DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois

CHIP REPORT | **REPORT #20-00064-238** | **AUGUST 27, 2020**

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Figure 1. *Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois (Source: https://vaww.va.gov/directory/guide/, accessed on January 28, 2020)*

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Captain James A. Lovell Federal Health Care Center. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

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

The unannounced visit was conducted during the week of January 13, 2020, at the Captain James A. Lovell Federal Health Care Center and Evanston VA Clinic. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this healthcare center's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this healthcare center and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

Leadership and Organizational Risks

This healthcare center is the only fully integrated VA-Department of Defense (DoD) medical facility in the United States that addresses the needs of active duty military, military families, and the local veteran population. At the time of the OIG's visit, the leadership team consisted of VA and DoD staff. VA leaders included the Director, Chief Medical Executive, Associate Director for Facilities Support, and Chief Nurse Executive. DoD leaders included the Deputy Director/Commanding Officer, Executive Officer, Associate Director for Resources, and Navy Nurse Executive. The Chief Medical Executive and Nurse Executives oversee patient care which requires managing service directors and chiefs of programs and practices for VA, Navy active duty, and VA/Navy contractors.[1]

Organizational communications and accountability were managed through a committee reporting structure with the Executive Leadership Team overseeing several working groups. The leaders monitor patient safety and care through the Quality Council which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the healthcare center's leaders had been working together as a group for four months, although several had served in their positions for more than two years.

Selected employee satisfaction survey results indicate that the Chief Medical Executive and VA Chief Nurse Executive have opportunities to improve employee satisfaction and staff's feelings of "moral distress" at work.[2] Patient experience survey data indicated general satisfaction with the care provided. However, the OIG found that selected female respondent scores were generally less favorable than those for VHA female patients nationally, revealing opportunities for leaders to improve the overall female veteran care experience.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[3] However, the OIG identified concerns with Environmental Management staffing shortages.

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,

[1] Integrated VA-Department of Defense (DoD) medical facility leadership team. Executive leadership in this report refers primarily to VA leadership team members.

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

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

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.[4]

The executive leaders were able to speak in depth 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 knowledgeable within their scopes of responsibility about selected VHA data used by the SAIL and CLC SAIL models.

The OIG noted opportunities for improvement in all eight clinical areas reviewed and issued 27 recommendations that are directed to the Director, Chief Medical Executive, Associate Director for Facilities Support, and VA Chief Nurse Executive. These are briefly described below.

Quality, Safety, and Value

The healthcare center complied with requirements to establish a committee responsible for QSV oversight functions, protected peer reviews, and the patient safety elements reviewed. However, the OIG noted concerns with improvement action implementation.[5]

Medical Staff Privileging

The OIG identified deficiencies with focused and ongoing professional practice evaluation and healthcare provider exit review processes.[6]

Environment of Care

The healthcare center largely met the selected inpatient mental health requirements reviewed. The OIG did not note any issues with the availability of medical equipment or supplies. However, the OIG identified deficiencies in general safety, environmental cleanliness and infection prevention, privacy, and IT security.

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

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

[6] The definitions of focused professional practice evaluation and ongoing professional practice evaluations can be found within Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2). An ongoing professional practice evaluation is "the ongoing monitoring of privileged providers to confirm the quality of care delivered and ensures patient safety." A focused professional practice evaluation is "a time-limited process whereby the clinical leadership evaluates the privilege-specific competence of a provider who does not yet have documented evidence of competently performing the requested privilege(s) at the facility."

Medication Management

The OIG identified concerns with initial pain screening, aberrant behavior risk assessment, informed consent, and patient follow-up after therapy initiation but did not issue recommendations due to the small study population. The OIG also identified a concern with the evaluation of pain management outcomes and quality.

Mental Health

The OIG found compliance with requirements for a designated suicide prevention coordinator, no-show appointment follow-up, and suicide safety plans. However, the OIG identified a deficiency with suicide prevention training.

Women's Health

The healthcare center complied with requirements for each of the staffing elements reviewed. The OIG noted concerns with Primary Care Mental Health Integration services, community-based outpatient clinic women's health primary care providers, and Women Veterans Health Committee processes.

High-Risk Processes

The healthcare center complied with quality assurance monitoring and most of the reprocessing and storage area physical inspection components. The OIG identified deficiencies with administrative processes; equipment storage; and staff training, competency, and ongoing education.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued 27 recommendations for improvement to the Director, Chief Medical Executive, Associate Director for Facilities Support, and VA Chief Nurse Executive. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this healthcare center. The intent is for center leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if not addressed, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Healthcare Center Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 80–81, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities providing healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Captain James A. Lovell Federal Health Care Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare center leaders so that informed decisions can be made to improve care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[1] Investments in a culture of safety and continuous quality improvement, in concert with robust leadership and communication, significantly contribute to positive patient outcomes.[2] Figure 2 illustrates the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

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

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

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[1] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (The website was accessed on September 25, 2019.)

