SPS Management Board.

[127] VHA Directive 1116(2).

Recommendation 9

9. The Associate Director for Patient Care Services evaluates and determines any additional reason(s) for noncompliance and makes certain that the Chief of Sterile Processing Services reports the annual risk analysis results to the VISN Sterile Processing Services Management Board.[128]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Associate Director for Patient Care Services ensured that the Chief of Sterile Processing Services sent the annual sterile processing risk analysis to VISN 12 for reporting purposes at the VISN Sterile Processing Services Management Board. The risk analysis dated February 26, 2020 was forwarded to VISN 12 on February 28, 2020.

Additionally, VHA requires that SPS staff complete competency assessments for the reprocessing of RME and include two methods of verification "to validate and measure the proficiency of an individual for a specific task. Competency verification methods can include return demonstrations, observation, and verbalization."[129] The OIG reviewed competency assessment documents for each SPS employee and found that none of the four SPS employees had two methods of verification. This could result in improper cleaning of RME and compromise patient safety. The ADPCS stated the prior Chief of SPS departed in November 2019 with minimal time for handoff of the position duties or status of work and was unable to provide a reason for differing versions or incomplete assessments.

Recommendation 10

10. The Associate Director for Patient Care Services evaluates and determines additional reason(s) for noncompliance and ensures that Sterile Processing Services staff complete competency assessments that include at least two methods of verification for reprocessing reusable medical equipment.

[128] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

[129] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: October 30, 2020

Medical center response: The Associate Director for Patient Care Services will ensure that the Sterile Processing Services staff complete competency assessments that include at least two methods of verification for the reprocessing of reusable medical equipment. The Chief of Sterile Processing has updated all current competencies to ensure at least two methods of verification exist. Compliance will be tracked monthly by the Chief of Sterile Processing and considered compliant when required competencies are completed using at least two methods of verification. The number of completed competencies as the numerator and the number of completed competencies required for the month as the denominator will be reported at the Reusable Medical Equipment Committee quarterly. If no competencies were required during the month this will also be reported. This recommendation will be considered compliant when there are 6 consecutive months of data showing 90% compliance with the newly developed competency forms and/or data showing no competencies were required that month. Compliance will be reported to Quality Board at least quarterly.

VHA requires SPS staff to receive continuing education that includes monthly in-service education.[130] The OIG was unable to determine that all four SPS staff had received monthly education for most of the months from January through December 2019 due to documentation not having completion dates. This resulted in a potential knowledge gap in the technical aspects of sterile processing duties. As reported earlier, the ADPCS stated the prior Chief of SPS departed in November 2019 with minimal time for handoff of the position duties or status of work and was unable to provide a reason beyond competing priorities with VISN SPS lead position.

Recommendation 11

11. The Associate Director for Patient Care Services evaluates and determines additional reason(s) for noncompliance and ensures Sterile Processing Services staff receive monthly continuing education.

[130] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: July 31, 2020

Medical center response: The Associate Director for Patient Care Services and the Chief of Sterile Processing will ensure Sterile Processing Services staff receive monthly continuing education. The number of sterile processing staff completing monthly continuing education as the numerator and the total number of sterile processing staff as the denominator will be reported at the Reusable Medical Equipment Committee quarterly. This recommendation will be considered compliant when 90% or greater of monthly staff continuing education has been completed for six consecutive months. Compliance will be reported to Quality Board at least quarterly.

