DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 15: VA Heartland Network in Kansas City, Missouri

CHIP REPORT | REPORT #19-06848-209 | AUGUST 19, 2020

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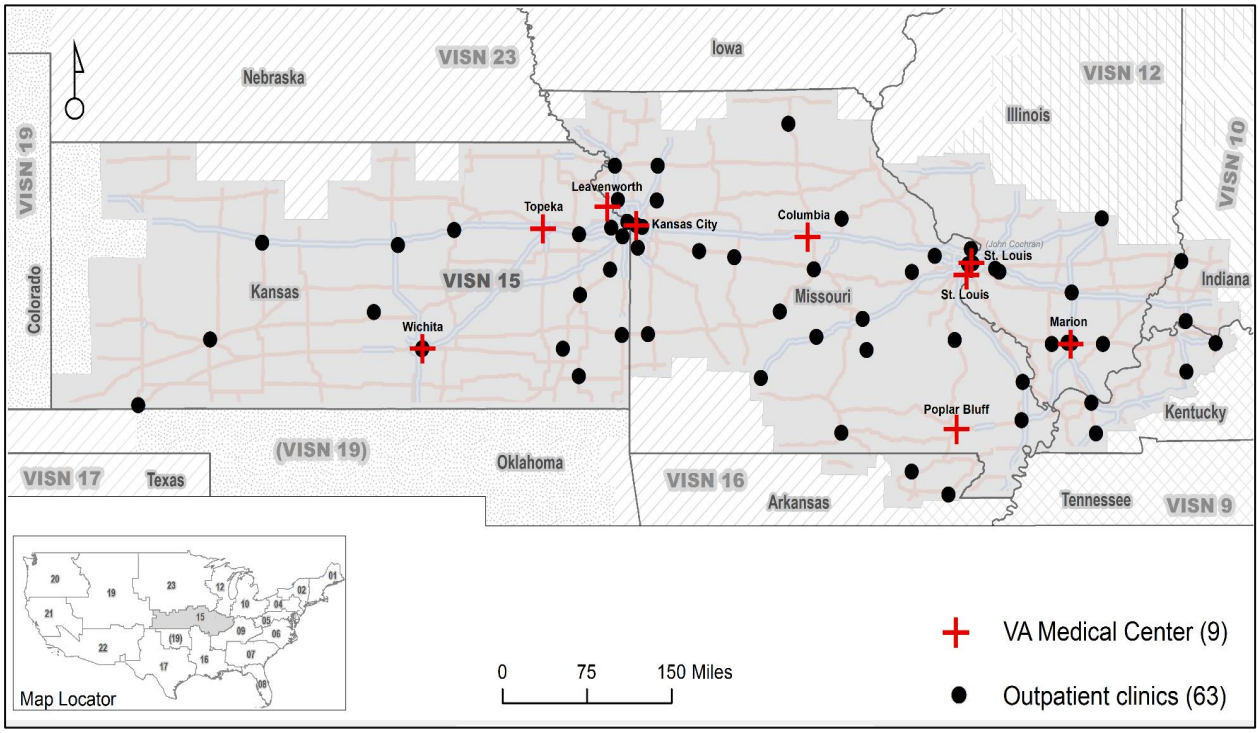

Figure 1. *VA Heartland Network –Veterans Integrated Service Network 15 in Kansas City, MO*
Source: Veterans Administration Site Tracking (VAST). December 16, 2019.

Abbreviations

CDC	Centers for Disease Control and Prevention
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	chief medical officer
FTE	full-time equivalent
FY	fiscal year
HCS	health care system
HRO	human resource officer
OIG	Office of Inspector General
POC	point of contact
QMO	quality management officer
QSV	quality, safety, and value
RME	reusable medical equipment
SAIL	Strategic Analytics for Improvement and Learning
SPS	Sterile Processing Services
UM	utilization management
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WVPM	women veterans program manager

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of leadership performance and oversight by the Veterans Integrated Service Network (VISN) 15: VA Heartland Network. This inspection covers key clinical and administrative processes 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 OIG selects and evaluates specific areas of focus each year.

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

1. Quality, safety, and value (QSV)
2. Medical staff credentialing
3. Environment of care
4. Medication management (targeting long-term opioid therapy for pain)
5. Women's health (examining comprehensive care)
6. High-risk processes (emphasizing reusable medical equipment)

The OIG conducted this unannounced visit during the week of November 18, 2019. Inspections of the following VISN 15 facilities were also performed during the weeks of November 4, 2019, and November 18, 2019:

- Harry S. Truman Memorial Veteran's Hospital (Columbia, Missouri)
- John J. Pershing VA Medical Center (VAMC) (Poplar Bluff, Missouri)
- Kansas City VAMC (Missouri)
- Marion VAMC (Illinois)
- Robert J. Dole VAMC (Wichita, Kansas)
- VA Eastern Kansas Health Care System (Topeka and Leavenworth)
- VA St. Louis Health Care System (John Cochran and Jefferson Barracks Divisions)

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient care outcomes. The findings presented in this report are a snapshot of VISN 15 and facility performance within the identified focus areas at the time of the OIG visit. The findings in this report may help the VISN identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

Leadership and Organizational Risks

The VISN leadership team consists of the Network Director, Deputy Network Director, Chief Medical Officer (CMO), Quality Management Officer (QMO), and Human Resource Officer (HRO). Organizational communication and accountability are managed through a committee reporting structure, with the VISN's Executive Leadership Council overseeing several working groups that include the Community Care Network Council; Integrated Ethics Council; and Quality, Safety and Value Council.

At the time of the OIG site visit, the executive team was led by the Network Director, who had been assigned since 2009. The rest of the executive team had worked together in a permanent capacity for five months.

The OIG reviewed selected employee satisfaction survey results and concluded that VISN leaders were engaged and promoted a culture of safety where employees feel safe bringing forward issues and concerns. The selected patient experience survey scores for the VISN were similar to or better than the VHA averages.

The OIG's evaluation of VISN access metrics and clinician vacancies did not identify any significant organizational risks. Interviewed leaders were knowledgeable about efforts taken to reduce veteran suicide in VISN 15 and shared information that highlighted efforts to develop and implement strategies for high-risk veterans.

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[1]

The leadership team was knowledgeable within their scope of responsibility about selected SAIL and CLC metrics but should continue to take actions to sustain and improve performance.[2] In individual interviews, the executive leaders were able to speak knowledgeably about actions

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

[2] Based on fiscal year 2019, Quarter 3 ratings at the time of the site visit; According to VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers,* June 1, 2017, CLCs, previously known as Nursing Home Care Units, provide a skilled nursing environment and a variety of interdisciplinary programs for persons needing short and long stay services.

taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

However, the OIG identified that the Director, CMO, and QMO had opportunities to improve their oversight of facility-level QSV, medical staff privileging, environments of care, medication management, mental health, care coordination, women's health, and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

The OIG noted areas for improvement in four of the six clinical areas reviewed and issued 10 recommendations that are attributable to the Network Director and CMO. These are briefly described below.

Quality, Safety, and Value

The OIG found general compliance with requirements for a written utilization management plan, collection and analysis of peer review data, and institutional disclosure reports for each facility. However, the OIG identified a concern with the annual utilization management program summary review.

Medication Management

The OIG observed compliance with many elements of expected performance, including the appointment of a VISN-level pain management point of contact and availability of tertiary interdisciplinary pain care services. However, the OIG found deficiencies with processes for Pain Management Strategy implementation progress reports and a VISN-level pain committee.

Women's Health

The VISN has multiple opportunities to improve its oversight for the provision of care for women veterans, including those that involve strategic planning activities, quarterly program updates to executive leaders, annual site visits, educational program and/or resources when needs were identified, women veterans' access and satisfaction data analysis, and maternity care outcome data monitoring.

High-Risk Processes

The VISN complied with establishment of a sterile processing services management board and VISN-led facility inspections. However, the OIG found a deficiency with timely development and submission of corrective action plans.

Conclusion

The OIG conducted a detailed inspection across seven key areas and subsequently issued 10 recommendations for improvement to the Network Director and CMO. The number of

recommendations should not be used, however, as a gauge for the overall quality provided within this VISN. The intent is for the leaders to use these recommendations as a road map to help improve operations and clinical care throughout the network of assigned facilities. The recommendations address systems issues as well as other less-critical findings that, if not addressed, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendix G, page 55, and the responses within the body of the report for the full text of the Network Director's comments.) The OIG considers recommendations 3, 5, and 7 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to evaluate leadership performance and oversight by the Veterans Integrated Service Network (VISN) 15: VA Heartland Network. This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN 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 in healthcare organizations.[2]

To examine risks to patients and the organization, the OIG focused on core processes in the following seven areas of administrative and clinical operations:

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff credentialing
4. Environment of care
5. Medication management (targeting long-term opioid therapy for pain)
6. Women's health (examining comprehensive care)
7. High-risk processes (emphasizing reusable medical equipment (RME))

[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 January 24, 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.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected documents and administrative and performance measure data. The OIG inspection team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection period examined operations from February 6, 2016, through November 22, 2019, the last day of the unannounced week-long site visit.[3]

Inspections of the following VISN 15 facilities were also performed during the weeks of November 4, 2019, and November 18, 2019:

- Harry S. Truman Memorial Veterans' Hospital (Columbia, Missouri)
- John J. Pershing VA Medical Center (VAMC) (Poplar Bluff, Missouri)
- Kansas City VAMC (Missouri)
- Marion VAMC (Illinois)
- Robert J. Dole VAMC (Wichita, Kansas)
- VA Eastern Kansas Health Care System (HCS) (Topeka and Leavenworth)
- VA St. Louis HCS (John Cochran and Jefferson Barracks Divisions)

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 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 VISN completes corrective actions. The Network Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that the VISN leaders developed based on the reasons for noncompliance.

[3] The range represents the time from the Combined Assessment Program inspection of the Kansas City VA Medical Center to the completion of the unannounced week-long CHIP site visit on November 22, 2019. (See Appendix D.)

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. Leadership and organizational risks can impact the ability to provide care in the clinical focus areas.[4] To assess the VISN's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Access to care
5. Clinician vacancies
6. VISN efforts to reduce veteran suicide
7. Oversight inspections
8. VHA performance data

Additionally, the OIG briefed VISN managers on identified trends in noncompliance for facility CHIP reviews performed during the weeks of November 4, 2019, and November 18, 2019.