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

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

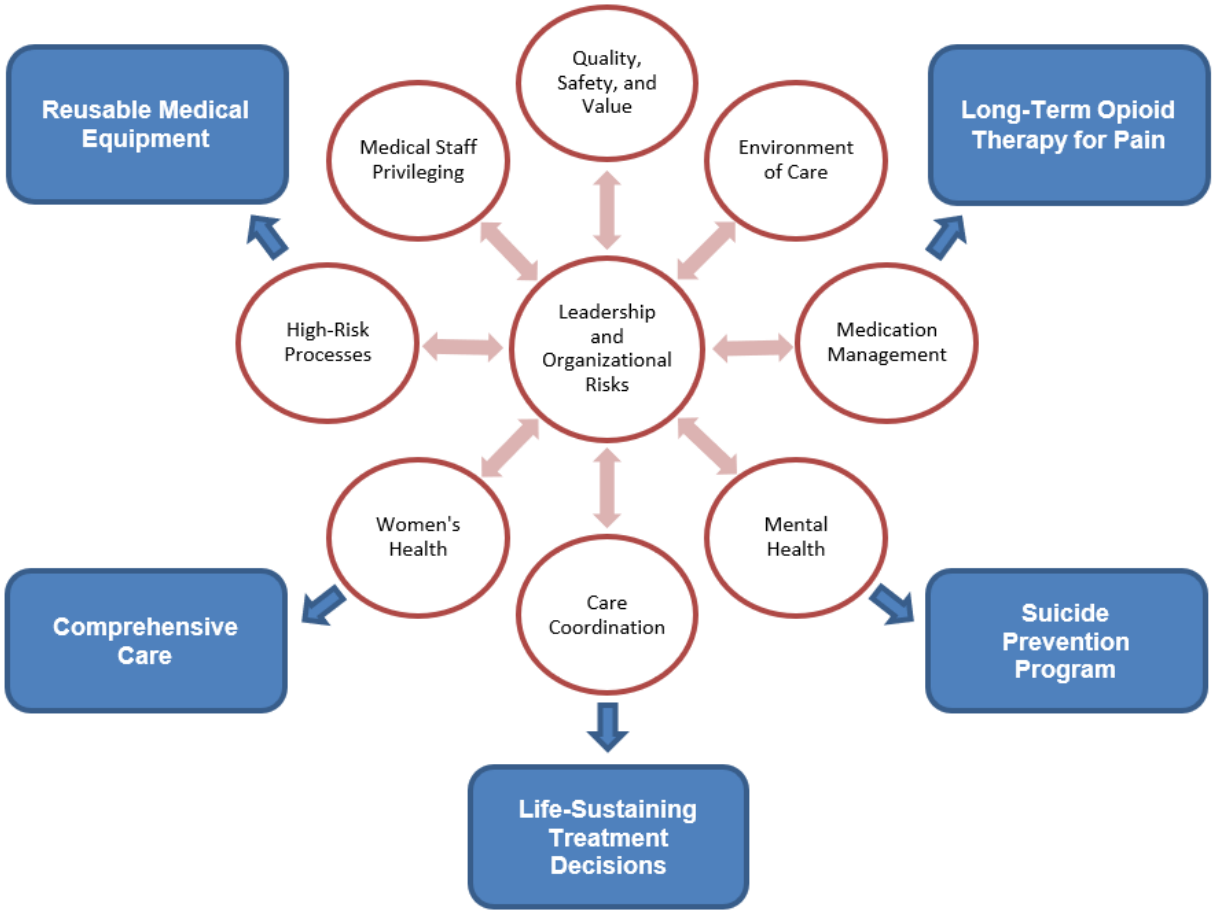

Figure 2. *Fiscal Year (FY) 2020 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

Methodology

The Captain James A. Lovell Federal Health Care Center includes multiple outpatient clinics in Illinois and Wisconsin. Additional details about the types of care provided by the health care center can be found in Appendixes B and C.

To determine compliance with Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports.[4]

The OIG team also selected and physically inspected areas of the Evanston VA Clinic and the following areas of the Captain James A. Lovell Federal Health Care Center:

- Acute psychiatric units
- Community living centers (CLC)[5]
- Dental clinic
- Emergency Department
- Intensive care unit
- Medical/surgical inpatient unit
- Pediatric clinic[6]
- Podiatry clinic
- Post-anesthesia care unit
- Primary care clinic
- Sterile processing services areas

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

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

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

[6] Unique to this healthcare center.

The inspection examined operations from June 23, 2018, through January 17, 2020, the last day of the unannounced multiday site visit.[7] 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 healthcare center completes corrective actions. The Healthcare Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that the healthcare center leaders developed based on the reasons for noncompliance.