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 (medical center or system) • VHA performance data for CLCs	Eleven OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the 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	• None
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• OPPEs include service-specific criteria.	• Medical Executive Committee minutes consistently reflect the review of professional practice evaluation results.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Medical Centers
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Accommodation and privacy 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	• Clinicians complete a behavioral risk assessment that includes a history of substance abuse, psychological disease, and aberrant drug-related behaviors on all patients prior to initiating long-term opioid therapy. • Healthcare providers consistently conduct urine drug testing for patients prior to initiating or continuing long-term opioid therapy and periodically thereafter. • Healthcare providers consistently obtain and document informed consent for patients prior to initiating long-term opioid therapy. • Healthcare providers follow up with patients within the required time frame after initiating long-term opioid therapy.	• Pain Committee monitors the quality of pain assessment and the effectiveness of pain management interventions.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Mental Health: Suicide Prevention Program	• Designated facility Suicide Prevention Coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements	• None	• None
Care Coordination: Life-Sustaining Treatment Decisions	• Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated • LSTD multidisciplinary committee	• None	• None
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• None	• The Women Veterans Program Manager is full-time and free of collateral duties.
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Quality assurance monitoring • Physical inspections • Staff training, competency, and continuing education	• Sterile Processing Services staff complete competency assessments that include at least two methods of verification for reprocessing reusable medical equipment.	• Chief of Sterile Processing Services reports the annual risk analysis results to the VISN Sterile Processing Services Management Board. • Sterile Processing Services staff receive monthly continuing education.

Appendix B: Medical Center Profile

The table below provides general background information for this low complexity (3) medical center reporting to VISN 12.[1]

Table B. Profile for Oscar G. Johnson VA Medical Center (585)
(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 in dollars	$153,584,748	$178,912,650	$163,849,302
Number of:			
• Unique patients	20,506	20,528	20,416
• Outpatient visits	214,978	214,768	217,218
• Unique employees[5]	541	538	535
Type and number of operating beds:			
• Community living center	40	40	38
• Medicine	15	15	15
• Surgery	2	2	2
Average daily census:			
• Community living center	34	38	36
• Medicine	6	5	4
• Surgery	–	0	0

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 healthcare system 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. 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
Hancock, MI	585GA	4,661	2,419	Cardiology Dermatology Endocrinology Gastroenterology Infectious disease Nephrology Neurology Pulmonary/Respiratory disease Plastics Rheumatology	EKG	Nutrition Pharmacy Prosthetics Social work 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. (This directive expired on October 31, 2015, and has not been updated.) An encounter is a "professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

[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.

