DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Tomah VA Medical Center in Wisconsin

CHIP REPORT | REPORT #20-00082-189 | JULY 7, 2020

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Figure 1. *Tomah VA Medical Center in Wisconsin (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 Tomah VA Medical Center and multiple outpatient clinics in 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 27, 2020, at the Tomah VA Medical Center and Wausau 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 acting Medical Center Director, Chief of Staff, acting Associate Director for Patient Care Services (ADPCS), and acting Associate Director. Organizational communications and accountability were managed through a committee reporting structure with the Senior Executive Council overseeing several working groups. The leaders monitored patient safety and care through the Leadership Quality Council which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the assigned ADPCS was the acting Medical Center Director, the Deputy ADPCS was the acting ADPCS, and the Chief of Social Work was the acting Associate Director. The Chief of Staff was assigned in January 2019 and was the only permanently assigned executive team member. The executive members started working together in their acting roles the first day of the OIG visit.

The OIG noted specific survey leadership scores related to employees' satisfaction with the medical center leaders were generally similar to or better than the VHA averages. Opportunities appeared to exist for the ADPCS to decrease staff feelings of moral distress in the workplace.[1] Patient experience survey data reflected higher care ratings than the VHA averages in the outpatient setting, while inpatient results appeared to highlight opportunities for improvement. Additionally, the OIG noted that the specific survey results for male respondents were similar to or less favorable than the corresponding VHA averages, while those for female respondents were generally similar to or more positive when compared with female VHA patients nationally.

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.[2]

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.

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

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

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

In individual interviews, the executive leadership team members spoke knowledgeably within their scope of responsibility about selected VHA data used by the SAIL and CLC SAIL models and should continue to take actions to sustain and improve performance.

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

Mental Health

The OIG found compliance with the requirements for a suicide prevention coordinator, appointment tracking, suicide safety plans, and patient follow-up. However, the medical center did not meet suicide prevention refresher training requirements.

Women's Health

The medical center complied with many of the performance elements for women's health, including care provision and selected staffing requirements. The OIG noted concerns with community-based outpatient clinic women's health primary care providers and the Women Veterans Health Committee.

High-Risk Processes

The medical center met expectations for the proper operations and management of reprocessing reusable medical equipment. The OIG identified a deficiency with the annual risk analysis.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued four recommendations for improvement to the Medical Center Director, Chief of Staff, and ADPCS. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this medical center. The intent is for medical center leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if not addressed, may eventually interfere with the delivery of quality health care.

[3] 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.)

Comments

The Veterans Integrated Service Network Director and acting Medical Center Director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 58-59 and the responses within the body of the report for the full text of the directors' comments) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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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 Tomah 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:[3]

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)

[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.

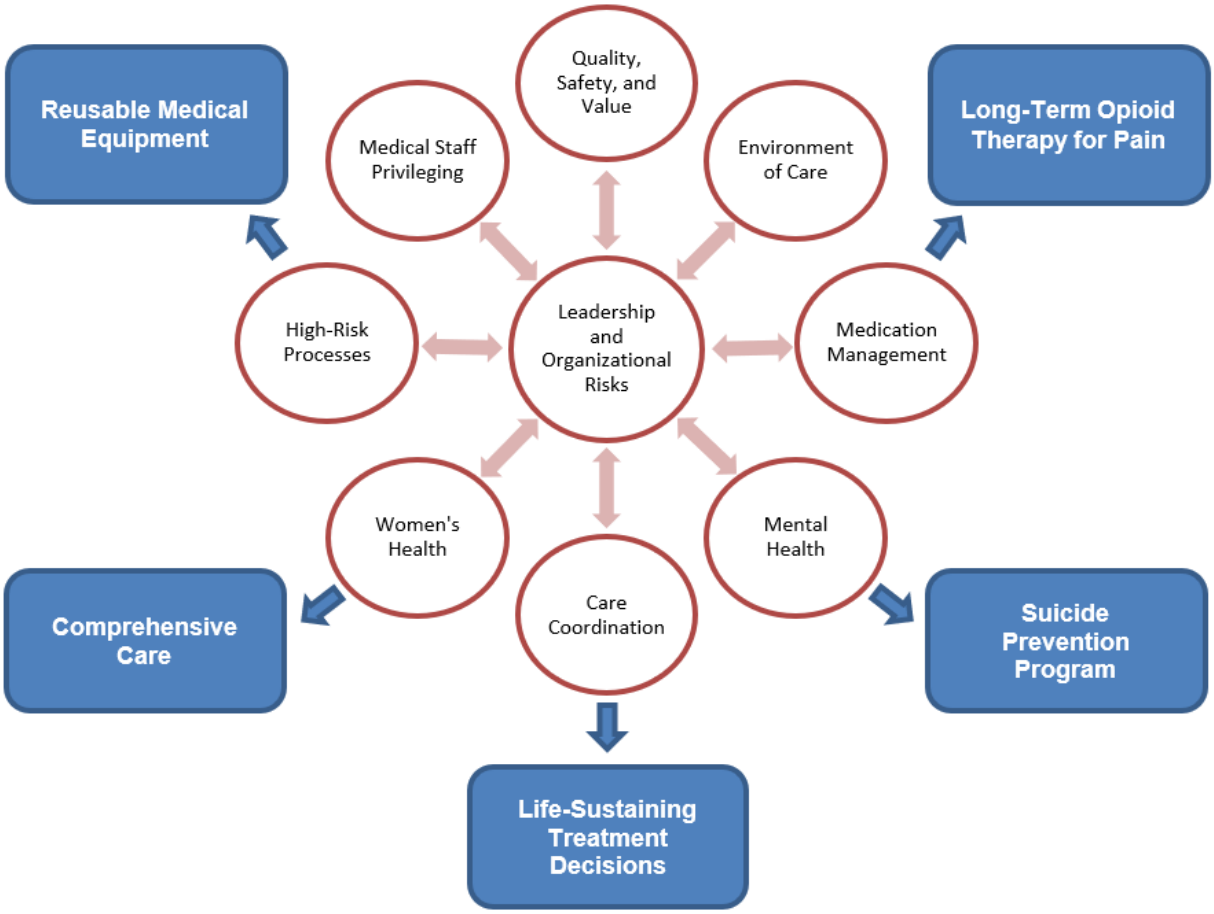

Figure 2. *Fiscal Year (FY) 2020 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

Methodology

The Tomah VA Medical Center includes multiple outpatient clinics in 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 the Wausau VA Clinic and the following areas of the medical center:

- Community Living Centers (CLC)
- Dental clinic
- Inpatient mental health unit
- Medical/surgical combined inpatient unit
- Outpatient clinics
- Reusable medical equipment (RME) clean storage area
- RME preparatory assembly area
- Urgent care clinic
- Women's health clinic

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

The inspection period examined operations from November 18, 2017, through January 30, 2020, the last day of the unannounced multiday site visit.[5] 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] The range represents the time period from the prior CHIP inspection to the completion of the unannounced, multiday CHIP site visit in November 2017.