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

[7] The range represents the time period from the prior CHIP inspection to the completion of the unannounced, multiday CHIP site visit in June 2018.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can impact the healthcare system's ability to provide care in the clinical focus areas.[8] To assess the healthcare center's risks, the OIG considered the following indicators:

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

Executive Leadership Position Stability and Engagement

The Captain James A. Lovell Federal Health Care Center is the only fully integrated VA-Department of Defense (DoD) medical facility in the United States that addresses the healthcare needs of active duty military, military families, and the local veteran population.[9] Because each VA facility organizes its leadership structure to address the needs and expectations of the local patient population it serves, organizational charts may differ across facilities. Figure 3 illustrates this healthcare center's reported organizational structure. The leadership team consists of VA and DoD staff. VA leaders include the Director, Chief Medical Executive, Associate Director for Facilities Support, and Chief Nurse Executive. DoD leaders include the Deputy Director/Commanding Officer, Executive Officer, Associate Director for Resources, and Navy Nurse Executive. The Chief Medical Executive and Nurse Executives oversee patient care which requires managing service directors and chiefs of programs and practices for VA, Navy active duty, and VA/Navy contractors.[10]

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

[9] Integrated VA-Department of Defense (DoD) medical facility leadership team. Executive leadership in this report refers primarily to VA leadership team members.

[10] Combined supervisory oversight by VA Nurse Executive and Navy Nurse Executive.

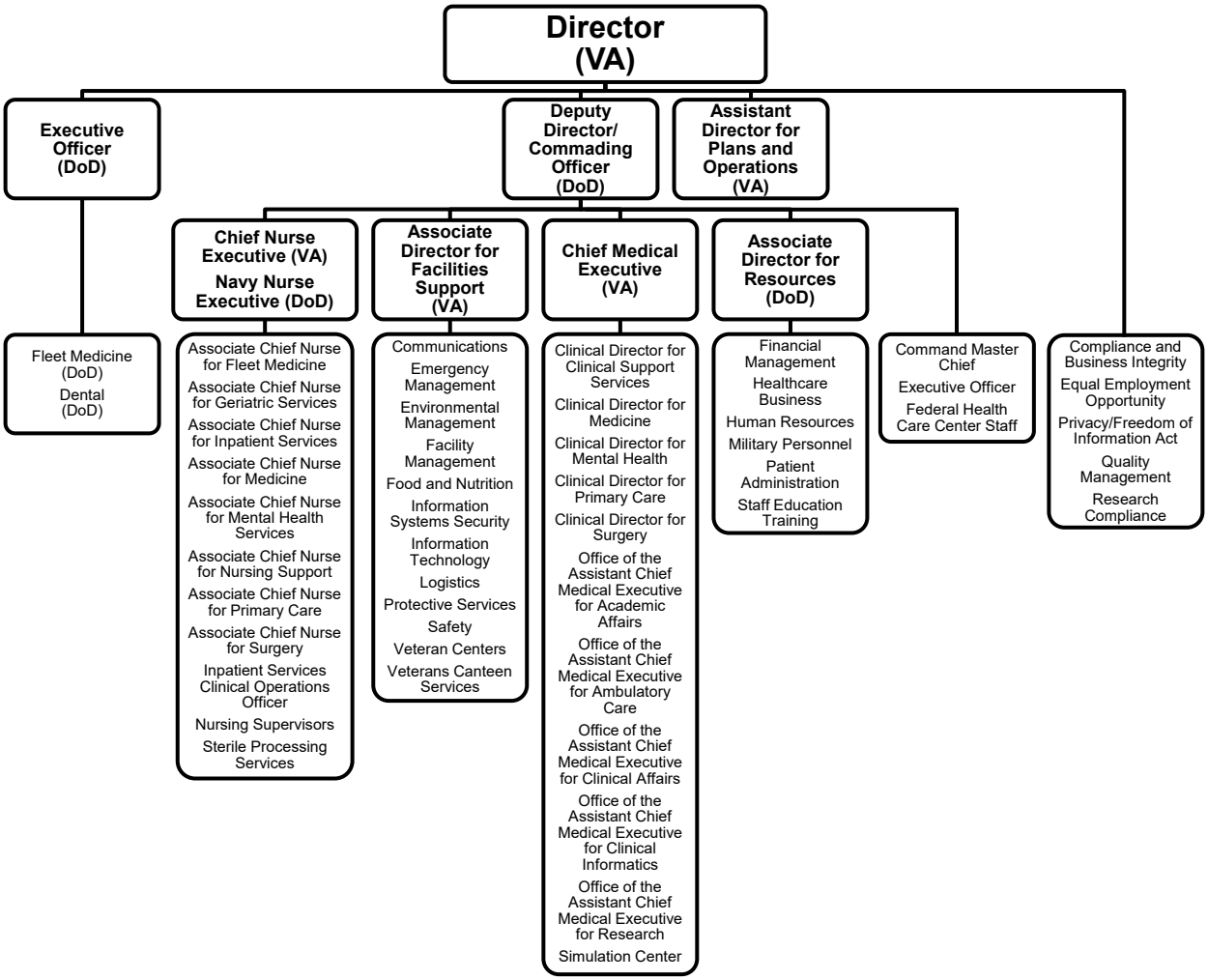

Figure 3. *Health Care Center Organizational Chart*
Source: Captain James A. Lovell Federal Health Care Center (received January 13, 2020)

At the time of the OIG site visit, the healthcare center's leaders had been working together four months, although the Chief Medical Executive had been in the role since 2016 and several leaders had served in their positions for more than two years (see Table 1).