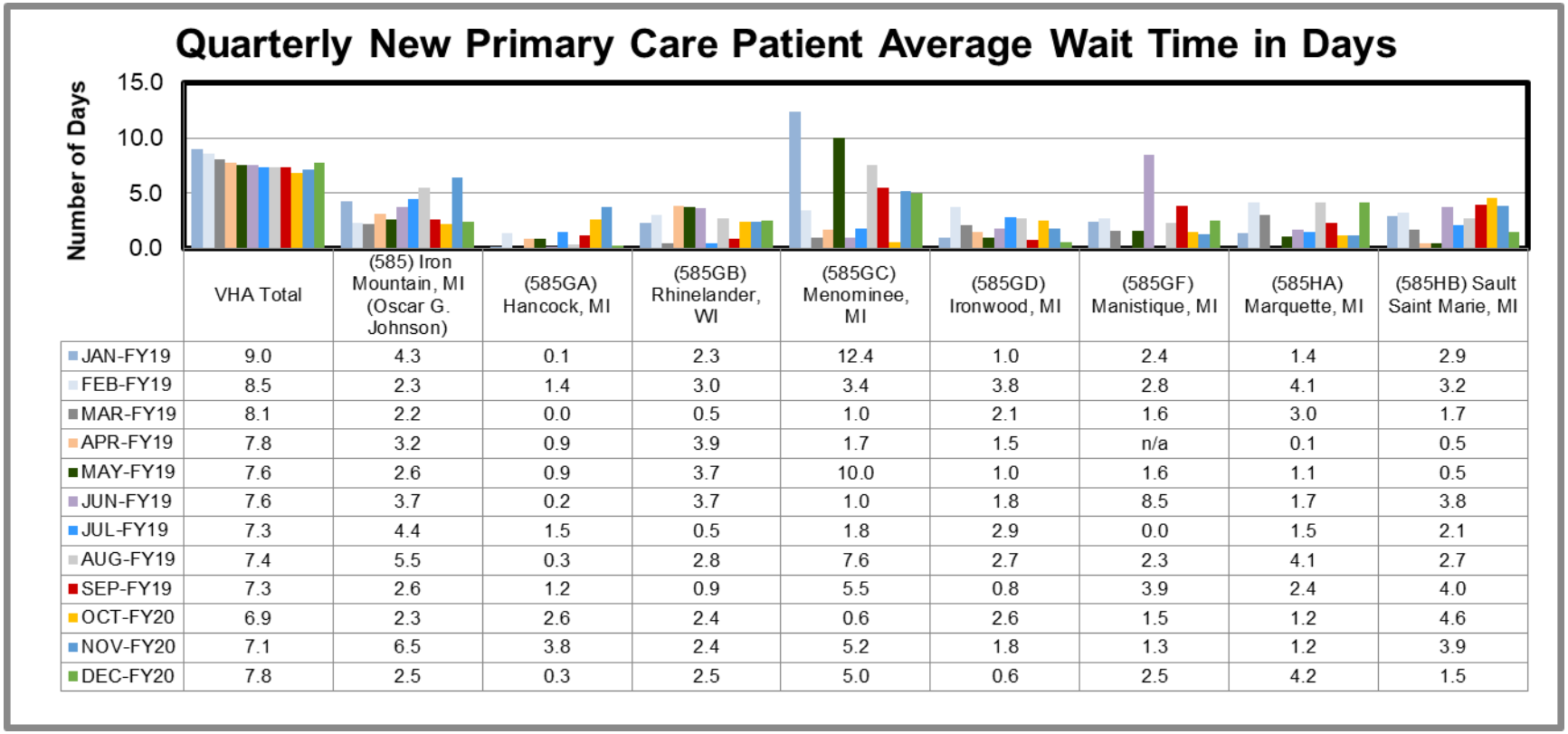
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Rhinelander, MI	585GB	6,910	2,327	Anesthesia Cardiology Dermatology Endocrinology Gastroenterology GYN (Gynecology) Hematology/Oncology Infectious disease Nephrology Neurology Pulmonary/Respiratory disease Rheumatology	EKG	Nutrition Pharmacy Prosthetics Social work Weight management
Menominee, MI	585GC	4,401	2,290	Cardiology Dermatology Endocrinology Gastroenterology Infectious disease Nephrology Neurology Pulmonary/Respiratory disease Rheumatology Urology	EKG	Nutrition Pharmacy Prosthetics Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Ironwood, MI	585GD	3,351	1,396	Cardiology Dermatology Endocrinology Infectious disease Nephrology Neurology Pulmonary/Respiratory disease Rheumatology	EKG	Nutrition Prosthetics Weight management
Manistique, MI	585GF	2,176	1,425	Cardiology Cardio-thoracic Dermatology Endocrinology Gastroenterology Nephrology Neurology Pulmonary/Respiratory disease Rheumatology	EKG	Nutrition Prosthetics Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Marquette, MI	585HA	6,574	4,011	Cardiology Dermatology Endocrinology General surgery GYN (Gynecology) Hematology/Oncology Infectious disease Nephrology Neurology Plastic Poly-Trauma Pulmonary/Respiratory disease Rheumatology	EKG	Nutrition Pharmacy Prosthetics Social work Weight management
Sault Sainte Marie, MI	585HB	4,635	1,695	Cardiology Dermatology Endocrinology Gastroenterology Infectious disease Nephrology Neurology Pulmonary/Respiratory disease Rheumatology	EKG	Nutrition Pharmacy Prosthetics 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