Executive Leadership Position Stability and Engagement

A VISN consists of a geographic area that encompasses a population of veteran beneficiaries. The VISN is defined based on VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VAMCs, clinics, and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is designed to be the basic budgetary and planning unit of the veteran's healthcare system.[5]

VISN 15 is responsible for oversight of nine medical facilities and 63 outpatient clinics. According to data from the VA National Center for Veterans Analysis and Statistics, VISN 15 had a veteran population of 725,470 within its borders at the end of fiscal year (FY) 2019.

[4] 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 February 2, 2017.)

[5] Detailed explanation of VISNs provided by Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration, Department of Veterans Affairs, before the House Committee on Veterans' Affairs, May 22, 2018.

VISN 15 has a leadership team consisting of the Network Director, Deputy Network Director, Chief Medical Officer (CMO), Quality Management Officer (QMO), and Human Resource Officer (HRO). The CMO is responsible for overseeing facility-level patient care programs. Figure 2 illustrates the VISN's reported organizational structure.

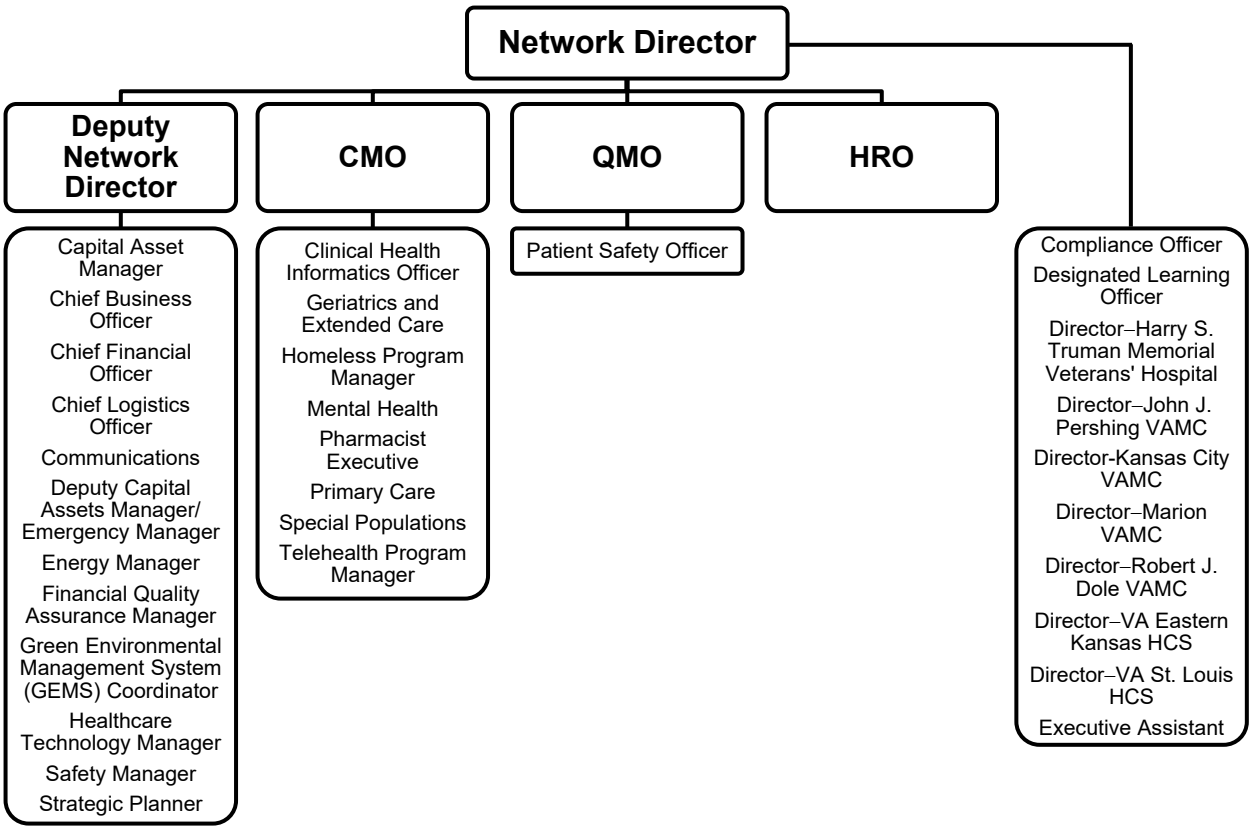

Figure 2. *VISN 15 Organizational Chart*[6]
Source: VA Heartland Network (received November 18, 2019)

At the time of the OIG's inspection, the VISN's executive team had been working together in a permanent capacity for five months, although the Network Director, Deputy Network Director, CMO and HRO had worked together since December 2015. The QMO was the newest member of the team, having served in the position since June 2019 (see Table 1).

[6] For this VISN, the Network Director is responsible for the directors of the VA Eastern Kansas HCS, Harry S. Truman Veteran's Hospital, John J. Pershing VAMC, Kansas City VAMC, Marion VAMC, Robert J. Dole VAMC, and St. Louis VA HCS.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network Director	January 4, 2009
Deputy Network Director	December 13, 2015
Chief Medical Officer	September 21, 2014
Quality Management Officer	June 9, 2019
Human Resources Officer	November 6, 2011

Source: VA Heartland Network (received November 18, 2019)

To help assess VISN executive leaders' engagement, the OIG interviewed the Network Director, Deputy Network Director, CMO, and QMO regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

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

The leaders are members of the VISN's Executive Leadership Council, which is responsible for processes that enhance network performance through

- Organizational values and strategic direction,
- Policy development and decision making,
- Compliance and financial performance,
- Creation and balancing of values for patients and other stakeholders,
- Regular review of organizational performance and capabilities,
- Priorities for improvement and opportunities for innovation, and
- Communication and development of organizational goals/objectives across the network.

The Network Director serves as the chairperson of the Executive Leadership Council, which has oversight of various committees, including the Community Care Network Council; Integrated Ethics Council; and Quality, Safety and Value Council. See Figure 3.

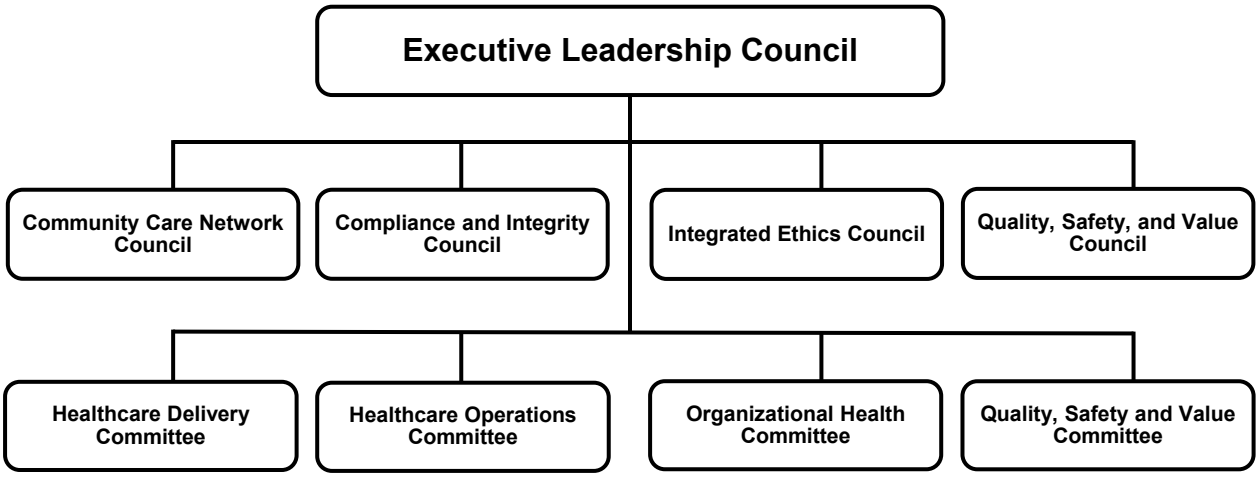

Figure 3. *VISN 15 Committee Reporting Structure*
Source: VA Heartland Network (received November 18, 2019)

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on VISN leadership.

To assess employee attitudes toward VISN and facility leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2018, through September 30, 2019.[7] Table 2 summarizes employee attitudes as expressed in VHA's All Employee Survey for VHA, the VISN office, and VISN leaders. It is important to note that the Deputy Network Director and QMO did not have a sufficient number of respondents to calculate an average response for the selected questions.[8] The OIG found the VISN office and leaders' averages for the selected survey leadership questions were consistently higher than VHA averages.[9]

[7] Ratings are based on responses by employees who report to or are aligned under the Network Director and CMO.

[8] The All Employee Survey ensures that "Reponses are confidential and data will remain anonymous…In order to maintain confidentiality, no data from groups smaller than five (5) will be released." http://aes.vssc.med.va.gov/SurveyInstruments/Pages/default.aspx. (The website was accessed on March 3, 2020, but is not accessible by the public.)

[9] The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

Table 2. Survey Results on Employee Attitudes toward VISN 15 Leadership (October 1, 2018, through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	VISN 15 Office Average	Network Director Average	CMO Average
All Employee Survey: *Servant Leader Index Composite*[10]	0–100 where HIGHER scores are more favorable	72.6	88.5	87.8	89.4
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	4.3	4.4	4.3
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	4.5	4.6	4.5
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	4.4	4.6	4.5

Source: VA All Employee Survey (accessed October 21, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the VISN office and executive leadership team averages for the selected survey questions were also consistently better than the VHA averages. VISN leaders appear to be maintaining an environment where employees feel safe bringing forth issues and concerns.

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

Table 3. Survey Results on Employee Attitudes toward the VISN 15 Workplace (October 1, 2018, through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	VISN 15 Office Average	Network Director Average	CMO Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	4.5	4.6	4.6
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) –5 (Strongly Agree)	3.7	4.4	4.4	4.5
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	0.8	1.1	0.8

Source: VA All Employee Survey (accessed October 21, 2019)

Patient Experience

To assess patient attitudes toward VISN and facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2018, through July 31, 2019. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support performance benchmarking against the private sector. Table 4 provides relevant survey results for VISN 15 and compares the results to the overall VHA averages.[11]

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). The VISN averages for each of the selected survey questions are similar to or higher than the VHA averages, indicating that VISN 15 patients are generally more satisfied compared to VHA patients in general.

[11] Ratings are based on responses by patients who received care within the VISN.

VISN leaders noted lower inpatient satisfaction scores at VA St. Louis HCS and VA Eastern Kansas HCS and highlighted efforts to assist in improving overall performance and satisfaction scores at these facilities. The VISN set up "Leadership Listening Posts"—a service recovery communication tool used to proactively solicit veteran feedback—to better understand patient and employee concerns and make system improvements.[12] VISN 15 facility scores for the selected questions are presented in Appendix C.