Table 1. VA Executive Leader Assignments

Leadership Position	Assignment Date
Director	October 14, 2018
Chief Medical Executive	December 11, 2016
Chief Nurse Executive (VA)	September 1, 2019
Associate Director for Facilities Support	January 12, 2017

Source: Captain James A. Lovell Federal Health Care Center Supervisory Human Resources Assistant (received January 13, 2020)

To help assess the healthcare center executive leaders' engagement, the OIG interviewed the Director, Chief Medical Executive, and Associate Director for Facilities Support regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance. The VA Chief Nurse Executive was on scheduled leave during the OIG site visit.

The executive leaders were knowledgeable within their scopes of responsibility about VHA data and/or system-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. Additionally, leaders appeared to have an understanding of CLC measures. In individual interviews, most of the executive leaders were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

At this healthcare center, the Executive Leadership Team has the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Team oversees the Board of Directors and Quality Council.

The leaders monitor patient safety and care through the Quality Council, which is responsible for tracking and trending quality of care and patient outcomes. See Figure 4.

Figure 4. *Health Care Center Committee Reporting Structure*
Source: Captain James A. Lovell Federal Health Care Center (received January 15, 2020)

Employee Satisfaction

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

To assess employee attitudes toward healthcare center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2018, through September 30, 2019.[11] Table 2 provides relevant survey results for VHA, the healthcare center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the healthcare center average for the selected survey leadership questions was generally similar to the VHA average.[12] The scores for the executive leaders were generally similar to or higher than the VHA and healthcare center averages.[13]

[11] Ratings are based on responses by employees who report to or are aligned under the Director, Chief Medical Executive, Nursing Practice Directorate Suite, and Associate Director for Facilities Support. Further, the Nursing Practice Directorate is led by the Chief Nurse Executive (VA) and Navy Nurse Executive (DoD); therefore, the results are not fully attributable to either leader.

[12] 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.

[13] It is important to note that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current VA Chief Nurse Executive who assumed the role after the survey was administered.

Table 2. Survey Results on Employee Attitudes toward Captain James A. Lovell Federal Health Care Center Leaders (October 1, 2018, through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	Healthcare Center Average	Director Average	Chief Medical Executive Average	VA Chief Nurse Executive Average	Assoc. Director for Facilities Support Average
All Employee Survey: *Servant Leader Index Composite.*[14]	0–100 where higher scores are more favorable	72.6	69.3	86.7	72.2	82.0	80.0
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce*.	1 (Strongly Disagree) – 5 (Strongly Agree)	3.4	3.4	4.6	3.6	3.8	4.1
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.6	4.6	3.8	4.0	4.4
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.7	4.6	3.7	4.0	4.4

Source: VA All Employee Survey (accessed on November 18, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[15] The healthcare center average for the selected survey questions was similar to the VHA average. Scores related to the Director and Associate Director for Facilities Support were consistently better than those for VHA and the healthcare center. However, opportunities appear to exist for the Chief Medical Executive and VA Chief Nurse Executive to improve employee feelings of moral distress at work.

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

[15] Ratings are based on responses by employees who report to or are aligned under the Director, Chief Medical Executive, Nursing Practice Directorate Suite, and Associate Director for Facilities Support.

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

Questions/Survey Items	Scoring	VHA Average	Healthcare Center Average	Director Average	Chief Medical Executive Average	VA Chief Nurse Executive Average	Assoc. Director for Facilities Support Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.7	4.7	3.7	4.1	4.5
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.6	4.4	3.7	4.2	3.8
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.4	1.6	0.5	1.9	2.4	1.2

Source: VA All Employee Survey (accessed on November 18, 2019)

Patient Experience

To assess patient experiences with the healthcare center, which directly reflect on its leaders, the OIG team reviewed patient experience survey results that relate to the period of October 1, 2018, through July 31, 2019. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its

performance against the private sector. Table 4 provides relevant survey results for VHA and the Captain James A. Lovell Federal Health Care Center.[16]

VHA also collects SHEP survey data from Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward their healthcare experiences (see Table 4). For this healthcare center, the patient survey results generally reflected higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

Table 4. Survey Results on Patient Experience (October 1, 2018, through July 31, 2019)

Questions	Scoring	VHA Average	Healthcare Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.1	76.7
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	82.5
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	78.0	82.1

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

In 2015, women represented 9.4 percent of the total veteran population in the United States, and it is projected that women will represent 16.3 percent of living veterans by 2043. Further, from 2005 to 2015, the number of women veterans using VA health care increased by 46.4 percent, from almost 240,000 to 455,875.[17] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients' experiences by gender (see Tables 5–7), including those for Inpatient, Patient-Centered

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

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

Medical Home, and Specialty Care Surveys. The results for male respondents were higher than the corresponding VHA averages, while those for female respondents were generally lower. However, healthcare center leaders appeared to be actively engaged with male and female patients (for example, by conducting women veteran town hall meetings, performing community outreach, and using the Joint Outpatient Experience Survey[18] and Interactive Customer Evaluation[19] to gain insight into patients' experiences). The leaders should continue efforts to improve the female veteran experience in all care settings.