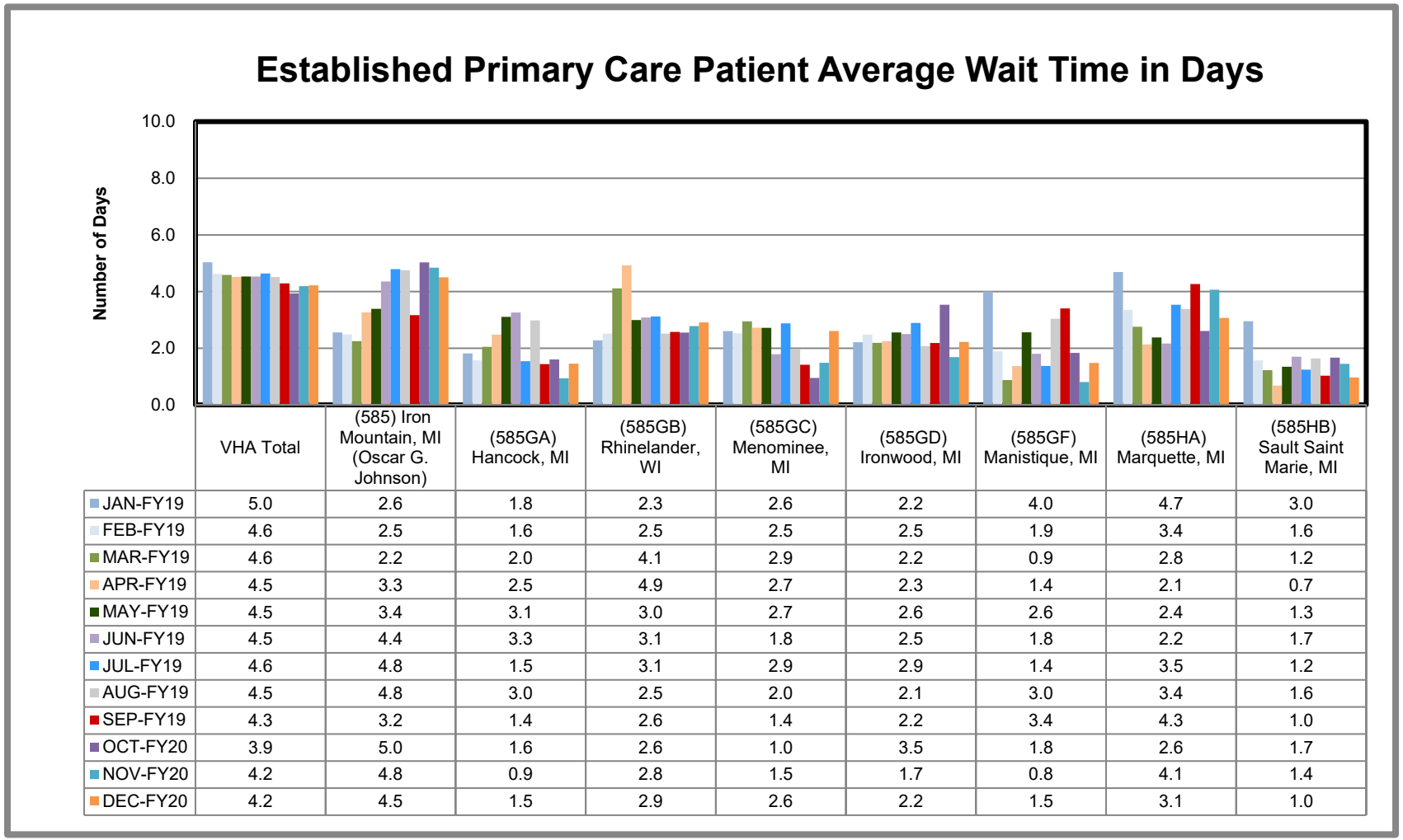
Appendix D: Patient Aligned Care Team Compass Metrics[1]



	VHA Total	(585) Iron Mountain, MI (Oscar G. Johnson)	(585GA) Hancock, MI	(585GB) Rhinelander, WI	(585GC) Menominee, MI	(585GD) Ironwood, MI	(585GF) Manistique, MI	(585HA) Marquette, MI	(585HB) Sault Saint Marie, MI
JAN-FY19	9.0	4.3	0.1	2.3	12.4	1.0	2.4	1.4	2.9
FEB-FY19	8.5	2.3	1.4	3.0	3.4	3.8	2.8	4.1	3.2
MAR-FY19	8.1	2.2	0.0	0.5	1.0	2.1	1.6	3.0	1.7
APR-FY19	7.8	3.2	0.9	3.9	1.7	1.5	n/a	0.1	0.5
MAY-FY19	7.6	2.6	0.9	3.7	10.0	1.0	1.6	1.1	0.5
JUN-FY19	7.6	3.7	0.2	3.7	1.0	1.8	8.5	1.7	3.8
JUL-FY19	7.3	4.4	1.5	0.5	1.8	2.9	0.0	1.5	2.1
AUG-FY19	7.4	5.5	0.3	2.8	7.6	2.7	2.3	4.1	2.7
SEP-FY19	7.3	2.6	1.2	0.9	5.5	0.8	3.9	2.4	4.0
OCT-FY20	6.9	2.3	2.6	2.4	0.6	2.6	1.5	1.2	4.6
NOV-FY20	7.1	6.5	3.8	2.4	5.2	1.8	1.3	1.2	3.9
DEC-FY20	7.8	2.5	0.3	2.5	5.0	0.6	2.5	4.2	1.5