Table 4. Survey Results on Patient Attitudes within VISN 15 (October 1, 2018, through July 31, 2019)

Questions	Scoring	VHA Average	VISN 15 Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.1	65.8
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	85.9
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	79.0
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	80.2

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 7, 2019)

Access to Care

A VA priority is achieving and maintaining an optimal workforce to ensure timely access to the best care and benefits for our nation's veterans. VHA has a goal of providing patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[13] VHA has utilized various measures to determine whether access goals are met for both new and established patients, including wait

[12] VHA Handbook 1003.2, Service *Recovery in the Veterans Health Administration*, February 4, 2004.

[13] According to VHA Directive 1230(2), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended January 22, 2020, the "Clinically Indicated Date (CID) is the date an appointment is deemed clinically appropriate by a VA health care provider. The CID is contained in a provider entered Computerized Patient Record System (CPRS) order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request…The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity."

time statistics based on appointment creation and patient preferred dates.[14] Wait time measures based on "create date" have the advantage of not relying upon the accuracy of the "preferred date" entered into the scheduling system and are particularly applicable for new primary care patients where the care is not initiated by referral, or consultation, that includes a "clinically indicated date." The disadvantage to "create date" metrics is that wait times do not account for specific patient requests/availability. Wait time measures based on patient preferred dates consider patient preferences but rely upon appointment schedulers accurately recording the patients' wishes into the scheduling software.[15]

When patients could not be offered appointments within 30 days of clinically indicated or preferred dates, patients became eligible to receive non-VA (community) care through the VA Choice program—eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.[16] However, with the passage of the VA MISSION Act of 2018 on June 6, 2018, and subsequent enactment on June 6, 2019, eligibility criteria for obtaining care in the community now include average drive times and appointment wait times:[17]

- Average drive time
  - 30-minute average drive time for primary care, mental health, and non-institutional extended care services
  - 60-minute average drive time for specialty care
- Appointment wait time
  - 20 days for primary care, mental health care, and non-institutional extended care services, unless the veteran agrees to a later date in consultation with a VA health care provider
  - 28 days for specialty care from the date of request, unless the veteran agrees to a later date in consultation with a VA health care provider

To examine access to primary and mental health care within VISN 15, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics for the most recently completed quarter. Tables 5 and 6 provide wait time statistics for

[14] Completed appointments cube data definitions, https://bioffice.pa.cdw.va.gov/. (The website was accessed on March 28, 2019.)

[15] Office of Veterans Access to Care, *Specialty Care Roadmap*, November 27, 2017.

[16] VHA Directive 1700, *Veterans Choice Program*, October 25, 2016.

[17] VA MISSION Act of 2018, Pub. L. No. 115-182, Stat. 1393; VA Office of Public Affairs Media Relations, *Fact Sheet: Veteran Community Care – Eligibility, VA MISSION Act of 2018*, April 2019. https://www.missionact.va.gov/library/files/MISSION-Act-Veteran-Community-Care-Eligibility-Fact-Sheet.pdf. (The website was accessed on June 27, 2019.)

completed primary care and mental health appointments from July 1, 2019, through September 30, 2019.

Table 5. Primary Care Appointment Wait Times[18] (July 1, 2019, through September 30, 2019)

Facility	New Patient Appointments	Average New Patient Wait from Create Date (in Days)
VA Heartland Network – VISN 15	5,686	17.1
Harry S. Truman Memorial Veteran's Hospital (Columbia, MO)	795	11.1
John J. Pershing VAMC (Poplar Bluff, MO)	496	11.6
Kansas City VAMC (MO)	676	17.8
Marion VAMC (IL)	752	19.6
Robert J. Dole VAMC (Wichita, KS)	953	22.8
VA Eastern Kansas HCS (Topeka and Leavenworth)	701	19.5
VA St. Louis HCS (MO)	1,313	15.5

Source: VHA Support Service Center (accessed October 21, 2019)
Note: The OIG did not assess VA's data for accuracy or completeness.

[18] Reported primary care wait times are for appointments designated as clinic stop 323, Primary Care Medicine, and records visits for comprehensive primary care services.

Table 6. Mental Health Appointment Wait Times[19] (July 1, 2019, through September 30, 2019)

Facility	New Patient Appointments	Average New Patient Wait from Create Date (in Days)
VA Heartland Network –VISN 15	1,186	14.1
Harry S. Truman Memorial Veterans' Hospital (Columbia, MO)	134	20.0
John J. Pershing VAMC (Poplar Bluff, MO)	126	14.5
Kansas City VAMC (MO)	151	11.6
Marion VAMC (IL)	157	12.2
Robert J. Dole VAMC (Wichita, KS)	195	13.0
VA Eastern Kansas HCS (Topeka and Leavenworth)	338	12.5
VA St. Louis HCS (MO)	85	19.4

Source: VHA Support Service Center (accessed October 21, 2019)
Note: The OIG did not assess VA's data for accuracy or completeness.

Based upon wait times alone, the OIG noted opportunities to improve wait times for new primary care patients at the Marion VAMC, Robert J. Dole VAMC, and VA Eastern Kansas HCS and new mental health patients at Harry S. Truman Memorial Veterans' Hospital and VA St. Louis HCS where the average wait times were near or above 20 days. The wait times also highlight opportunities for these facilities to improve the timeliness of care provided "in house" and thus decrease the potential for fragmented care among those who are referred to community providers.

To improve mental health wait times in 2019, VISN 15 offered telehealth appointments through the VA Video Connect program with clinicians at the VISN Mental Health Telehealth Hub located at VA Eastern Kansas HCS.[20] The Mental Health Telehealth Hub brings specialty staff and services closer to the veteran's home. Veterans connect with VA health specialists in medical centers from the veteran's community clinic. Providers perform exams, make diagnoses, and manage care virtually. The VISN also supported the conversion of clinical space at John J. Pershing VAMC and Marion VAMC into a residential rehabilitation unit, which allows patients in these areas to receive treatment closer to home and their individual support systems. The

[19] Reported mental health wait times are for appointments designated as clinic stop 502, Mental Health Clinic Individual, and records visits for the evaluation, consultation, and/or treatment by staff trained in mental diseases and disorders.

[20] VA Video Connect connects veterans with their health care team from anywhere, using encryption to ensure a secure and private session. This technology makes VA health care more convenient and reduces travel times for veterans, especially those in very rural areas with limited access to VA health care facilities, and allows quick and easy health care access from any mobile or web-based device.

Mental Health Telehealth Hub has also hired additional support staff and a group practice manager whose position is funded by the VA Office of Rural Health.[21]

Clinical Vacancies

Within the healthcare field, there is general acceptance that staff turnover, or instability, and high clinical vacancy rates negatively impact access to care, quality of health care provided, patient safety, and patient and staff satisfaction. Turnover can directly affect staffing levels and further reduce staff and organizational performance through the loss of experienced staff.[22]

To assess the extent of clinical vacancies across VISN 15 facilities, the OIG held discussions with the HRO and reviewed the total number of vacancies by facility, position, service/section, and full-time equivalent (FTE) employees. Upon closer inspection, the OIG found multiple clinical vacancies across VISN 15 for physicians (~101 FTE), physician assistants (~11 FTE), registered nurses (~296 FTE), and licensed practical nurses (~78 FTE). Table 7 provides the number of vacancies and vacancy rates for these professions as well as the total vacancy rate by VISN 15 facilities as of November 18, 2019.

Table 7. Reported Vacancy Rates for VISN 15 Facilities (as of November 5, 2019)

Facility	Clinical Vacancies	Clinical Vacancy Rate	Total Vacancy Rate
Harry S. Truman Memorial Veterans' Hospital (Columbia, MO)	36	5.1%	7.3%
John J. Pershing VAMC (Poplar Bluff, MO)	23	7.8%	7.7%
Kansas City VAMC (MO)	117	11.6%	12.8%
Marion VAMC (IL)	74	10.8%	9.2%
Robert J. Dole VAMC (Wichita, KS)	40	7.2%	5.5%
VA Eastern Kansas HCS (Topeka and Leavenworth)	119	15.0%	12.6%
VA St. Louis HCS (MO)	81	6.1%	9.1%

Source: VISN 15 Deputy Human Resources Officer (received November 19, 2019)

Given the potential opportunities to improve primary care wait times at the Marion VAMC, Robert J. Dole VAMC, and VA Eastern Kansas HCS, the OIG also reviewed the number of primary care clinical vacancies related to the identified positions. Clinical staffing may be a contributing factor for primary care wait time challenges at the VA Eastern Kansas HCS, where 28 physician and six physician assistant FTEs were vacant. Mental health wait times might also

[21] In 2006, the VA Office of Rural Health was established under 38 USC § 2006 to coordinate care for the millions of veterans who reside in rural communities.

[22] J. Buchanan, "Reviewing the Benefits of Health Workforce Stability," *Human Resources for Health* 8, no. 29 *(2010)*.

be impacted by clinical staffing at Harry S. Truman Memorial Veterans' Hospital, where four psychologist and five social worker FTEs were vacant; and at VA St. Louis HCS where five psychiatrist, six psychologist, and three social worker FTEs were vacant.

The VISN reviews the status of mental health positions monthly and analyzes its coverage based on the ratio of providers to patients. The VISN and facilities engage in continuous recruiting and use all available options for special pay incentives and salaries.[23]

VISN Efforts to Reduce Veteran Suicide

Suicide is a leading cause of death in the United States, and suicide rates in almost all states increased from 1999 through 2016.[24] Although the unadjusted rate of suicide among veterans decreased from 30.5 to 30.1 per 100,000 veterans from 2015 to 2016, the suicide rate for veterans age 18 to 34 has risen substantially since 2005. With approximately 20 million veterans in United States, the number of veterans who die by suicide annually is significant.[25] Further, the issue of suicide has garnered recent congressional and media interest given the suicides of three veterans at VA facilities in Georgia and Texas within five days of each other in April 2019.[26]

VA has made suicide prevention its top priority with the Office of Mental Health and Suicide Prevention through significant suicide prevention initiatives: expansion of the Veterans Crisis Line to three call centers, release of a suicide prevention training video,[27] launch of the Mayor's

[23] Education Debt Reduction Program (EDRP) authorizes VA to provide student loan reimbursement to employees with qualifying loans who are in difficult to recruit and retain direct patient care positions. Loans must be for the health professional's education that qualified the applicant for a specific position. Each Veterans Health Administration (VHA) facility determines which positions are hard to recruit and retain and when the facility will offer EDRP for these positions. EDRP is a recruitment and retention incentive only offered or approved for certain positions. https://www.vacareers.va.gov/Content/Documents/Print/EDRP_VA_Careers_Page.pdf. (The website was accessed on March 11, 2020.)