Table 5. Inpatient Survey Results on Experiences by Gender (October 1, 2018, through July 31, 2019)

Questions	Scoring	VHA[20]		Healthcare Center[21]	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.3	83.8	85.9	75.7
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.6	83.4	86.3	89.3
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	68.4	62.2	76.3	81.0

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

[18] Joint Outpatient Experience Survey (JOES) is a consolidated survey that asks patients about the care received at a specific appointment. https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/MHS-Patient-Satisfaction-Surveys. (The website was accessed on March 19, 2020.)

[19] Interactive Customer Evaluation (ICE) system is a web-based program that allows patients to provide feedback on services and products provided by the health care facility. https://www.cnic.navy.mil/regions/ndw/installations/nas_patuxent_river/about/ice.html. (The website was accessed on March 3, 2020.)

[20] The inpatient VHA averages are based on 38,790–39,236 male and 1,858–1,875 female respondents, depending on the question.

[21] The inpatient healthcare center averages are based on 312–317 male and 25–26 female respondents, depending on the question.

Table 6. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2018, through July 31, 2019)

Questions	Scoring	VHA[22]		Healthcare Center[23]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.6	43.1	61.7	0.0
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.7	49.7	71.6	37.7
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.5	65.8	75.4	55.2

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

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

[23] The healthcare center patient centered medical home averages are based on 273–828 male and 22–40 female respondents, depending on the question.

Table 7. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2018, through July 31, 2019)

Questions	Scoring	VHA[24]		Healthcare Center[25]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.0	46.0	58.5	0.0
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	55.4	67.7	5.6
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	70.4	70.8	76.5	64.9

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

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[26] Table 8 indicates the relevant healthcare center inspection most recently performed by the OIG. Of note, at the time of the OIG visit, the healthcare center had closed all recommendations for

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

[25] The healthcare center specialty care averages are based on 256–770 male and 20–48 female respondents, depending on the question.

[26] The Joint Commission conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.

improvement issued since the previous comprehensive healthcare inspection conducted in June 2018.[27]

At the time of the site visit, the OIG team also noted the healthcare center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[28] Additional results included the Long Term Care Institute's inspection of the center's CLCs.[29]

Table 8. Office of Inspector General Inspection

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
VA OIG (*Comprehensive Healthcare Inspection Program Review of the Captain James A. Lovell Health Care Center, North Chicago, Illinois,* Report No. 18-01143-302, September 27, 2018)	June 2018	5	0

Source: OIG (inspection/survey results verified with the Chief, Quality Management on January 16, 2020)

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

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms.

[27] VA OIG. *Comprehensive Healthcare Inspection Program Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois*, Report No. 18-01143-02, September 27, 2018.

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

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

The OIG identified no concerns related to lapses in care or the potential for patient harm. However, the OIG identified a substantial organizational risk with Environmental Management staffing deficiencies. The Chief of Environmental Care reported 30 housekeeping vacancies, including the assistant department chief and evening shift supervisory positions. This is discussed in detail in the environment of care review. Table 9 lists the reported patient safety events from June 23, 2018 (the prior OIG comprehensive healthcare inspection), through January 15, 2020.[30]

Table 9. Summary of Selected Organizational Risk Factors (June 23, 2018, through January 15, 2020)

Factor	Number of Occurrences
Sentinel Events[31]	0
Institutional Disclosures[32]	4
Large-Scale Disclosures[33]	0

Source: Captain James A. Lovell Federal Health Care Center Chief Medical Executive and Patient Safety Manager (received January 15, 2020)

[30] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Captain James A. Lovell Health Care Center is a mid-high complexity (1c) affiliated system as described in Appendix B.)

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

[32] According to VHA Directive 1004.08, *Disclosure of Adverse Events To Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or [his or her] personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."