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 acting 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.[6] 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 (CLCs)

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, which includes a leadership team consisting of the Medical Center Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. The Chief of Staff and ADPCS oversee patient care which requires managing service directors and chiefs of programs and practices.

[6] 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.)

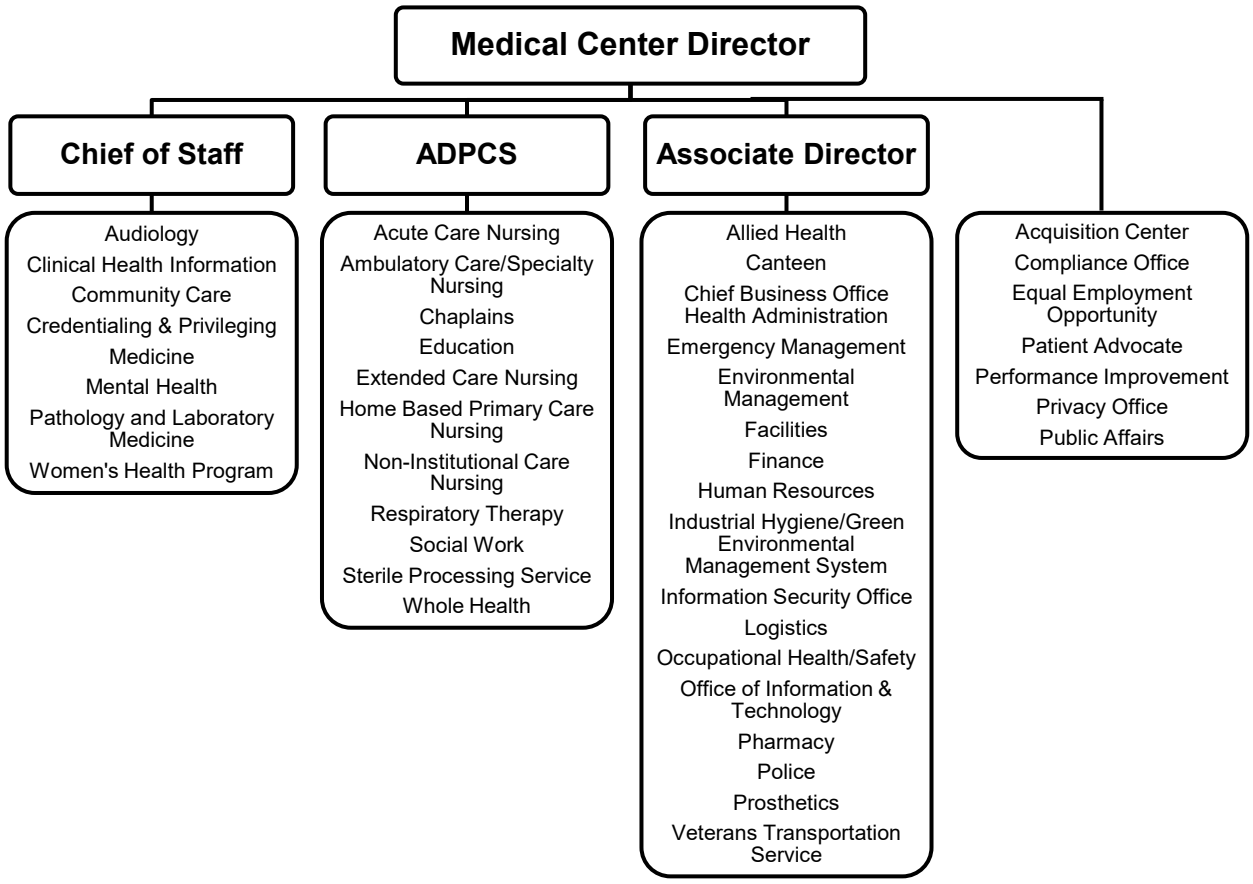

Figure 3. *Medical Center Organizational Chart*
Source: Tomah VA Medical Center (received January 27, 2020)

At the time of the OIG site visit, the positions of medical center director, ADPCS, and associate director were filled by staff in acting roles:

- The Medical Center Director was detailed to the VISN 12 Director role.
- The ADPCS was the acting Medical Center Director.
- The Deputy ADPCS was the acting ADPCS.
- The Chief of Social Work was the acting Associate Director.

The Chief of Staff was assigned in January 2019 and was the only permanently assigned executive team member. The executive members started working together in their acting roles on the first day of the OIG visit (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	February 5, 2017[7]
Chief of Staff	January 16, 2019
Associate Director for Patient Care Services	April 17, 2016[8]
Associate Director	December 10, 2017[9]

Source: Tomah VA Medical Center Supervisory Human Resources Specialist (received January 27, 2020)

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

The executive leaders were generally knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) and CLC measures. In individual interviews, the executive leadership team members were able to usually 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 Senior Executive Council serves as the governing body of the medical center. The Medical Center Director serves as the chairperson and has the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Senior Executive Council oversees various working groups such as the Health Systems, Patient Care Services Leadership, and Leadership Quality Councils.

The leaders monitor patient safety and care through the Leadership Quality Council, chaired by the Medical Center Director. The Leadership Quality Council is responsible for understanding the complex environments that result in adverse events and loss of value and efficiency. See Figure 4.

[7] The Medical Center Director was detailed as the VISN 15 Director on May 5, 2019. The ADPCS was detailed as Medical Center Director on May 5, 2019 (not to exceed 120 days), September 1, 2019 (not to exceed 120 days), and from January 27–29, 2020.

[8] The Deputy ADPCS was detailed as the ADPCS on May 5, 2019 (not to exceed 120 days), September 1, 2019 (not to exceed 120 days), and from January 27–29, 2020.

[9] The Associate Director was detailed as the Medical Center Director on December 29, 2019 (not to exceed 30 days), and the Chief of Social Work was detailed as the Acting Associate Director on December 29, 2019 (not to exceed 29 days).