[24] The Centers for Disease Control and Prevention (CDC), *CDC Vitalsigns™*, June 2018. https://www.cdc.gov/vitalsigns/index.html. (The website was accessed on August 4, 2020.)

[25] U.S. Department of Veterans Affairs, "Mental Health.". https://www.mentalhealth.va.gov/suicide_prevention/. (The website was accessed on June 22, 2020.)

[26] Elizabeth McLaughlin, "Legislation to address uptick of veteran suicides at VA facilities: Three veterans took their lives at VA facilities this month," *ABC News*, April 18, 2019.

[27] VA Operation S.A.V.E. outlines steps for staff to help veterans—Signs of suicidal thinking, Ask questions, Validate the veteran's experience, Encourage treatment, and Expedite getting help. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4071. (The website was accessed on June 21, 2019.)

Challenge,[28] and partnerships with the Departments of Defense and Homeland Security to support veterans during their transition from military to civilian life.[29]

The OIG found that VISN 15 leaders appeared engaged and supportive of facilities' efforts to prevent veteran suicides and noted that the VISN mental health lead conducted site visits in the past year to identify program weaknesses and corrective actions. Also, in 2019, VISN facilities increased suicide prevention staff and held mental health summits for mental health chiefs, suicide prevention coordinators, and community partners. The summits provided training on suicide prevention screening procedures for hospital-wide staff and facilitated the development of strategic plans for the upcoming year.

Based on the 2019 National Veteran Suicide Prevention Annual Report's findings, VISN leaders suggested that expanding mental health care for National Guard and Reserve members, who had never been federally activated, may help identify those veterans outside the scope of VHA care who may be at increased risk for suicide.[30] VISN leaders noted that a public health model can lead to reduction in suicidal behavior and violence by delivering resources and support to veterans earlier, before they reach a crisis point.[31] VISN leaders also suggested that increased funding to inform the public about VA suicide prevention efforts would be effective.

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders respond to identified problems. Except for one recommendation made in a recently published report, VISN and facility leaders have closed all recommendations for improvement listed in Appendix D.[32]

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[28] VA Office of Public and Intergovernmental Affairs, *VA continues community suicide-prevention challenge.* https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5230. (The website was accessed on June 22, 2020.) "The Mayor's Challenge was launched in March 2018, bringing together representatives of eight cities to develop local action plans to prevent Veteran suicide. Since then, the Mayor's Challenge program has expanded to a total of 24 cities. An inaugural Governor's Challenge that involved seven state teams took place in February, replicating the effort on the state level. Participants in both programs form interagency teams to bolster Veteran suicide-prevention efforts in their communities."

[29] Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016,* September 2018.

[30] According to the Office of Mental Health and Suicide Prevention, *2019 National Veteran Suicide Prevention Annual Report*, "There were 919 suicides among never federally activated former National Guard and Reserve members in 2017, an average 2.5 suicide deaths per day."

[31] According to the CDC, public health uses a population approach, which focuses on prevention approaches that impact groups or populations of people, versus treatment of individuals. https://www.cdc.gov/violenceprevention/pdf/ASAP_Suicide_Issue2-a.pdf. (The website was accessed on March 3, 2020.)

[32] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations. The OIG will follow up on the planned actions for the open recommendation until it is completed.

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[33]

Figure 4 illustrates the VISN's quality of care and efficiency metric rankings and performance as of June 30, 2019. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of continued (cont) stay reviews met, complications, and capacity). Metrics that need improvement are denoted in orange and red (for example, rating (of) hospital, acute care 30-day standardized mortality ratio (SMR30), hospital wide readmission (RSRR-HWR), mental health (MH) population (popu) coverage, and health care (HC) associated (assoc) infections).[34]

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

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

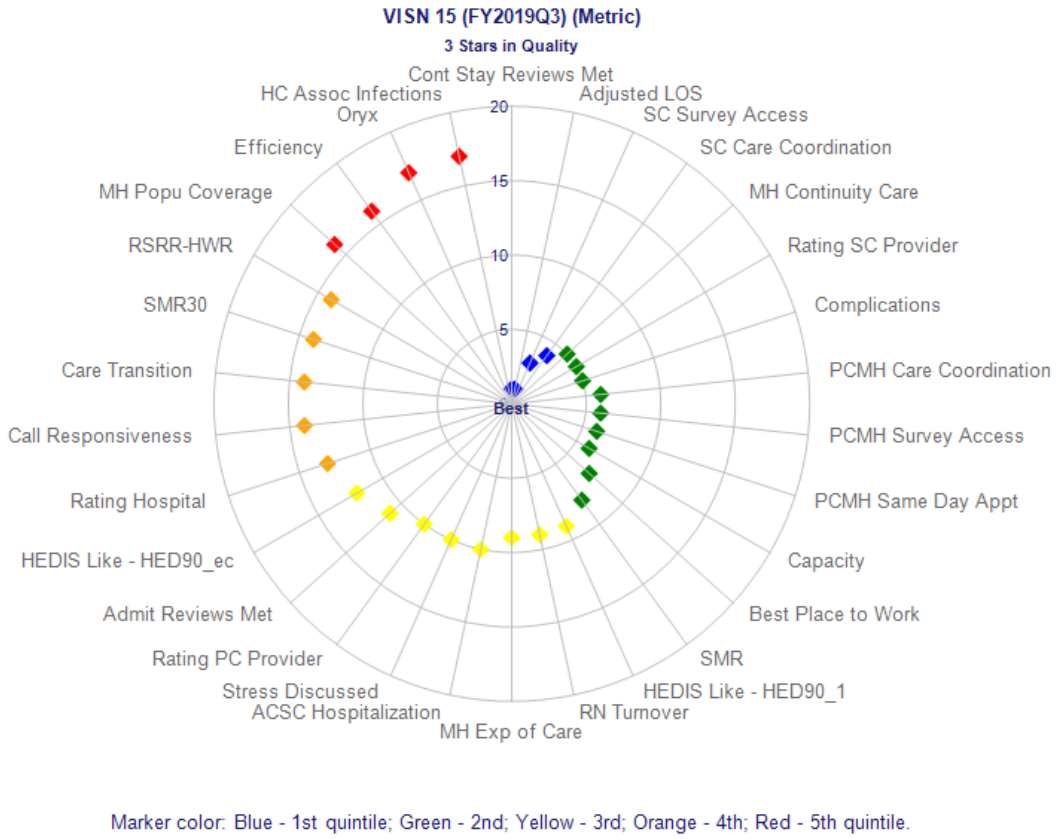

Figure 4. *Facility Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

In 2019, VISN 15's oversight and efforts to improve performance measures included a proactive performance team staff visit and a review of standardization of sepsis recognition and intervention at the Kansas City VAMC, quality management oversight for hospital-wide readmissions for cardiac patients at the Marion VAMC, and implementation of an enhanced recovery of surgery protocol to decrease the length of stay in the hospital for colorectal surgery patients at the Robert J. Dole VAMC.[35]

To address performance scores in mental health population coverage, the VISN Mental Health Lead visited select VISN facilities to review and assist service chiefs in improving quality and access to care. The lead made recommendations in primary care mental health integration (PC-

[35] Centers for Disease Control, "What is sepsis?" https://www.cdc.gov/sepsis/what-is-sepsis.html. (The website was accessed on February 17, 2019. The CDC defines sepsis as the body's extreme response to an infection, which can be life-threatening; and without timely treatment, can rapidly lead to tissue damage, organ failure, and death. According to O. Ljungqvist, M. Scott, and K.C. Fearon, "Enhanced Recovery After Surgery: A Review," *JAMA Surg*. 152, no. 3 (2017): 292-298, "Enhanced Recovery After Surgery (ERAS) is a paradigm shift in perioperative care, resulting in substantial improvements in clinical outcomes and cost savings." https://jamanetwork.com/journals/jamasurgery/fullarticle/2595921 (The website was accessed on February 24, 2020.)

MHI), adoption of the VHA Flow Initiative, substance use disorder outpatient treatment, and monitoring of suicide risk assessments.[36]

The SAIL Value Model also includes "SAIL CLC," which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in the Centers for Medicare & Medicaid Services' *Nursing Home Compare*.[37] The SAIL CLC provides a single resource to review quality measures and health inspection results.

The SAIL CLC includes a radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 5 illustrates the VISN's CLC quality rankings and performance compared to other VA CLCs as of June 30, 2019. The figure uses blue data points to indicate high performance (for example, in the areas of physical restraints–long-stay (LS) and improvement in function–short-stay (SS)). Measures that need improvement are denoted in orange and red (for example, urinary tract infections (UTI) (LS), falls with major injury (LS), catheter in bladder (LS), moderate-severe pain (LS) (SS), and ability to move independently worsened (LS)).[38]

[36] The VA's Primary Care-Mental Health Integration (PC-MHI) Functional Tool describes PC-MHI as a collaboration between mental health and primary care services. These services are integrated into the primary care setting and support patient-aligned care teams based treatment of both mental health conditions and behavioral aspects of chronic medical conditions. https://www.mirecc.va.gov/cih-visn2/Documents/Clinical/PC-MHI_Functional_Tool_v10_090712.pdf . (The website was accessed on March 10, 2020.) The FLOW Initiative is based on a VHA study of veterans receiving treatment in mental health clinic settings that would benefit from transition to primary care. The initiative was publicized in a September, 12, 2019 VA Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum. The study recommends collaboration between mental health and primary care providers in making the decision of which setting is most appropriate for treatment. The initiative has an electronic health record report to assist providers in identifying good candidates for a transition in care.

[37] According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, August 22, 2019, "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."