[33] According to VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

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.[34]

Figure 5 illustrates the healthcare center's division's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2019. Of note, Figure 5 uses blue and green data points to indicate high performance for the Captain James A. Lovell Federal Health Care Center (for example, in the areas of patient-centered medical home (PCMH) same day appointment (appt), PCMH care coordination, and rating (of) specialty care (SC) provider). Metrics that need improvement are denoted in orange and red (for example, registered nurse (RN) turnover, healthcare (HC) associated (assoc) infections, and best place to work).[35]

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

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

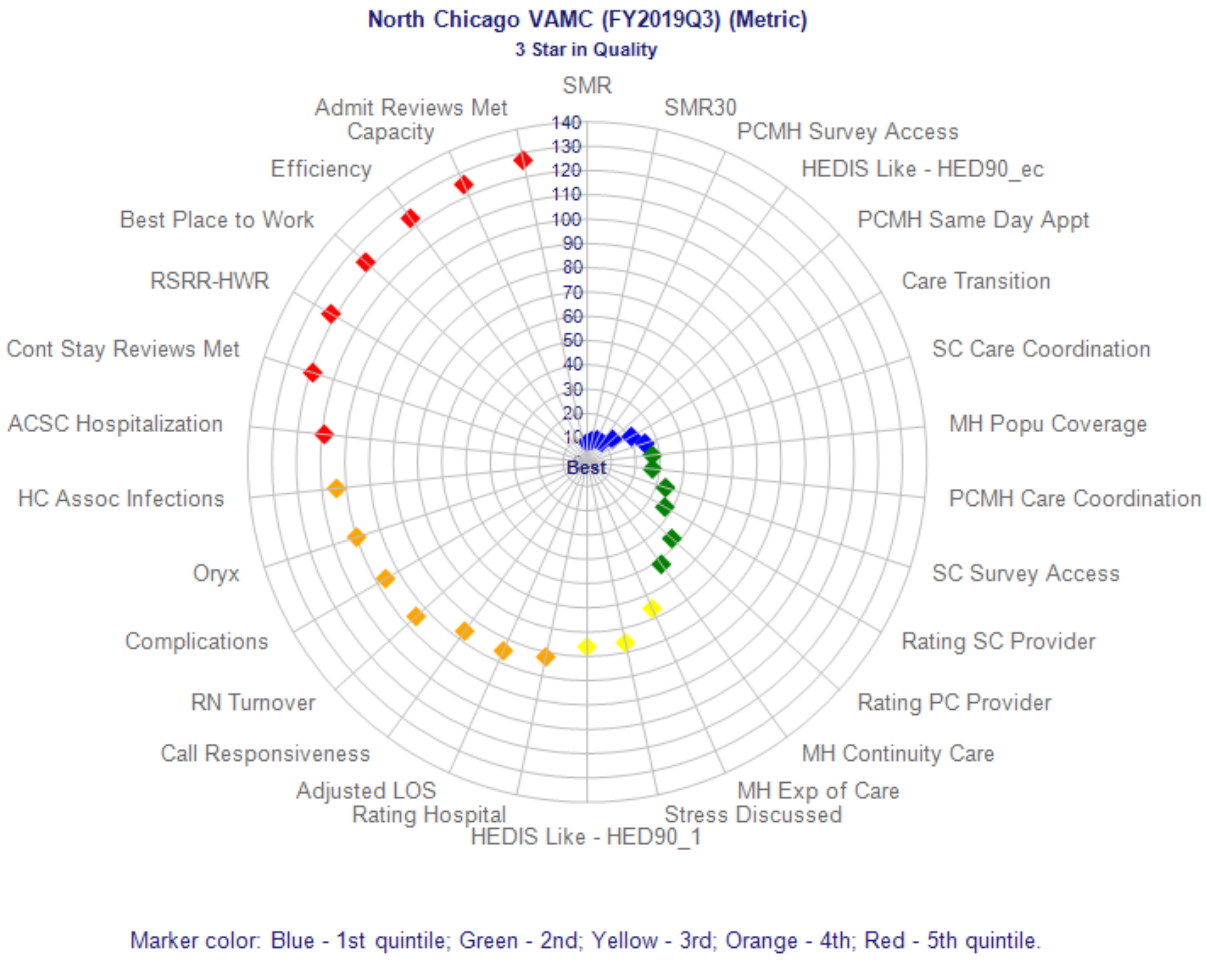

Figure 5. *Healthcare Center Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

Veterans Health Administration Performance Data for Community Living Centers

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

Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource to review quality measures and health inspection results.[36]

Figure 6 illustrates the center's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2019. Figure 6 uses blue and green data points to indicate high performance for the Captain James A. Lovell Federal Health Care Center CLC (for example, in the areas of physical restraints–long-stay (LS), high risk pressure ulcers (PU)–LS, and urinary tract infections (UTI)–LS). Metrics that need improvement are denoted in orange (for example, moderate-severe pain–short-stay (SS) and new or worse PU–SS).[37]