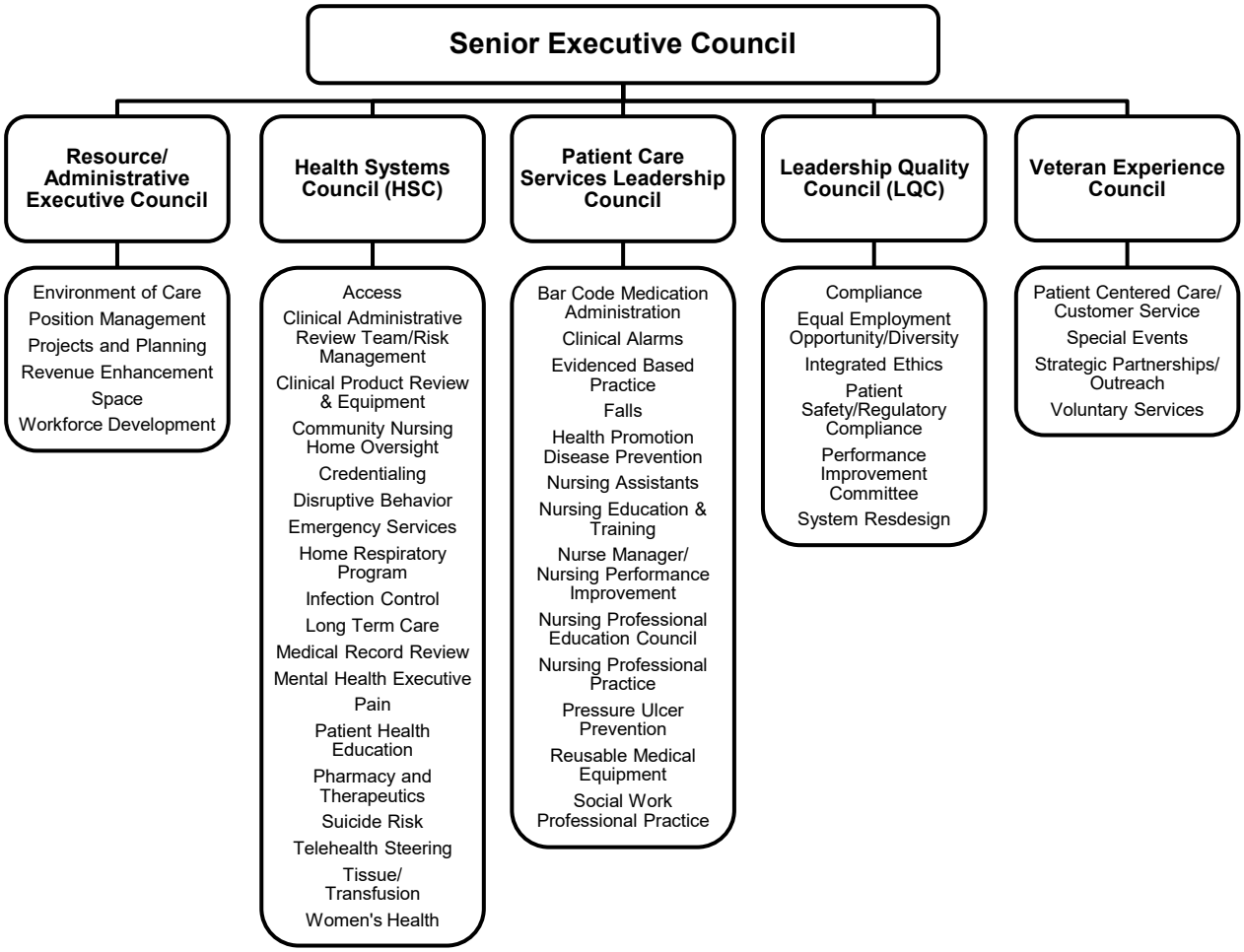

Figure 4. *Medical Center Committee Reporting Structure*
Source: Tomah VA Medical Center (January 27, 2020)

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.[10] Table 2 provides relevant survey results for VHA, the medical center, and executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center averages for the survey leadership questions were lower than the VHA averages;[11] however, scores related to the Medical Center Director, Chief of Staff, and ADPCS were similar to or higher than those for VHA and the medical center.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Medical Center Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.*[12]	0–100 where higher scores are more favorable	72.6	69.5	94.1	89.2	70.7	79.7
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.4	3.2	4.7	3.6	3.6	2.9
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.4	4.7	3.6	3.5	3.3

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

[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	Medical Center Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.4	4.7	3.6	3.5	3.2

Source: VA All Employee Survey (accessed December 19 and 23, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[13] Note that the medical center average for the specific survey questions was similar to the VHA average. Scores related to the Medical Center Director, Chief of Staff, and Associate Director were similar to or better than those for VHA and the medical center. However, opportunities appear to exist for the ADPCS to decrease staff's feelings of moral distress in the workplace.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Medical Center Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.7	4.6	3.8	3.8	4.0
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.6	4.7	4.1	3.1	3.9

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Medical Center Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *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	1.6	1.3	1.4	2.7	1.8

Source: VA All Employee Survey (accessed December 19 and 23, 2019)

Patient Experience

To assess patient experiences with the medical center, which directly reflect on its leaders, the OIG team reviewed patient survey results that relate to the period of October 1, 2018, through September 30, 2019. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for VHA and the medical center.[14]

VHA also collects SHEP survey data from Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward their healthcare experiences (see Table 4). For this medical center, the outpatient survey results reflected higher care ratings than the VHA averages, while the inpatient results appear to highlight opportunities for improvement.

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

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.3	62.2
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	75.0
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	82.2
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	82.6

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 23, 2019)

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

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients' experiences by gender (see Tables 5–7), including those for Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG noted that the results for male respondents were similar to or less favorable than the corresponding VHA averages, while those for female respondents were generally similar to or more positive when compared with female VHA patients nationally. The Chief of Staff reported the medical center hosts an annual women's health town hall via telephone. Medical center leaders reported looking forward to opening a Women's Center of Excellence in Fall 2020.

[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 September 30, 2019)

Questions	Scoring	VHA[16]		Medical Center[17]	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	82.8	79.0	—[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).	84.8	83.1	84.4	—
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).	68.7	61.8	62.0	—

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 19, 2019)

[16] The VHA averages are based on 48,259–48,798 male and 2,342–2,359 female respondents, depending on the question.

[17] The medical center averages are based on 107 or 108 male respondents, depending on the question.

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

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

Questions	Scoring	VHA[19]		Medical Center[20]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.2	43.3	45.5	36.1
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).	59.9	49.7	65.0	56.6
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).	71.6	65.7	68.2	68.8

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 19, 2019)

[19] The VHA averages are based on 79,450–241,828 male and 5,762–13,041 female respondents, depending on the question.

[20] The medical center averages are based on 354–1,449 male and 23–62 female respondents, depending on the question.