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

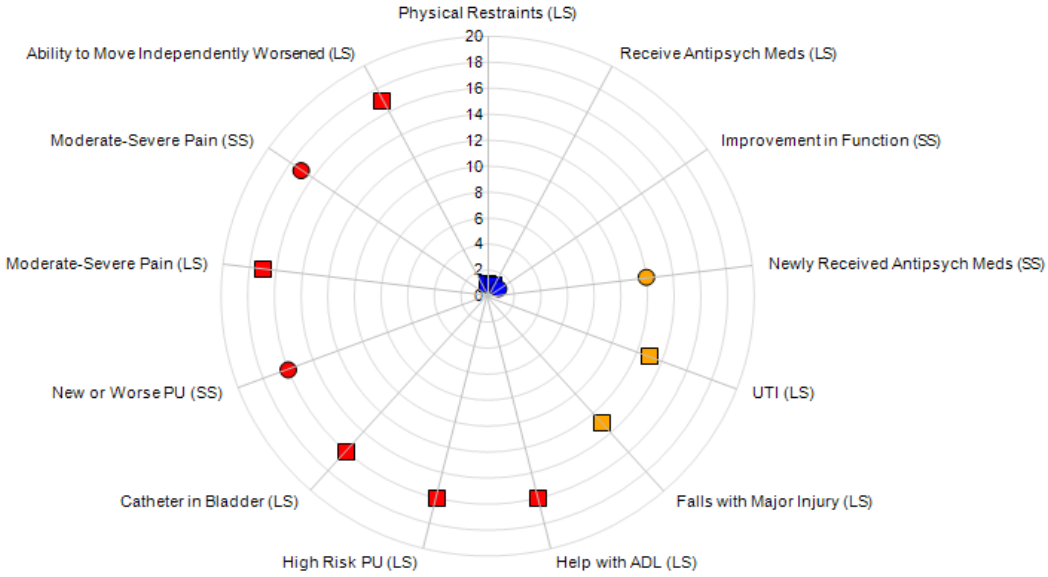

***Figure 5**. CLC Quality Measure Rankings (as of June 30, 2019)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix F.

The VISN leaders acknowledged issues with the quality ratings and Long Term Care Institute unannounced survey findings for some VISN CLCs. In June 2019, the VISN sponsored a CLC Improvement Workshop for CLC staff, which included presentations and action planning that ranged from understanding the CLC SAIL report, identifying and coding of pressure ulcers, to developing effective strategies to reduce indwelling catheter use.[39] The VISN leaders also disseminated best practices for improving CLC quality scores developed by staff at the John J. Pershing VAMC CLC, where quality scores had consistently improved over the past two years.

Observed Trends in Noncompliance

During CHIP inspections of the VISN 15 facilities performed during the weeks of November 4, 2019, and November 18, 2019, the OIG noted several trends in noncompliance for the following areas:

[39] Centers for Disease Control and Prevention, *Urinary Tract Infection (Catheter-Associated Urinary Tract Infection [CAUTI] and Non-Catheter-Associated Urinary Tract Infection [UTI] Events*, January 2020. https://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf. (The website was accessed February 18, 2020. According to the CDC, "Urinary tract infections (UTIs) are the fifth most common type of healthcare-associated infection." Also, "each day the indwelling urinary catheter remains, a patient has a 3% to 7% increased risk of acquiring a catheter-associated urinary tract infection (CAUTI)...Complications associated with CAUTI cause discomfort to the patient, prolonged hospital stay, and increased cost and mortality."

- Quality, safety, and value – inconsistent (1) documentation of physician utilization management (UM) advisor decisions, (2) documentation of utilization management reviews by interdisciplinary teams, and (3) inclusion of required elements in root cause analyses.
- Medical staff privileging – absence of service-specific criteria for ongoing professional practice evaluations (OPPEs), not using similarly privileged providers to complete evaluations, not documenting the decision to continue privileges based in part on OPPE results, not defining and communicating focused professional practice evaluation expectations in advance, and not completing provider exit reviews timely.
- Environment of care – inconsistent protection of personally identifiable information on laboratory specimens during transport.
- Medication management (specifically long-term opioid therapy for pain) – incomplete (1) documentation of behavioral risk assessments, (2) urine drug testing, (3) informed consent, and (4) timely follow-up for long-term opioid therapy patients and the inadequate monitoring of the quality of pain assessment and effectiveness of pain management interventions by pain committees.
- Mental health (focusing on the suicide prevention program) – inconsistent (1) inclusion of required elements in suicide safety plans, (2) follow-up of patients designated as high-risk, and (3) provision of annual suicide prevention training.
- Care coordination (spotlighting life-sustaining treatment decisions) – absence of multidisciplinary committees to review proposed life-sustaining treatment plans.
- Women's health (examining comprehensive care) – lack of assurance that Women Veterans Health Committees are staffed with required core members.
- High-risk processes (specifically RME) – incomplete (1) maintenance of standard operating procedures, (2) competency assessment of staff who reprocess RME, and (3) reporting to the VISN SPS Management Board and inadequate storage of endoscopes and provision of monthly continuing education to SPS staff.

In response to these trends, the Network Director noted that the VISN would follow up with responsible facility directors, chiefs of staff, associate directors for Patient Care Services, and associate directors.

Leadership and Organizational Risks Conclusion

The VISN's executive leadership team appeared stable, with the Network Director, Deputy Network Director, CMO, and HRO serving together for the past four years. The QMO joined the team in June 2019.

Selected survey scores related to employees' satisfaction with the VISN executive team leaders were consistently better than VHA averages. In review of patient experience survey data, the OIG noted VISN averages for each of the selected survey questions were similar to or higher than the VHA averages. The VISN leaders appeared actively engaged with employees and

patients and were working to sustain and further improve employee and patient engagement and satisfaction.

The executive team leaders seemed to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as conducting site visits to improve performance measures and quality of care for high-risk veterans and providing VISN-wide training for mental health and CLC staff).

The OIG's review of access metrics and clinical vacancies did not identify any substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and CLC metrics but should continue to take actions to sustain and improve performance.

Further, the OIG identified that the Network Director, CMO, and QMO had opportunities to improve their oversight of facility-level QSV, Medical Staff Privileging, Environment of Care, Medication Management, Mental Health, Care Coordination, Women's Health, and/or High-Risk Process functions. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

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.[40] 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.[41] Designated leaders are directly accountable for program integration and communication within their level of responsibility. 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.[42]

To determine whether the VISN implemented and incorporated OIG-identified key processes for quality and safety, the inspection team interviewed VISN managers and reviewed meeting minutes and other relevant documents. Specifically, OIG inspectors examined completion of the following:

- Written utilization management plan[43]
- Annual utilization management program summary reviews[44]
- Collection, analysis, and action, as appropriate, in response to VISN peer review data[45]
    - Facility outlier data monitored and follow-up actions communicated to Network Director and System/VAMC Director
    - Quarterly VISN peer review data analysis reports submitted to the Office of Quality, Safety, and Value
- Institutional disclosures for each facility reported quarterly[46]

Quality, Safety, and Value Findings and Recommendations

The VISN complied with requirements for a written utilization management plan, collection and analysis of peer review data, and institutional disclosure reports for each facility. However, the OIG identified a weakness with the annual utilization management program summary review.

[40] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence,* September 2014.
[41] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.
[42] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.
[43] VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019.
[44] VHA Directive 1117(2).
[45] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018.
[46] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

Specifically, VHA requires that the VISN conduct "annual summary reviews of all VISN facilities to validate that the UM [utilization management] Program is fully implemented."[47] Although utilization management trends were documented quarterly, the OIG did not find evidence of an annual program summary review. This could limit the VISN's awareness of obstacles in program implementation and trends that affect patient access to care. The QMO reported that reviewing and documenting the utilization management trends in the QSV Committee minutes met the intent of the VHA directive.

Recommendation 1

1. The Network Director evaluates and determines any additional reasons for noncompliance and ensures that annual utilization management program summary reviews are completed for each facility.

[47] VHA Directive 1117(2).

VISN concurred.

Target date for completion: November 30, 2020

VISN response: The Network Director and the Quality Management Officer evaluated to determine additional reasons for non-compliance and concluded there was not a standardized process for conducting annual utilization management summary reviews. Therefore, an annual utilization management program summary review was added to the existing annual Quality Management Officer assessment. On March 20, 2020, a revised VISN 15 annual Quality Management Officer assessment form was completed that included questions to perform a summary review of each facilities utilization management program. Facilities were asked to provide utilization management documents for the Quality Management Officer or designee to review in advance, and site visits were scheduled to perform on-site reviews of each facilities' utilization management program. However, due to travel restrictions put into place because of COVID-19, on-site reviews were rescheduled and changed to virtual assessments.

The Network Director will ensure that all VISN 15 facilities undergo a virtual summary review of their utilization management programs by the Quality Management Officer or her designee by the end of fiscal year 2020 and annually thereafter. Results from this review will be reported to the VISN Quality, Safety and Value Committee. Quality Management staff will track the minutes of this committee to ensure that all annual facility utilization management program summary reviews are reported to them and documented in their minutes. The numerator is the number of annual facility utilization management program summary reviews reported to the Quality, Safety and Value Committee and the denominator is the number of facilities in VISN 15. The target for compliance is 100 percent. Additionally, minutes from the Quality, Safety and Value Committee which will contain results from annual facility utilization management summary reviews are reported to the VISN Executive Leadership Board which the Network Director chairs.

Medical Staff Credentialing

VHA has defined procedures for the credentialing of medical staff—"the systematic process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training and experience, and current competence and health status."[48] When certain actions are taken against one of a provider's licenses, the chief of Human Resources Management Service, or Regional Counsel, must determine whether the provider meets licensure requirements for VA employment.[49] Further, physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued, and/or placed on probational status, or denied upon application, must not be appointed without a through documented review" by Regional Counsel and concurrence and approval of the appointment by the VISN CMO. The Deputy Under Secretary for Health for Operations and Management is responsible for ensuring that VISN directors maintain an appropriate credentialing and privileging process consistent with VHA policy, which includes VISN CMO oversight of facilities' processes.[50]

The OIG inspection team reviewed VISN facility physicians hired after January 1, 2018.[51] When reports from the National Practitioner Data Bank and/or Federation of State Medical Boards appear to confirm that a physician has a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined evidence of the

- Chief of Human Resources Management Service or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements,
- Regional Counsel or designee's documented review to determine if the physician meets appointment requirements, and
- VISN CMO concurrence and approval of the Regional Counsel or designee's review.

Medical Staff Credentialing Findings and Recommendations

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

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

[49] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012.

[50] VHA Handbook 1100.19.

[51] According to the Government Accountability Office (GAO) report GAO-19-6, *Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*, February 2019, VHA Central Office directed VHA-wide licensure reviews that were "started and completed in January 2018, focused on approximately 39,000 physicians across VHA and used licensure-action information from the Federation of State Medical Boards." The OIG reviewed VISN facility physicians hired after January 1, 2018, to continue efforts to identify staff not meeting VHA employment requirements since "VHA officials told us [GAO] these types of reviews are not routinely conducted…[and] that the initial review was labor intensive."