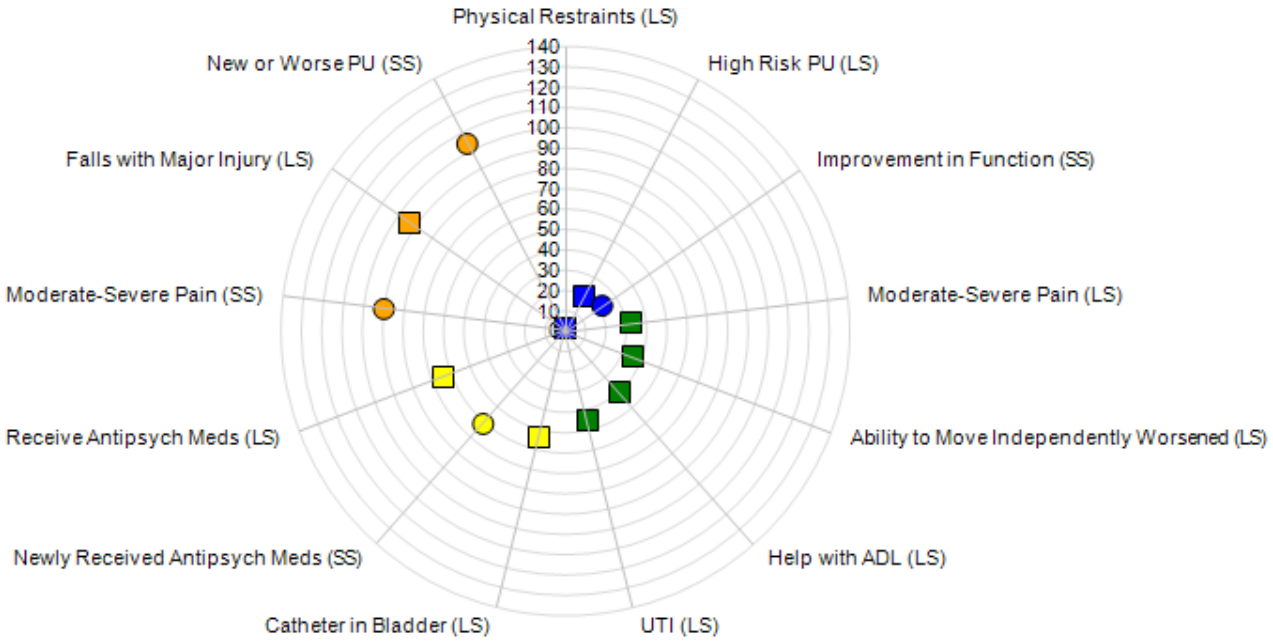

Figure 6. *Captain James A. Lovell Federal Health Care Center CLC Quality Measure Rankings (as of June 30, 2019)*
LS = Long-Stay Measure *SS = Short-Stay Measure*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

[36] According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, November 19, 2018, "In December 2008, the Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

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

Leadership and Organizational Risks Conclusion

The healthcare center's executive leadership teams appeared stable. Although the VA executive team had worked together for four months; the Director, Associate Director, and Chief Medical Executive had worked together for over two years. Employee satisfaction survey results revealed opportunities for the Chief Medical Executive and VA Chief Nurse Executive to improve employees' feelings of "moral distress" at work. Patient experience survey data indicated general satisfaction with the care provided. However, the OIG found that selected female respondent scores were generally less favorable than those for VHA female patients nationally, revealing opportunities for leadership to improve the overall female veteran care experience. The OIG's review of accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. However, the OIG identified concerns with Environmental Management staffing shortages. In individual interviews, the executive leaders were able to speak in depth about actions taken during the previous 12 months to maintain or improve employee satisfaction and patient experiences. In addition, the executive leaders were knowledgeable within their scopes of responsibility about selected VHA data used by the SAIL and CLC SAIL models.

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.[38] 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.[39] 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.[40]

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

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

The OIG reviewers also assessed the healthcare center's processes for conducting protected peer reviews of clinical care.[41] Protected peer reviews, when conducted systematically and credibly, reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[42] The OIG team examined the completion of the following elements:

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

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

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

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

[41] The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a critical review of care, performed by a peer, to evaluate care provided by a clinician for a specific episode of care, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements. In the context of protected peer reviews, "protected" refers to the designation of review as a confidential quality management activity under 38 U.S.C. 5705 as "a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for improving the quality of medical care or the utilization of health-care resources in VA facilities."

[42] VHA Directive 1190.

- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[43]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee
- Quarterly review of Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Next, the inspection team assessed the healthcare center's utilization management (UM) program, a key component of VHA's framework for quality, safety, and value, which provides vital tools for managing the quality and the efficient use of resources.[44] It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[45] Inspectors reviewed several aspects of the UM program:

- Completion of at least 80 percent of all required inpatient reviews
- Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
- Interdisciplinary review of UM data
- Implementation and monitoring of improvement actions recommended by the interdisciplinary UM group

Finally, the OIG reviewers assessed the healthcare center's reports of patient safety incidents with related root cause analyses.[46] Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the healthcare center.[47] The healthcare center was assessed for its performance on several dimensions:

[43] VHA Directive 1190.

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

[45] VHA Directive 1117(2).

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

[47] VHA Handbook 1050.01.

- Annual completion of a minimum of eight root cause analyses[48]
- Inclusion of required content in root cause analyses
- Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
- Provision of feedback about root cause analysis actions to reporting employees
- Submission of annual patient safety report to the healthcare center leaders

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents.[49]

Quality, Safety, and Value Findings and Recommendations

The healthcare center complied with requirements to establish a committee responsible for QSV oversight functions, peer reviews, and the patient safety elements reviewed. However, the OIG identified weaknesses in improvement action implementation.