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

Questions	Scoring	VHA[21]		Medical Center[22]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.5	44.7	50.1	63.5
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	55.0	58.5	52.0
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	70.1	68.5	79.1

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 19, 2019)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[23] Table 8 summarizes the relevant medical center inspections most recently performed by the OIG and The

[21] The VHA averages are based on 65,968–208,722 male and 3,460–11,072 female respondents, depending on the question.

[22] The medical center averages are based on 287–1,119 male and 14–42 female respondents, depending on the question.

[23] 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.

Joint Commission (TJC).[24] Of note, at the time of the OIG visit, the medical center had closed all recommendations for improvement issued since the previous CHIP review conducted in November 2017.

At the time of the site visit, the OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[25] Additional results include the Long Term Care Institute's inspection of the medical center's CLCs.[26]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the Tomah VA Medical Center, Wisconsin*, Report No. 17-05400-246, August 9, 2018.)	November 2017	2	0
OIG (*Review of Opioid Monitoring and Allegations Related to Opioids Prescribing Practices and Other Concerns at the Tomah VA Medical Center, Wisconsin*, Report #18-05872-103, March 28, 2019.)	September 2018	1	0

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

[25] According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs; According to the College of American Pathologists, for 70 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." College of American Pathologists. https://www.cap.org/about-the-cap. (The website was accessed on February 20, 2019.) In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
TJC Hospital Accreditation	May 2018	13	0
TJC Behavioral Health Care Accreditation		3	0
TJC Home Care Accreditation		3	0

Source: OIG and TJC (inspection/survey results verified with the Chief of Performance Improvement on January 27, 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 no concerns related to the potential for patient harm.

Table 9 lists the reported patient safety events from November 18, 2017 (the prior OIG comprehensive healthcare inspection), through January 28, 2020.[27]

[27] 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 Tomah VA Medical Center is a low complexity (3) affiliated system as described in Appendix B.)

Table 9. Summary of Selected Organizational Risk Factors (November 18, 2017, through January 28, 2020)

Factor	Number of Occurrences
Sentinel Events[28]	1
Institutional Disclosures[29]	5
Large-Scale Disclosures[30]	0

Source: Tomah VA Medical Center Risk Manager, Patient Safety Manager, and Chief of Performance Improvement (received January 27 and 28, 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.[31]

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 Tomah VA Medical Center (for example, in the areas of complications, stress discussed, and patient-centered medical home (PCMH) care coordination). Metrics that need improvement are denoted in orange and red (for

[28] 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."

[29] 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."

[30] 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."

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

example, best place to work, rating (of) specialty care (SC) provider, registered nurse (RN) turnover, and capacity).[32]

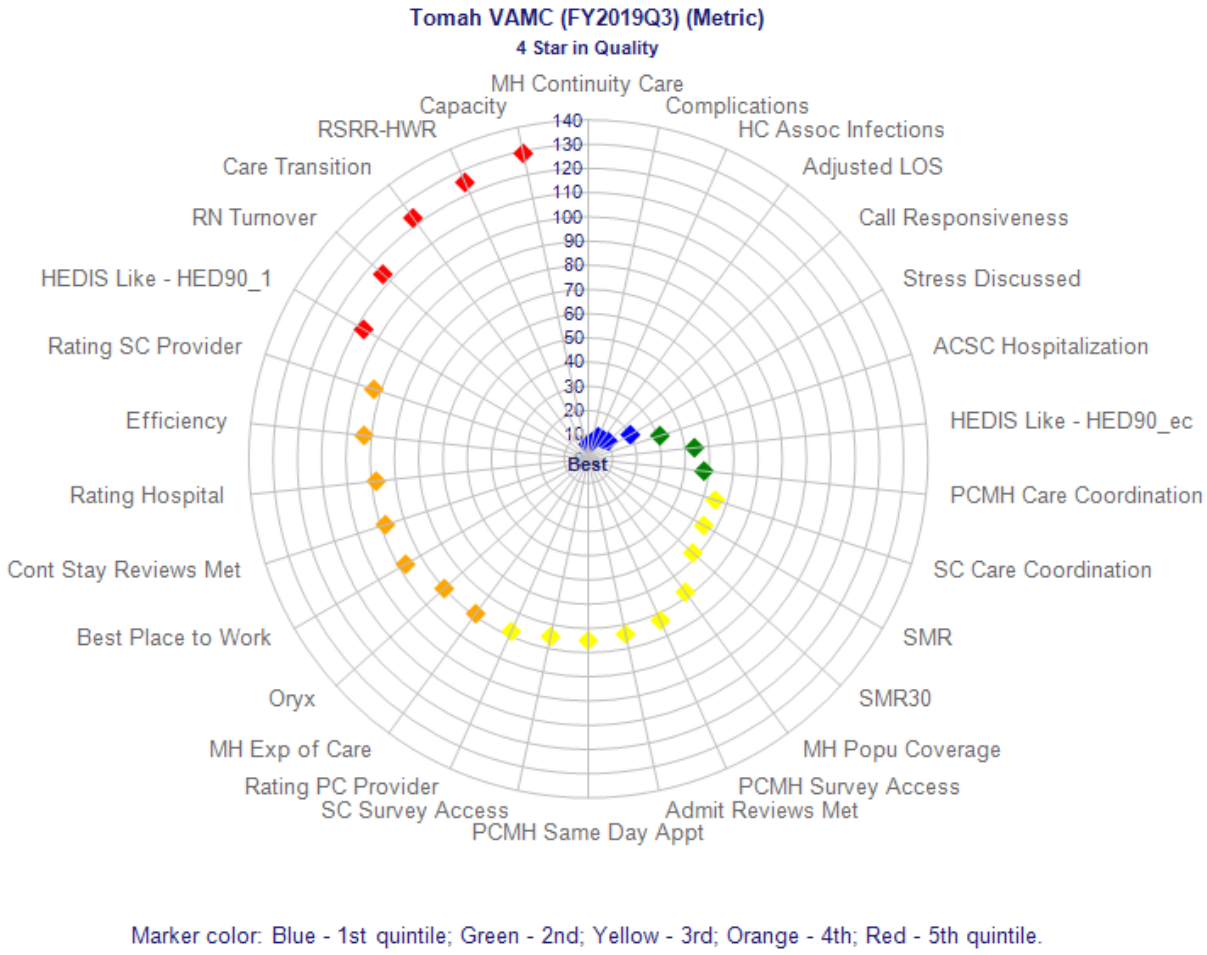

Figure 5. *System Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

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 &

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

Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource to review quality measures and health inspection results.[33]