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires that veterans, their families, visitors, and employees in VHA healthcare facilities be provided a safe, clean, and functional environment of care in accordance with applicable Joint Commission Environment of Care standards, federal regulatory requirements, and applicable VA and VHA requirements.[52] The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.[53] VHA also provides policy, mandatory procedures, and operational requirements for implementing an effective VHA supply chain management program at VA medical facilities, which includes VISN-level oversight responsibility.[54]

The OIG inspection team reviewed relevant documents and interviewed VISN managers. Specifically, inspectors examined the following VISN-level requirements:

- Establishment of policy that maintains a comprehensive environment of care program at the VISN level
- Establishment of a VISN Emergency Management Committee[55]
    - Met at least quarterly
    - Documented an annual review within the previous 12 months of the VISN's
        - Emergency Operations Plan
        - Continuity of Operations Plan
        - Hazards Vulnerability Analysis
    - Conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leaders for review and approval
- Assessment of inventory management programs through a quality control review once per FY

[52] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program,* February 1, 2016; VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[53] VHA Directive 1608.

[54] VHA Directive 1761(2), *Supply Chain Inventory Management*, October 24, 2016, amended October 26, 2018.

[55] VHA Directive 0320.01.

Environment of Care Findings and Recommendations

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

Medication Management: Long-Term Opioid Therapy for Pain

VHA has established pain management as a national priority. The VHA National Pain Management Strategy was initiated in November 1998, with its main objective being to "develop a comprehensive, multicultural, integrated, system-wide approach to pain management that reduces pain and suffering and improves quality of life for Veterans experiencing acute and chronic pain associated with a wide range of injuries and illnesses, including terminal illness."[56]

The VHA National Pain Management Program Office is responsible for policy development, coordination, oversight, and monitoring of the VHA National Pain Management Strategy. VHA requires VISNs to implement the Pain Management Strategy throughout VISN facilities. VHA also requires a VISN-level pain management point of contact (POC) to annually describe the progress in implementing the Pain Management Strategy to the VISN Director and establish a VISN pain committee to develop timelines for achieving and maintaining pain management standards. In addition, VHA requires VISNs have at least one Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited tertiary, interdisciplinary pain care program.[57]

To determine whether the VISN complied with OIG-selected VHA requirements for pain management, the inspection team reviewed relevant documents and interviewed VISN managers on the following requirements:

- Appointment of a VISN-level pain management POC
- Annual reporting of the Pain Management Strategy implementation progress
- Establishment of a VISN-level Pain Committee
    - Monitoring of pain management standards
- Availability of a CARF-accredited tertiary interdisciplinary pain care program

Medication Management Findings and Recommendations

The VISN complied with many of the requirements. However, the OIG identified improvement opportunities under the responsibility of the pain management POC.

VHA requires that the Network Director evaluate implementation of the VHA Pain Management Strategy according to National Pain Management Program Office standards. The VISN-level pain management POC is charged with annually reporting the strategy implementation and

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

[57] VHA Directive 2009-053. According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities (CARF) "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.

progress to the Network Director.[58] The OIG did not find evidence of annual reporting to the Network Director. A lack of reporting could impede identification of resource, process, and training needs to support successful implementation and evaluation of the Pain Management Strategy. The CMO acknowledged the lack of annual reporting but noted that the VISN-level pain management POC has been in the role less than a year and is still getting familiarized with the responsibilities. Of note, the VISN-level pain management POC held a VIP-Post (Veterans in Pain-Pain management, Opioid safety, and Suicide prevention Teams) meeting in September 2019, which included discussion of updates to VISN 15's pain services and structuring of a pain committee.[59] The VISN-level pain management POC stated that the meeting summary and results will be presented to the Network Director.

Recommendation 2

2. The Network Director evaluates and determines any additional reasons for noncompliance and ensures the Veterans Integrated Service Network-level pain management point of contact submits an annual Pain Management Strategy implementation and progress report.

[58] VHA Directive 2009-053.

[59] The Veterans in Pain-Pain management, Opioid safety, and Suicide prevention Teams (VIP-Post) meeting was held September 10–11, 2019, for VISN 15 pain and whole health providers, psychologists, and pharmacists. Meeting goals included discussion of structuring pain management teams and metrics to improve program success, suggested updates to VISN 15 pain services, and structuring of a VISN pain committee.

VISN concurred.

Target date for completion: December 31, 2020

VISN response: The Network Director evaluated to determine additional reasons for non-compliance and concluded that VISN-level Pain Management Committee was needed to monitor and report facility progress towards implementation of VHA's Pain Management Strategy. The VISN Pain Management Committee was established on December 23, 2019 and is chaired by the VISN Pain Management Point of Contact. The Committee is responsible for oversight and improvement of the VHA Pain Management Improvement strategy. Metrics included in the Committee's charter will be used to evaluate facility-level progress pain management strategies during their quarterly meetings.

The Network Director or his designee will ensure that the VISN 15 Pain Management Committee provides an annual report on facility-level implementation and progress in support of VHA's Pain Management Strategy. This will be accomplished by staff from Quality Management auditing the minutes of the VISN 15 Pain Management Committee to determine if they provided an annual report on pain management metrics as evidence of implementation and progress on VHA's Pain Management Strategy. Results from the audit will be reported to the VISN Quality, Safety and Value Committee and to the VISN Executive Leadership Board which the Network Director chairs.

VHA also requires that the VISN has a pain committee "to develop timelines for achieving and maintaining pain management standards."[60] The OIG did not find evidence of a VISN pain committee. The lack of a formal committee could limit the opportunity to identify issues impacting pain management standards and development of action plans. The CMO told the OIG that in the absence of a charter, there was no formal committee. However, the VISN holds informal but structured meetings, via teleconference, with facilities' clinical pharmacy specialists, pain management physicians, associate chiefs of staff for primary care, and service chiefs for specialty and clinical services. The CMO also reported that the pain committee charter will be in effect on or before December 31, 2019.

Recommendation 3

3. The Network Director determines the reason for noncompliance and ensures the Veterans Integrated Service Network-level pain management point of contact establishes a pain committee.[61]

[60] VHA Directive 2009-053.

[61] The OIG reviewed evidence sufficient to demonstrate that the VISN had completed improvement actions and therefore closed the recommendation before publication of the report.

VISN concurred.

Target date for completion: Completed June 10, 2020

VISN response: The Network Director and the VISN-level pain management point of contact evaluated to determine additional reasons for non-compliance and established the multidisciplinary VISN 15 Pain Management Committee which includes representatives from all VISN 15 facilities. The VISN 15 Pain Management Committee has responsibility for oversight and improvement of the VISN 15 Pain Management system of care, including oversight of implementation and progress on the VHA Pain Management strategy. The first meeting of the VISN Pain Management Committee was held on March 11, 2020 where members developed a charter with metrics that will be used to evaluate quarterly progress on facility-level pain management strategies. The Committee met again on June 10, 2020 and will meet quarterly, hereafter. Corrective actions for this recommendation have been completed and closure is requested based upon the documentation provided.

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[62] 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.[63] 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."[64] 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."[65]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in all VA medical facilities.[66] VHA also requires that VISNs appoint a lead women veterans program manager (WVPM) to serve as the VISN representative on women veterans' issues and identify gaps through VISN-wide needs assessments, site visits, surveys, and/or other means, including conducting yearly site visits at each facility within the VISN.[67]

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

- Appointment of a lead WVPM
- Establishment of a multidisciplinary team for comprehensive care

[62] 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.)

[63] 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.)

[64] 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.)

[65] 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.)

[66] VHA Directive 1330.01(3), *Health Care Services For Women Veterans,* February 15, 2017, amended June 29, 2020.

[67] VHA Directive 1330.02, *Women Veterans Program Manager*, August 10, 2018.

- Execution of interdisciplinary comprehensive strategic planning for women's health at the VISN level
- Provision of quarterly program updates to executive leaders
- Monthly calls held with facility WVPMs and women's health medical directors
- Completion of annual site visits
  - Needs assessment conducted
  - Progress toward implementation of recommended interventions tracked
- Assessment of staff education gaps
  - Development of educational program and/or resources when needs identified
- Availability of VISN-level support staff for implementing performance improvement projects
- Analysis of women veterans access and satisfaction data
  - Improvement actions implemented when recommended
- Tracking of maternity care data[68]

Women's Health Findings and Recommendations

The VISN complied with the appointment of a lead WVPM, monthly calls with facility WVPMs and women's health medical directors, staff education gap analyses, and the availability of support staff. However, the OIG identified weakness with strategic planning activities, program updates to executive leaders, annual site visits, educational programs and/or resources, and data analysis and monitoring.

VHA requires that the lead WVPM execute "inter-disciplinary comprehensive strategic planning for women's health at the VISN level that improves the overall quality of care provided to women Veterans and achieves program goals and outcomes."[69] The lead WVPM participated in the April 2018 VISN-level strategic planning meeting; however, the OIG did not find evidence of women's health strategic planning activities in 2019. Failure to implement strategic planning could impede development of plans to improve quality and comprehensive women veterans healthcare. The lead WVPM did not provide a reason for noncompliance and was unaware if a VISN-level 2019 strategic planning meeting had occurred.

[68] VHA Handbook 1330.03, *Maternity Health Care and Coordination*, October 5, 2012.
[69] VHA Directive 1330.02.

Recommendation 4

4. The Network Director determines the reasons for noncompliance and makes certain that the lead Women Veterans Program Manager executes interdisciplinary strategic planning activities for comprehensive women's health care.

VISN concurred.

Target date for completion: November 30, 2020

VISN response: The Network Director and the lead WVPM evaluated to determine additional reasons for non-compliance and the VISN 15 Women's Health Services Strategic Plan for 2020-2024 was developed which serves as the overarching plan for comprehensive women's health care for VISN 15 and mirrors VHA's national priorities. Multidisciplinary members of the VISN 15 Women Veterans Healthcare Committee use the strategic plan as a foundation for identifying priorities and monitoring progress through defined metrics.

The Network Director will ensure the lead WVPM presents women's health issues and quality outcomes to the VISN 15 Women Veterans Healthcare Committee in alignment with the strategic plan. This will be accomplished by staff from Quality Management auditing the minutes of the VISN 15 Women Veterans Healthcare Committee to determine if women's health issues and quality outcomes were presented and discussed at all meetings for two consecutive quarters. The numerator will be the number of meetings held where women's health issues and/or outcomes were presented and the denominator will be total number of meetings held. Results from the audit will be reported to the VISN Quality, Safety and Value Committee and to the VISN Executive Leadership Board which the Network Director chairs.

Regarding updates to executive leaders, VHA requires that the lead WVPM provide at least quarterly program updates directly to the Network Director or the CMO.[70] Although the lead WVPM met with the CMO in May, June, July, August, and November 2019, the OIG did not find evidence that the lead WVPM met with the Network Director or CMO during Fiscal Year 2019 Quarter 1. Failure to communicate program updates to the Network Director or the CMO could limit resource allocation for program needs that support provision of optimal women veterans care. The observed noncompliance was due to the WVPM being on leave from late 2018 until the middle of April 2019.