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
Data Definition: "The average number of calendar days between 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. The absence of reported data is indicated by "n/a."

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



	VHA Total	(585) Iron Mountain, MI (Oscar G. Johnson)	(585GA) Hancock, MI	(585GB) Rhinelander, WI	(585GC) Menominee, MI	(585GD) Ironwood, MI	(585GF) Manistique, MI	(585HA) Marquette, MI	(585HB) Sault Saint Marie, MI
JAN-FY19	5.0	2.6	1.8	2.3	2.6	2.2	4.0	4.7	3.0
FEB-FY19	4.6	2.5	1.6	2.5	2.5	2.5	1.9	3.4	1.6
MAR-FY19	4.6	2.2	2.0	4.1	2.9	2.2	0.9	2.8	1.2
APR-FY19	4.5	3.3	2.5	4.9	2.7	2.3	1.4	2.1	0.7
MAY-FY19	4.5	3.4	3.1	3.0	2.7	2.6	2.6	2.4	1.3
JUN-FY19	4.5	4.4	3.3	3.1	1.8	2.5	1.8	2.2	1.7
JUL-FY19	4.6	4.8	1.5	3.1	2.9	2.9	1.4	3.5	1.2
AUG-FY19	4.5	4.8	3.0	2.5	2.0	2.1	3.0	3.4	1.6
SEP-FY19	4.3	3.2	1.4	2.6	1.4	2.2	3.4	4.3	1.0
OCT-FY20	3.9	5.0	1.6	2.6	1.0	3.5	1.8	2.6	1.7
NOV-FY20	4.2	4.8	0.9	2.8	1.5	1.7	0.8	4.1	1.4
DEC-FY20	4.2	4.5	1.5	2.9	2.6	2.2	1.5	3.1	1.0

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

[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=9248. The website was accessed on March 6, 2020, but is not accessible by the public.)

Measure	Definition	Desired Direction
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	ORYX	A higher value is better than a lower value
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: May 1, 2020

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

Subj: Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center, Iron Mountain, MI

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

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

1. I have reviewed the Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center Iron Mountain, MI draft report.
2. I concur with the recommendations proposed.
3. I have reviewed and am in agreeance with the facility's action plan for recommendations 1-11 listed.
4. I would like to thank the OIG Inspection team for a thorough review of the Oscar G. Johnson VA Medical Center.

(Original signed by:)

Victoria P. Brahm, MSN, RN, VHA-CM

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: May 14, 2020

From: Medical Center Director, Oscar G. Johnson Medical Center (585/00)

Subj: Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center, Iron Mountain, MI

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

1. The recommendations provided during the Comprehensive Healthcare Inspection Program (CHIP) review conducted the week of January 13,2020, have been reviewed. A plan of action for the eleven recommendations have been developed. The plans of actions have been carefully analyzed and will be implemented and monitored through satisfactory completion.
2. The Oscar G. Johnson VA Medical Center would like to respectfully request closure of recommendation 8 and recommendation 9 at this time. Action plans have been identified for the remaining nine recommendations and will monitored until satisfactory completion.
3. I would like to thank the Officer of Inspector General (CHIP) Survey team for their professionalism and constructive feedback to our employees during out review. This review provides the opportunity to continue to improve care to our Veterans.

(Original signed by:)

James W. Rice

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