Figure 6 illustrates the CLC quality rankings and performance compared with other VA CLCs as of September 30, 2019. Figure 6 uses blue and green data points to indicate high performance for the Tomah CLC (for example, in the areas of physical restraints–long-stay (LS), improvement in function–short stay (SS), and catheter in bladder (LS)). Metrics that need improvement are denoted in orange and red (for example, falls with major injury (LS) and receive antipsychotic (antipsych) medications (meds) (LS)).[34]

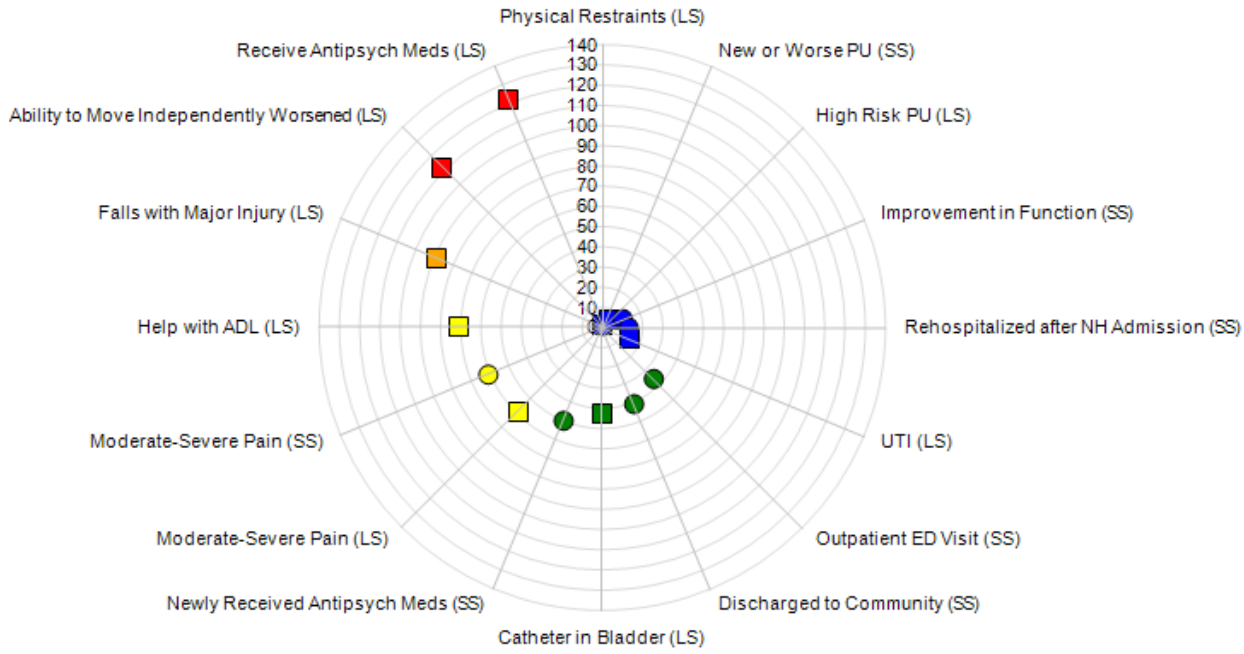

Figure 6. *Tomah VA Medical Center CLC Quality Measure Rankings (as of September 30, 2019)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

[33] 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."

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

Leadership and Organizational Risks Conclusion

At the time of the OIG site visit, the positions of Medical Center Director, ADPCS, and Associate Director were filled by staff in acting roles. The Chief of Staff was the only permanently assigned executive team member. The executive members started working together in their acting roles the first day of the OIG visit. All executive team members had worked at the medical center for over one year. Specific survey scores related to employees' satisfaction with the medical center leaders were generally similar to or better than the VHA averages; however, opportunities appeared to exist for the ADPCS to decrease staff's feelings of moral distress in the workplace. Patient experience survey data reflected higher care ratings than the VHA averages in the outpatient setting, while inpatient results appeared to highlight opportunities for improvement. Additionally, the OIG noted that the specific survey results for male respondents were similar to or less favorable than the corresponding VHA averages, while those for female respondents were generally similar to or more positive when compared with female VHA patients nationally. The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. The leadership team was generally knowledgeable within their scope of responsibility about selected VHA data used by the SAIL and CLC SAIL models 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.[35] 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.[36] 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.[37]

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.[38] 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.[39] The OIG team examined 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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[35] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

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

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

[38] 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."

[39] 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[40]
- 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.[41] 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.[42] 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.[43] 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

[40] VHA Directive 1190.

[41] 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."

[42] VHA Directive 1117(2).

[43] The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

communicate potential and actual causes of harm to patients throughout the medical center.[44] The medical center was assessed for its performance on several dimensions:

- Annual completion of a minimum of eight root cause analyses[45]
- 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.[46]

Quality, Safety, and Value Findings and Recommendations

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

[44] VHA Handbook 1050.01.

[45] 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]."

[46] 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).[47]

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 (known as Health Systems Council) and approved by the Medical Center Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[48]

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

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[50]
  - 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[51]
  - Evaluation by another provider with similar training and privileges

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

[48] VHA Handbook 1100.19.

[49] VHA Handbook 1100.19.

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

[51] 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 (known as Health Systems Council) 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.[52] 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."[53] The OIG reviewers assessed whether the medical center's staff

- Designated an individual and backup responsible for 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:

- Five solo/few practitioners who underwent initial or reprivileging during the previous 12 months[54]
- Seven LIPs hired within 18 months before the site visit
- Seventeen LIPs privileged within 12 months before the visit
- Three LIPs who left the medical center in 12 months before the visit

Medical Staff Privileging Findings and Recommendations

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

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

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

[54] VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers few practitioners as being less than three providers in the facility that are privileged in a particular specialty. The 12-month review period was from November 4, 2018, through November 4, 2019.

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.[55]

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. The OIG examined whether the medical center met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the inpatient mental health unit where patients with active suicidal ideation or attempts are treated. Inspectors reviewed 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
- Inpatient mental health unit
  - General safety
  - Special use spaces
  - Environmental cleanliness and infection prevention
  - Privacy
  - Accommodation for women veterans
  - Logistics
- Community-based outpatient clinic (CBOC)
  - General safety
  - Special use spaces

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

- Environmental cleanliness and infection prevention
- Privacy
- Privacy for women veterans
- Logistics

During its review of the environment of care, the OIG team inspected the Wausau VA Clinic and the following 11 patient care areas of the medical center:

- CLCs (401B, 402B, 403AN, 406B)
- Dental clinic
- Inpatient mental health unit (403)
- Medical/surgical combined inpatient unit
- Outpatient clinics (Red and Blue clinics)
- Urgent care clinic
- Women's health clinic

The inspection team reviewed relevant documents and interviewed key employees and managers.