[70] VHA Directive 1330.01(3).

Recommendation 5

5. The Chief Medical Officer evaluates and determines any additional reasons for noncompliance and ensures the lead Women Veterans Program Manager provides quarterly updates to the Network Director or Chief Medical Officer.[71]

VISN concurred.

Target date for completion: Completed May 24, 2020

VISN response: The Chief Medical Officer and the lead WVPM evaluated to determine additional reasons for non-compliance and concluded that there needed to be a designated individual assigned to provide back-up coverage for the VISN lead WVPM when she is away in order to ensure that quarterly updates are provided. On June 6, 2020, a backup lead WVPM was officially designated.

Additionally, written updates on the Women's Health Program have been provided by the WVPM to the Chief Medical Officer at least quarterly since May 2019. Among the standing issues covered in the written report are hot topics affecting women's health, current project updates (if any), and the status of women's health site visits with number of unresolved issues. Because the VISN has achieved 100 percent compliance on this recommendation, closure is requested based upon the evidence provided.

VHA requires that the lead WVPM conduct "...yearly site visits at each facility within the VISN and additional site visits as needed."[72] The OIG did not find compliance with annual facility site visits. The lead WVPM conducted facility site visits in 2018 for the John J. Pershing, Kansas City, Marion, and Robert J. Dole VAMCs; but, due to being on extended leave from late 2018 through middle of April 2019, the WVPM was unable to continue site visits. The failure to conduct facility site visits could potentially hinder identification of program needs and development of action plans that support the provision of optimal women veterans care. The lead WVPM expressed the intent to resume facility visits in FY 2020.

Recommendation 6

6. The Network Director evaluates and determines any additional reasons for noncompliance and makes certain that the lead Women Veterans Program Manager conducts yearly site visits at each facility within the Veterans Integrated Service Network.

[71] The OIG reviewed evidence sufficient to demonstrate that the VISN had completed improvement actions and therefore closed the recommendation before publication of the report.

[72] VHA Directive 1330.02.

VISN concurred.

Target date for completion: September 30, 2020

VISN response: The Network Director and the lead WVPM evaluated to determine additional reasons for non-compliance and determined that annual facility site-visits needed to be scheduled in advance for the fiscal year to ensure that all visits could be conducted within the required timeframe. Site visits were scheduled in late January 2020; however, on March 4, 2020, VHA travel restrictions were enacted due to COVID-19. Therefore, on March 23, 2020 the lead WVPM developed a virtual site visit program agenda and facilities were instructed to sign-up for virtual site visit dates. All facilities have their virtual site visit scheduled and all are expected to be completed by September 30, 2020.

The Network Director will ensure the lead WVPM conducts yearly site visits to each facility in the Veterans Integrated Service Network by having Quality Management staff track completion of facility site visits to determine if the lead WVPM conducted either an in-person or virtual site visit to all Network facilities by September 30, 2020. The numerator will be the number of facilities that underwent a site visit by the lead WVPM by the end of the fiscal year and the denominator will be the number of facilities in VISN 15. Results from the audit will be reported to the VISN Quality, Safety and Value Committee and to the VISN Executive Leadership Board which the Network Director chairs.

VHA requires that the lead WVPM conduct "assessments to identify VA staff education gaps related to women's health, and developing or adapting educational programs, materials, and resources where gaps are identified."[73] The lead WVPM conducted an educational needs assessment; however, the OIG did not find evidence of activities or resources to address the identified gaps. A failure to address educational gaps could limit staff's ability to provide key women veterans services. The lead WVPM was unaware of the requirement and was on leave from late 2018 until the middle of April 2019.

Recommendation 7

7. The Network Director evaluates and determines any additional reasons for noncompliance and ensures that the lead Women Veterans Program Manager develops educational programs and/or resources for needs identified from the staff education gap assessment.[74]

[73] VHA Directive 1330.02.

[74] The OIG reviewed evidence sufficient to demonstrate that the VISN had completed improvement actions and therefore closed the recommendation before publication of the report.

VISN concurred.

Target date for completion: Completed March 6, 2020

VISN response: The WVPM completed an educational needs assessment for VISN 15 Women Veterans Healthcare Providers on December 16, 2019 which identified the need for trained Designated Women Veteran Providers at every facility across VISN 15. Additionally, it was determined during the FY20 gap assessment that 66 percent of Designated Women Veteran Providers had less than 100 women veterans on their panel, indicating a need for general training on common complaints and new practice guidelines for women veterans to keep them current because of their small panel sizes. To address the identified gap, a 1-day Women's Health Summit was held on March 6, 2020 which included common women complaints and current practice guidelines affecting women veterans. Attending the Summit were 96 participants with representation from six facilities across VISN 15, including: forty-three nurses, twenty-one physicians, five physician assistants, one psychologist, seven social workers and nineteen support staff.

Additionally, VISN 15 applied for and was awarded a national grant to hold a three-day training program for providers and nurses on women's health. The training was scheduled for May 2020 but had to be cancelled due to COVID-19. A grant was also received to hold an Emergency Room Mini Residency on women's health in July 2020, thus addressing another identified gap, but that training also had to be cancelled due to COVID-19.

At the time of this response, national VA travel restrictions remain in place due to COVID-19. Additional training programs for women's health are planned to address educational needs and will resume once the travel ban has been lifted. In the meantime, the course that was provided to women's health providers on March 6, 2020 shows evidence of compliance with this recommendation, therefore, closure is requested based upon the evidence provided.

VHA requires the lead WVPM to analyze data and identify gaps "that limit access and decrease veteran satisfaction."[75] The OIG did not find evidence that the WVPM analyzed women veteran access and satisfaction data to identify gaps, which could delay the VISN's ability to take appropriate corrective actions. The lead WVPM cited being unaware of the requirement but reported conducting data analysis, informally discussing opportunities for improvement, and lacking a good documentation process.

Recommendation 8

8. The Network Director evaluates and determines any additional reasons for noncompliance and makes certain that the lead Women Veterans Program Manager analyzes women veterans' access and satisfaction data.

[75] VHA Directive 1330.02.

VISN concurred.

Target date for completion: December 31, 2020

VISN response: The Network Director and the lead WVPM evaluated to determine additional reasons for non-compliance and quarterly facility reports on women veterans' access and satisfaction were added to the VISN 15 Women Veterans Healthcare Committee as a standing agenda item. There, facility-level data will be analyzed and trends identified by the WVPM and used to guide improvement, as appropriate. The VISN 15 Women Veterans Healthcare Committee minutes which contain an analysis of women veterans' access and satisfaction data will be reported to the VISN 15 Healthcare Delivery Committee on a quarterly basis.

The Network Director will ensure that the WVPM analyzes and reports data on women veterans' access and satisfaction to the VISN 15 Healthcare Delivery Committee at their quarterly meetings. Quality Management staff will audit minutes of the VISN 15 Healthcare Delivery Committee to evaluate if data on women veterans' access and satisfaction were analyzed and presented during their meetings for two consecutive quarters. The numerator will be the number of VISN 15 Healthcare Delivery Committee meetings held that had documentation of an analysis of women veterans' access and satisfaction reports and the denominator will be total number of VISN 15 Healthcare Delivery Committee meetings held. Results from the audit will be reported to the VISN Quality, Safety and Value Committee and to the VISN Executive Leadership Board which the Network Director chairs.

VHA requires the implementation of "...a mechanism to track outcome information for women Veterans receiving any maternity care through VA facilities under their jurisdiction. Such outcomes must include cost and medical pregnancy outcomes through business and quality reporting for internal use and future referencing."[76] The OIG did not find evidence of maternity care data tracking at the VISN level. Lack of tracking maternity data prevents identification of best practices and development of action plans addressing opportunities for improvement. The lead WVPM reported reviewing the maternity care data quarterly but could not provide any evidence of those efforts and cited a lack of knowledge regarding the VHA requirement.

Recommendation 9

9. The Network Director evaluates and determines any additional reasons for noncompliance and ensures the lead Women Veterans Program Manager tracks maternity care outcome data.

[76] VHA Directive 1330.03.

VISN concurred.

Target date for completion: December 31, 2020

VISN response: The Network Director and the lead WVPM evaluated to determine additional reasons for non-compliance and concluded there was a need for a standardized tracking report to track maternity care outcomes for VISN 15. On January 13, 2020, the lead WVPM in collaboration with facility-level Women's Health Nurse Navigators created a maternity outcome tracking spreadsheet for use in reporting quarterly maternity care outcome data. Facility-level maternity care outcomes are now reported quarterly to the VISN 15 Women Veterans Healthcare Committee.

The Network Director will ensure the lead WVPM tracks and reports maternity care outcome data to the VISN 15 Women Veterans Healthcare Committee at least quarterly. Quality Management staff will audit all minutes of the VISN 15 Women Veterans Healthcare Committee to determine if maternity care outcome data were reported at least quarterly for two consecutive quarters. The numerator will be the number of meetings held where maternity care outcome data were reported and the denominator will be total number of VISN 15 Women Veterans Healthcare Committee meetings held. Results from the audit will be reported to the VISN Quality, Safety and Value Committee and to the VISN Executive Leadership Board which the Network Director chairs.

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. The goal of sterile processing services (SPS) is to "...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[77]

VHA requires VISNs to appoint and maintain a VISN SPS Management Board charged with oversight of SPS and all reprocessing of critical and semi-critical RME at VISN facilities.[78] VHA also requires VISNs to conduct facility inspections using the RME Inspection Tool, provide the results to VISN leadership for review by a VISN-level committee or board, and post the results to the RME SharePoint site within 30 days of the completed inspection. VISN SPS leads must ensure corrective action plans are developed within 30 days of the completed inspections and track the action plans until all items are closed.[79]

To determine the VISN's compliance with the following requirements, the OIG examined relevant documents and interviewed key managers:

- Establishment of a VISN SPS Management Board
- VISN-led RME inspection at each facility
  - Use of RME Inspection Tool
  - Documentation review of climate control
  - Reporting of inspection results to executive leaders
  - Posting of inspection results within the required time frame
  - Tracking of corrective action plans

High-Risk Processes Findings and Recommendations

The VISN complied with requirements for a VISN SPS Management Board and VISN-led facility inspections. However, the OIG identified a concern with the VISN SPS lead tracking the development and submission of action plans.

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[77] 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.)

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

[79] Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Information and Instructions for Fiscal Year 2019 Sterile Processing Services Inspections*, December 11, 2018.