Environment of Care Findings and Recommendations

Generally, the medical center achieved the requirements listed above. The OIG did not note any issues with the availability of medical equipment and supplies. 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.[56] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[57] 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.[58] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[59]

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.[60] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[61] 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.[62] 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.[63]

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

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

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[56] 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.)

[57] 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.)

[58] *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.)

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

[60] 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.)

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

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

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

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

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures include, but are not limited to, adherence to published clinical practice guidelines, timeliness of treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment, patient satisfaction, and quality of life.[64] 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 seven 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 OIG 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

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

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

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.[65] 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.[66] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[67]

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.[68]

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.[69] 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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[65] Centers for Disease Control and Prevention. *Preventing Suicide*. https://www.cdc.gov/violenceprevention/suicide/fastfact.html. (The website was accessed on March 4, 2020.)

[66] 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*.

[67] 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.*

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

[69] 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."[70] 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."[71] 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.[72] 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.[73]

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."[74] However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management changed the requirement for the HRS PRF placement to be "as soon as possible but no later than 1 business day after determination by the SPC."[75] 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."[76]

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

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

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

[72] *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.

[73] 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*.

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

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

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

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

On March 27, 2020, VHA also updated existing policy requirements to allow the review of HRS PRFs to "occur no earlier than 10 days before and no later than 10 days after the 90-day due date."[77]

Inspectors examined the completion of several requirements:

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

All VHA employees must complete suicide risk and intervention training within 90 days of entering their position. Clinical staff (including physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and Vet Center counselors) must complete Suicide Risk Management Training for Clinicians, and nonclinical staff must complete Operation S.A.V.E. training.[78] VHA also requires that all staff receive annual refresher training.[79] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[80]

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

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

[78] 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.

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

[80] 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.

- Relevant documents;
- The electronic health records of 21 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 an SPC, appointment tracking, suicide safety plans, and patient follow-up. However, the OIG noted a concern with suicide prevention refresher training.

VHA requires that all staff, clinical and nonclinical, "must complete the appropriate annual refresher training specific to their position."[81] The OIG found that 3 of 20 staff did not complete the annual refresher training within one year from the previous training. Failure to complete the training may result in staff not being current on care and treatment for patients with suicidal ideations. The Chief of Performance Improvement stated that despite supervisors monitoring for training completion, some staff did not complete all training on time.

Recommendation 1

1. The Chief of Staff determines the reasons for noncompliance and ensures all staff complete annual suicide prevention refresher training.

Medical center concurred.

Target date for completion: November 15, 2020

Medical center response: The Chief of Staff evaluated and determined there are no additional reasons for non-compliance.

The Director of Education is monitoring the compliance of annual suicide prevention training. The Suicide Prevention Coordinator supervisor will report monthly suicide training compliance rates through Health Systems Council. As the chair, the Chief of Staff will ensure continued reporting until the number of staff current with annual suicide prevention training (numerator) equals ninety percent or greater as compared to the number of total staff assigned annual suicide prevention training (denominator). This action will be monitored through Health Systems Council until six consecutive months of compliance has been reached.

[81] VHA Directive 1071.

Care Coordination: Life-Sustaining Treatment Decisions

Life-sustaining treatments (LSTs) are intended to extend the life of a patient expected to die soon without medical intervention. 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."[82]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.[83] 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.[84] 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.[85]

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

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

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

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

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

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

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

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

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

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

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

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[86] 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 44 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

Care Coordination Findings and Recommendations

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

[86] VHA Handbook 1004.03.

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[87] 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.[88] 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."[89] 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."[90]

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.[91] 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."[92]

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:

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[87] 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.)

[88] 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.)

[89] 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.)

[90] 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.)

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

[92] VHA Directive 1330.01(2).

- Provision of care requirements
  - Designated Women's Health Patient Aligned Care Team established
  - Primary Care Mental Health Integration services available
  - Gynecologic care coverage available 24/7
  - Gynecology care accessible
  - Facility women health primary care providers designated
  - CBOC women's health primary care providers designated
  - Emergency contraception accessible
- Oversight of program and monitoring of performance improvement data
  - Women Veterans Health Committee established
    - Quarterly meetings held
    - Core members attended
    - Quality assurance data collected and tracked
    - Reports made to clinical executive leaders
- Assignment of required staff
  - 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 OIG found the medical center complied with many of the requirements for the provision of women's health care, collection and tracking of quality assurance data, submission of reports to clinical executive leaders, and many of the staffing elements reviewed. However, the OIG identified deficiencies with CBOC-designated women's health primary care providers and the Women Veterans Health Committee membership.

VHA requires that each CBOC has at least two designated women's health primary care providers (WH-PCPs).[93] The OIG found that the Wausau VA Clinic had six primary care providers on staff but only one designated WH-PCP, which could limit the system's ability to provide comprehensive healthcare services to women veterans. The acting Associate Chief of

[93] VHA Directive 1330.01(2).

Medicine was aware of the requirement and reported primary care providers lacked interest in becoming WH-PCPs since they were already established in their practices.

Recommendation 2

2. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that each community-based outpatient clinic has at least two designated women's health primary care providers.

Medical center concurred.

Target date for completion: June 1, 2021

Medical center response: The Medical Center Director has evaluated and determined that the Wausau CBOC needs an additional designated women's health primary care provider.

The Medical Center Director ensures that the Wausau CBOC prioritizes training, recruitment, and hiring for designated women's health primary care providers. The Associate Chief of Staff for Medicine is working with Human Resources recruiting for interested candidates and offering robust training plans for those already employed at the Wausau CBOC. For interested providers, education includes focused women's health annual training for a total of five hours to include breast issues, chronic pelvic pain, abnormal uterine bleeding, contraception, and gynecologic emergencies. Additionally, the provider attends a women's health mini-residency for a total of twenty four hours of continuing education and simulation training focused on enhancing knowledge and skill in the areas of pelvic exams, vaginitis and cervicitis, abnormal uterine bleeding, contraception, interpersonal violence, chronic pelvic pain, menopause, breast issues, gynecologic emergencies, and post-deployment/reintegration issues. The mini-residency is offered for primary care providers and also for primary care providers and their paired registered nurse and meets the requirement for designation as a women's health primary care provider.

Compliance will be measured as the number of designated women's health primary care providers at each CBOC (numerator) equals the number of women's health primary care providers required at each CBOC (denominator). This recommendation will be considered compliant when each CBOC can demonstrate one hundred percent of CBOC have two designated women's health primary care providers. Compliance will be reported by the Director of Performance Improvement to Leadership Quality Council which is chaired by the Medical Center Director.

VHA requires that the Women Veterans Health Committee meets quarterly and has a core membership. That membership must include a Women Veterans Program Manager; a Women's Health Medical Director; "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED

[emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care; and a member from executive leadership."[94]

The OIG examined the Women Veterans Health Committee charter and found that it lacked core membership from laboratory, quality management, and the business office/non-VA medical care. This may have resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans. The Women Veterans Program Manager attributed noncompliance to not thoroughly reading the VHA directive and overlooking the required committee membership.

Recommendation 3

3. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that required members are included in the Women Veterans Health Committee charter and attend the quarterly meetings.

Medical center concurred.

Target date for completion: April 1, 2021

Medical center response: The Medical Center Director evaluated and determined that the charter did not include all required members per directive. The Women Veterans Coordinator updated the charter and ensured that the required members were included in the Women's Health Committee charter on January 30, 2020. The Medical Center Director reviewed and concurred, and compliance was reported to Performance Improvement Director on January 30, 2020.

Attendance at quarterly meetings will be monitored to ensure that the number of members present (numerator) at meetings is greater than or equal to ninety percent of the total required members per directive (denominator). Attendance rates will be reported by the Women Veterans Coordinator through Health Systems Council quarterly until six months of compliance has been achieved.

[94] VHA Directive 1330.01(2).

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 Sterile Processing Services (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment…"[95] The goal of SPS is to "...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[96] 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[97]
- 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[98]

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.[99] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[100]

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,

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

[96] 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.)

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

[98] VHA Directive 1116(2).

[99] 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.

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

personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[101]

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.[102]

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 and sterile storage areas; and interviewed key managers and staff on the following:

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

[101] VHA Directive 1116(2).
[102] VHA Directive 1116(2).

  - 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
  - Competency assessments performed
  - Monthly continuing education received

High-Risk Processes Findings and Recommendations

The medical center met many of the requirements for the proper operations and management of reprocessing RME. The OIG identified a deficiency with the annual risk analysis.

As previously mentioned, VHA requires that the Chief of SPS performs an annual risk analysis and reports the results to the VISN SPS Management Board.[103] The OIG found that an FY 2019 annual risk analysis was performed but did not find evidence that the results were reported to the VISN SPS Management Board. Failure to report the analysis may prevent leaders from identifying potential problems or process failures and taking appropriate action(s).[104] The Chief of SPS reported being under the impression that the VISN reporting requirement was met since the VISN SPS Lead participated in the medical center's October 2019 annual review.

Recommendation 4

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

[103] VHA Directive 1116(2).
[104] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: March 30, 2021

Medical center response: The Associate Director for Patient Care Services evaluated and determined no additional reasons for non-compliance.

The Associate Director for Patient Care Services confirmed that the Chief of Sterile Processing Services sent the completed fiscal year 2020 annual sterile processing risk analysis to VISN 12 on February 28, 2020 for reporting purposes to the VISN 12 Sterile Processing Services Management Board. Compliance was reported in April 13, 2020 to Patient Care Services Leadership Council through the Reusable Medical Equipment Committee.

Further compliance will be monitored by the Chief of Sterile Processing Service, ensuring that the fiscal year 2021 annual sterile processing risk analysis be sent to the VISN 12 Sterile Processing Services Management Board. This recommendation will be considered compliant when the Chief of Sterile Processing sends the annual risk analysis to VISN 12 for review. This will be reported at Patient Care Services Leadership Council, chaired by the Associate Director for Patient Care Services.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

Healthcare Processes	Requirements	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Factors related to possible lapses in care and medical center response • VHA performance data (facility or system) • VHA performance data for CLCs	Four OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the Director, Chief of Staff, and 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	• None	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• None	• None
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements	• None	• Staff complete annual suicide prevention refresher training.
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• None	• None
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• The Wausau VA Clinic has at least two designated women's health primary care providers.	• Required members are added to the Women Veterans Health Committee charter and attend the quarterly meetings.
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Data monitoring • Physical inspection • Staff training	• None	• The annual risk analysis is consistently reported to the VISN SPS Management Board.

Appendix B: Medical Center Profile

The table below provides general background information for this low complexity (3) affiliated[1] medical center reporting to VISN 12.[2]

Table B.1. Profile for Tomah VA Medical Center (676)
(October 1, 2016, through September 30, 2019)

Profile Element	Medical Center Data FY 2017[3]	Medical Center Data FY 2018[4]	Medical Center Data FY 2019[5]
Total medical care budget	$170,044,138	$202,913,370	$192,951,061
Number of:			
• Unique patients	25,968	25,870	25,795
• Outpatient visits	264,164	264,324	288,323
• Unique employees[6]	954	1,027	1,050
Type and number of operating beds:			
• Community living center	180	180	180
• Domiciliary	60	70	80
• Medicine	10	10	10
• Mental health	11	11	11
• Residential rehabilitation	10	10	10
Average daily census:			
• Community living center	132	132	128
• Domiciliary	26	32	48
• Medicine	5	5	3
• Mental health	5	5	4
• Residential rehabilitation	8	7	8

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] Associated with a medical residency program.

[2] 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."

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

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

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

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

Appendix C: VA Outpatient Clinic Profiles[1]

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Wausau, WI	676GA	9,917	5,908	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious disease Nephrology Poly-Trauma Rheumatology	n/a	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. 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.

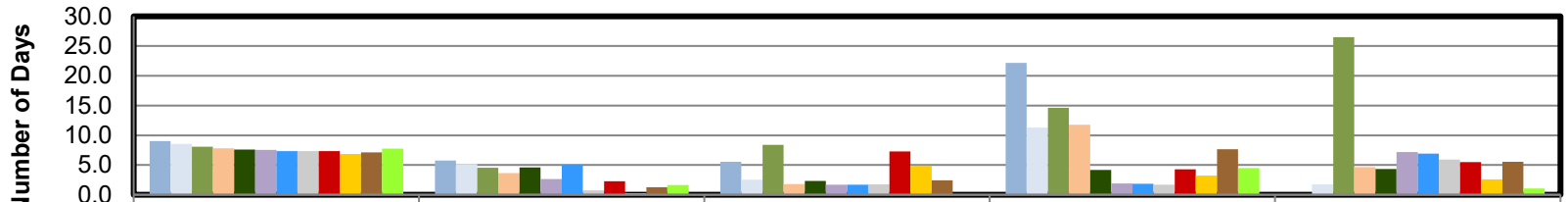
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
La Crosse, WI	676GC	13,027	8,301	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious disease Nephrology Neurology Pulmonary/ Respiratory disease Rheumatology	n/a	Nutrition Pharmacy Prosthetics Weight management
Wisconsin Rapids, WI	676GD	9,582	4,140	Cardiology Dermatology Endocrinology Eye Gastroenterology Hematology/ Oncology Infectious disease Nephrology Neurology Poly-Trauma Rheumatology	n/a	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
Owen, WI	676GE	2,069	1,078	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious disease Nephrology Rheumatology	n/a	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]