VHA requires that VISN SPS leads ensure facility corrective action plans are developed within 30 days of the completed inspections and track the action plans until closure.[80] The OIG did not find action plans developed for inspections of the Harry S. Truman Memorial Veteran's Hospital, Kansas City VAMC, or Marion VAMC. In addition, the St. Louis VA HCS action plan was not submitted within 30 days. Lack of action plan development and timely submission could hinder corrective measures to prevent untoward events. The QMO reported being unsure why the Harry S. Truman Memorial Veteran's Hospital and Kansas City VAMC action plans did not exist, stated that the previous QMO did not send the VISN-led inspection results to the Marion VAMC for response and action plan submission, and did not know why the St. Louis VA HCS action plan was not submitted within 30 days.

Recommendation 10

10. The Network Director determines the reasons for noncompliance and ensures that facility corrective action plans are developed and submitted within 30 days of each completed inspection.

[80] VHA DUSHOM Memorandum, *Information and Instructions for Fiscal Year 2019 Sterile Processing Services Inspections*, December 11, 2018.

VISN concurred.

Target date for completion: November 30, 2020

VISN response: The Network Director and the Quality Management Officer evaluated to determine additional reasons for non-compliance and concluded that variation existed in the methods that Quality Management staff used to monitor and track receipt of facility corrective action plans following VISN Sterile Processing Service inspections. Additionally, because there was not a standardized, centralized method to track submission of their corrective action plans, when the Quality Management Health System Specialist was away, VISN Health System Specialist staffs were unaware that they needed to follow-up to ensure they were submitted timely. Therefore, on February 24, 2020 the Quality Management Health System Specialist added facility corrective action plans for VISN Sterile Processing Service inspections to the existing "QM Suspense Tracker" on the VISN SharePoint site where they could be monitored and tracked by the Quality Management Health System Specialist and other VISN Health System Specialist who cover for the her when she is away.

The Network Director will ensure that all facilities submit their Sterile Processing Service corrective action plan to the VISN within 30 days of completion of their annual inspection. To accomplish this, data will be collected by Quality Management staff on the timeliness of facility corrective action plan submission following the annual VISN Sterile Processing Service inspection. The numerator is the number of facilities that submitted their corrective action plan to the VISN within 30-days of their completed Sterile Processing Service VISN inspection. The denominator is the number of facilities who had one or more areas marked as non-compliant during their annual VISN Sterile Processing Service inspection. Results from the audit will be reported to the VISN Quality, Safety and Value Committee and to the VISN Executive Leadership Board which the Network Director chairs.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

Healthcare Processes	Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Access to care • Clinician vacancies • VISN efforts to reduce veteran suicides • Oversight inspections • VHA performance data • Observed trends in noncompliance	Ten OIG recommendations that can lead to patient and staff safety issues or adverse events are attributable to the Network Director and Chief Medical Officer. See details below.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Written utilization management plan • Annual utilization management program summary reviews • Collection, analysis, and action, as appropriate, in response to VISN peer review data • Quarterly VISN peer review data analysis reports submitted • Institutional disclosures for each facility reported quarterly	• None	• Annual utilization management program summary reviews are completed for each facility.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Credentialing	• Chief of Human Resources Management Service or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements • Regional Counsel or designee's documented review to determine the physician meets appointment requirements • VISN CMO concurrence and approval of the Regional Counsel or designee's review	• None	• None
Environment of Care	• Establishment of VISN policy that maintains a comprehensive environment of care program at the VISN level • Establishment of a VISN emergency management committee • Assessment of inventory management programs through a quality control review once per FY	• None	• None
Medication Management: Long-Term Opioid Therapy	• Appointment of a pain management point of contact • Reporting of the Pain Management Strategy implementation progress • Establishment of a pain committee • Availability of a CARF-accredited tertiary interdisciplinary pain care program	• None	• The VISN-level pain management point of contact submits an annual Pain Management Strategy implementation and progress report. • The VISN-level pain management point of contact establishes a pain committee.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Comprehensive Care	• Appointment of a lead women veteran program manager • Establishment of a multidisciplinary team for comprehensive care • Execution of interdisciplinary comprehensive strategic planning for women's health • Provision of quarterly program updates to executive leaders • Monthly calls held with facility women veterans program managers and women's health medical directors • Completion of annual site visits • Assessments to identify staff education gaps • Availability of VISN-level support staff for implementing performance improvement projects • Analysis of women veterans access and satisfaction data • Tracking of maternity care data	• The lead WVPM conducts yearly site visits at each facility.	• The lead WVPM executes interdisciplinary strategic planning activities for comprehensive women's health care. • The lead WVPM provides quarterly updates to the Network Director or CMO. • The lead WVPM develops educational programs and/or resources for needs identified from the staff education gap assessment. • The lead WVPM analyzes women veterans' access and satisfaction data. • The lead WVPM tracks maternity care outcome data.
High-Risk Processes: Reusable Medical Equipment	• Establishment of a VISN SPS Management Board • VISN-led inspection at each facility	• Corrective action plans are developed and submitted within 30 days of each completed inspection.	• None

Appendix B: VISN 15 Profile

The table below provides general background information for VISN 15.

Table B.1. Profile for VISN 15
(October 1, 2016, through September 30, 2019)

Profile Element	VISN Data FY 2017[1]	VISN Data FY 2018[2]	VISN Data FY 2019[3]
Total medical care budget in dollars	$2,271,527,617	$2,500,678,559	$2,597,976,722
Number of:			
• Unique patients	257,070	255,630	258,756
• Outpatient visits	3,141,580	3,252,272	3,323,162
• Unique employees[4]	10,142	10,161	10,487
Type and number of operating beds:			
• Community living center	384	384	384
• Domiciliary	297	300	311
• Hospital	664	637	645
• Residential rehabilitation	29	49	49
Average daily census:			
• Community living center	216	214	208
• Domiciliary	197	211	212
• Hospital	357	345	332
• Residential rehabilitation	15	16	23

Source: VHA Support Service Center and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.

[1] October 1, 2016, through September 30, 2017.
[2] October 1, 2017, through September 30, 2018.
[3] October 1, 2018, through September 30, 2019.
[4] Unique employees involved in direct medical care (cost center 8200).

Appendix C: Survey Results

Table C.1. Survey Results on Patient Attitudes within VISN 15 (October 1, 2018, through July 31, 2019)

Questions	Scoring	Facility	Average Score
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.	VHA	68.1
		VISN 15	65.8
		Columbia, MO	79.2
		Kansas City, MO	67.2
		Marion, IL	68.0
		Poplar Bluff, MO	57.8
		St. Louis, MO	54.9
		Topeka/Leavenworth, KS	66.2
		Wichita, KS	69.4
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	84.9
		VISN 15	85.9
		Columbia, MO	89.5
		Kansas City, MO	88.9
		Marion, IL	86.2
		Poplar Bluff, MO	90.5
		St. Louis, MO	81.1
		Topeka/Leavenworth, KS	86.5
		Wichita, KS	85.9

Questions	Scoring	Facility	Average Score
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.	VHA	77.3
		VISN 15	79.0
		Columbia, MO	83.9
		Kansas City, MO	71.8
		Marion, IL	79.4
		Poplar Bluff, MO	80.8
		St. Louis, MO	77.2
		Topeka/Leavenworth, KS	80.3
		Wichita, KS	84.6
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.	VHA	77.9
		VISN 15	80.2
		Columbia, MO	86.2
		Kansas City, MO	81.5
		Marion, IL	79.2
		Poplar Bluff, MO	85.7
		St. Louis, MO	74.4
		Topeka/Leavenworth, KS	80.9
		Wichita, KS	79.9

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 7, 2019)

Appendix D: Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Clinical Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri, Report No. 16-00550-145, March 8, 2017	October 2016	0	13	n/a	0
Combined Assessment Program Review of the Kansas City VA Medical Center, Kansas City, Missouri, Report No. 15-04695-231, April 7, 2016	February 2016	0	10	n/a	0
Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Kansas City VA Medical Center, Kansas City, Missouri, Report No. 16-00013-242, April 14, 2016	February 2016	0	7	n/a	0
Comprehensive Healthcare Inspection Program Review of the Marion VA Medical Center, Illinois, Report No. 18-01155-48, December 27, 2018	September 2018	0	6	n/a	0
Comprehensive Healthcare Inspection Program Review of the John J. Pershing VA Medical Center, *Poplar Bluff, Missouri*, Report No. 18-01011-253, August 22, 2018	April 2018	0	2	n/a	0
Comprehensive Healthcare Inspection Program Review of the VA St. Louis Health Care System, Missouri, Report No. 18-00612-260, August 23, 2018	February 2018	0	7	n/a	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Alleged Mismanagement of Inpatient Care at the Colmery-O'Neil VA Medical Center within the VA Eastern Kansas Health Care System, Topeka, Kansas, Report No. 17-02484-189, June 18, 2018	April 2017	0	6	n/a	0
Comprehensive Healthcare Inspection Program Review of the VA Eastern Kansas Health Care System, *Topeka, Kansas*, Report No. 17-01850-38, December 7, 2017	May 2017	0	5	n/a	0
Delayed Radiology Test Reporting at the Dwight D. Eisenhower VA Medical Center, Leavenworth, Kansas, (VA Eastern Kansas Health Care System), Report No. 18-00980-84, March 7, 2019	June 2018	0	5	n/a	0
Alleged Deficiencies in Out of Operating Room Airway Management Processes at the Colmery-O'Neil VA Medical Center within the VA Eastern Kansas Health Care System, Topeka, Kansas, Report No.18-02765-144, June 20, 2019	August 2018	0	7	n/a	1
Comprehensive Healthcare Inspection Program Review of the Robert J. Dole VA Medical Center, *Wichita, Kansas*, Report No. 17-01748-82, February 6, 2018	July 2017	0	14	n/a	0

Source: Inspection/survey results verified with the Quality Management Health System Specialist on November 20, 2019
n/a = Not applicable

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

Measure	Definition	Desired Direction
ACSC hospitalization	Ambulatory care sensitive conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit reviews met	Percent acute admission reviews that meet interqual criteria	A higher value is better than a lower value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Care transition	Care transition (inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Cont stay reviews met	Percent acute continued stay reviews that meet interqual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like – HED90_1	HEDIS-EPRP based PRV TOB BHS	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS-eOM based DM IHD	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value

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

Measure	Definition	Desired Direction
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	ORYX	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

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

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

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

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 15, 2020

From: Director, VA Heartland Network –VISN 15 (10N15)

Subj: Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 15: VA Heartland Network in Kansas City, Missouri

To: Director, Office of Healthcare Inspections (54CH04)

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

Attached is our response to the Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 15: VA Heartland Network, Kansas City, MO draft report.

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

(Original signed by:)

William P. Patterson, M.D., MSS
Network Director
VA Heartland Network (VISN 15)

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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