Quarterly New Primary Care Patient Average Wait Time in Days

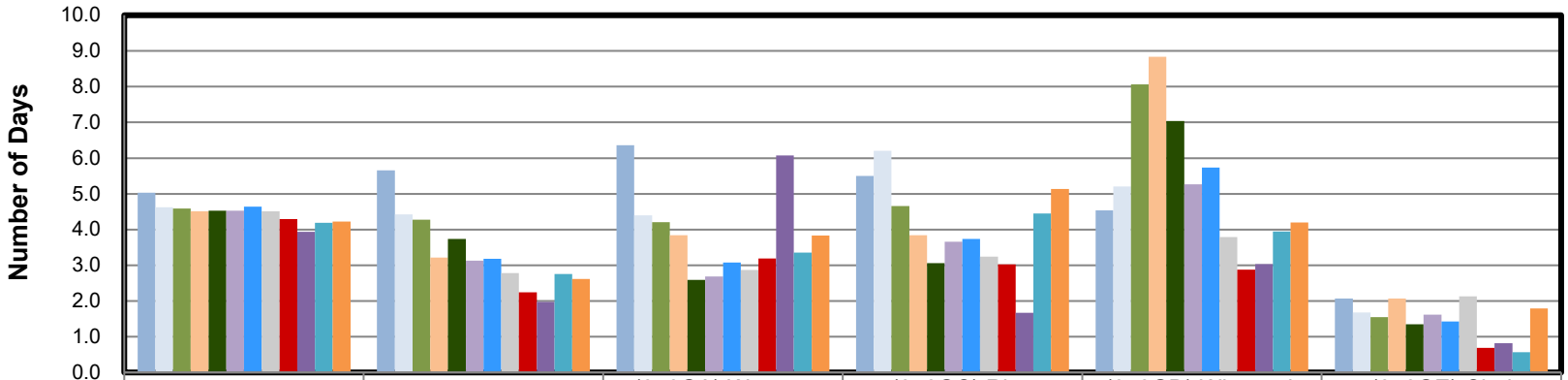


	VHA Total	(676) Tomah, WI	(676GA) Wausau, WI	(676GC) River Valley, WI	(676GD) Wisconsin Rapids, WI
JAN-FY19	9.0	5.8	5.6	22.2	0.0
FEB-FY19	8.5	5.2	2.5	11.3	1.7
MAR-FY19	8.1	4.6	8.4	14.6	26.5
APR-FY19	7.8	3.6	1.8	11.8	4.6
MAY-FY19	7.6	4.6	2.3	4.2	4.3
JUN-FY19	7.6	2.6	1.7	1.9	7.2
JUL-FY19	7.3	5.0	1.7	1.8	6.9
AUG-FY19	7.4	0.7	1.7	1.7	5.9
SEP-FY19	7.3	2.3	7.3	4.3	5.5
OCT-FY20	6.9	0.3	4.9	3.2	2.6
NOV-FY20	7.1	1.3	2.5	7.6	5.5
DEC-FY20	7.8	1.6	0.0	4.5	1.1

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (676GE) Clark County, WI, as no data were reported.
Data Definition: "The average number of calendar days between a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Note that prior to FY15, this metric was calculated using the earliest possible create date.

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

Quarterly Established Primary Care Patient Average Wait Time in Days



	VHA Total	(676) Tomah, WI	(676GA) Wausau, WI	(676GC) River Valley, WI	(676GD) Wisconsin Rapids, WI	(676GE) Clark County, WI
JAN-FY19	5.0	5.7	6.4	5.5	4.5	2.1
FEB-FY19	4.6	4.4	4.4	6.2	5.2	1.7
MAR-FY19	4.6	4.3	4.2	4.7	8.1	1.5
APR-FY19	4.5	3.2	3.8	3.8	8.8	2.1
MAY-FY19	4.5	3.7	2.6	3.1	7.0	1.4
JUN-FY19	4.5	3.1	2.7	3.7	5.3	1.6
JUL-FY19	4.6	3.2	3.1	3.7	5.7	1.4
AUG-FY19	4.5	2.8	2.9	3.2	3.8	2.1
SEP-FY19	4.3	2.2	3.2	3.0	2.9	0.7
OCT-FY20	3.9	2.0	6.1	1.7	3.0	0.8
NOV-FY20	4.2	2.8	3.4	4.4	3.9	0.6
DEC-FY20	4.2	2.6	3.8	5.1	4.2	1.8

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). 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.)

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.
Discharged to Community (SS)	Short-stay measure: percentage of short-stay residents who were successfully discharged to the community.
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.

[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.)

Measure	Definition
Outpatient ED visit (SS)	Short-stay measure: percent of short-stay residents who have had an outpatient emergency department (ED) visit.
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.
Rehospitalized after NH Admission (SS)	Short-stay measure: percent of residents who were re-hospitalized after a nursing home admission.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 16, 2020

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

Subj: Comprehensive Healthcare Inspection of the Tomah VA Medical Center in Wisconsin

To: Director, Office of Healthcare Inspections (54CH06)

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

1. I have reviewed the Comprehensive Healthcare Inspection of the Tomah VA Medical Center, Wisconsin draft report.
2. I concur with the findings, and four recommendations proposed.
3. I concur with the submitted action plans from the facility.
4. I would like to thank the OIG Inspection team for a thorough review of the Tomah VA Medical Center.

(Original signed by:)

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

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

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: June 16, 2020

From: Acting Medical Center Director, Tomah VA Medical Center (676/00)

Subj: Comprehensive Healthcare Inspection of the Tomah VA Medical Center in Wisconsin

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 27, 2020, have been reviewed. A plan of action for the four recommendations has been developed. The plans have been carefully analyzed and will be implemented and monitored through satisfactory completion.
2. I would like to thank the Office of Inspector General CHIP Survey team for their professionalism and constructive feedback to our employees during our reviews. This review provides the opportunity to continue improving care to our Veterans.

(Original signed by:)

Karen K. Long, MSN, RN

Acting Medical Center Director

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