The Joint Commission (TJC) requires that the healthcare center's governing body provides structure and resources to support quality and safety.[50] TJC also requires facilities to measure and analyze performance using data so that performance improvement "effectiveness can be sustained, assessed, and measured."[51] The healthcare center's Quality Council has oversight of QSV functions; it reviews relevant data and information and ensures that recommended actions are fully implemented and monitored.[52] The OIG reviewed Quality Council minutes for January through May 2019 and July through October 2019 and found no documentation of action item implementation, which may have hampered or prevented ongoing improvement of quality care and patient safety processes. The Chief of Quality Management reported that assigned staff are expected to complete each action; however, due to inattention to detail by the committee chairs, those staff were not consistently invited back to provide updates at meetings.

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

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

[50] TJC Leadership standard and rationale LD.01.03.01.

[51] TJC. Leadership standard LD.03.05.01.

[52] TJC. Performance Improvement standards PI.01.01.01, PI.02.01.01, and PI.03.01.01.

Recommendation 1

1. The Healthcare Center Director evaluates and determines any additional reasons for noncompliance and ensures improvement action items recommended by the Quality Council are fully implemented and monitored.

Healthcare center concurred.

Target date for completion: September 30, 2020

Healthcare center response: The Healthcare Center Director will ensure that the improvement action items recommended by the Quality Council are fully implemented and monitored. In January 2020, the Quality Council modified the template for minutes to reflect implementation and monitoring of improvement action items recommended in the Quality Council. The compliance will be monitored and reported to the Quality Council by the Chief of Quality Management, as the number of closed improvement action items recommended by the Quality Council (numerator) compared to the total number of improvement action items recommended by the Quality Council (denominator) for six consecutive months. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

VHA requires an interdisciplinary group to review UM data, identify problems or opportunities, document specific action items, implement the changes, and monitor the outcome of these changes.[53] The OIG reviewed the Patient Flow Committee meeting minutes for October 2018 through September 2019 and did not find evidence that action items were fully implemented. As a result, leaders could have missed opportunities to improve efficiency and ensure appropriate patient care resources were available. The Chief Hospitalist and Utilization Management Coordinator stated that staff did not transcribe all the content discussed into the meeting minutes.

Recommendation 2

2. The Chief Medical Executive evaluates and determines any additional reasons for noncompliance and makes certain the Patient Flow Committee meeting minutes reflect documentation, implementation, and evaluation of action items.

[53] VHA Directive 1117(2).

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The Chief Medical Executive will ensure that the Patient Flow Committee meeting minutes reflect documentation, implementation, and evaluation of action items. In June 2020, Patient Flow Committee modified the template for meeting minutes to reflect documentation, implementation and evaluation of action items. The Patient Flow Committee Chair and Co-chair will review the minutes to ensure that all action items, implementation and evaluations are documented before signing off the minutes. The Chief Medical Executive will ensure continued reporting of the compliance as the number of closed action items recommended by Patient Flow Committee (numerator) compared to the total number of improvement action items recommended by the Patient Flow Committee (denominator) for six consecutive months. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[54]

Clinical privileges need to be specific and based on the individual practitioner's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[55]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance." The FPPE process occurs when a provider is hired at the facility and granted initial privileges and before any new clinical privileges are granted. Additionally, VA facilities must continuously monitor the performance of their providers. VHA requirements state that "the on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered."[56] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[57]
  - Clear documentation of the results and time frames
  - Evaluation by another provider with similar training and privileges
- OPPEs
  - Application of criteria specific to the service or section
  - Use of minimum criteria for selected specialty LIPs[58]
  - Evaluation by another provider with similar training and privileges

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

[55] VHA Handbook 1100.19.

[56] VHA Handbook 1100.19.

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

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

The OIG also determined whether service chiefs recommended continuing the LIPs' current privileges based in part on the results of OPPE activities and if the healthcare center's Executive Committee of the Medical Staff decided to recommend continuing privileges based on FPPE and OPPE results.

Further, VA must put processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former licensed practitioner's clinical practice, VA has an obligation to notify state licensing boards (SLBs) and to subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[59] Further, "VA medical facility Directors must designate an individual, and backup, to be responsible for the SLB reporting process. This individual will be the subject matter expert (SME) for the facility…and ensure oversight of the exit review process, including receipt, review, and maintenance of the Provider Exit Review Forms."[60] The OIG reviewers assessed whether the healthcare center's staff

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

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

- No solo/few practitioners were hired within 18 months before the site visit or were privileged during the previous 12 months[61]
- Eight LIPs hired within 18 months before the site visit[62]
- Sixteen LIPs privileged within 12 months before the visit
- Twenty LIPs who left the healthcare center in 12 months before the visit

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

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

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

[62] The 18-month review period was from July 13, 2018, through January 13, 2020.

Medical Staff Privileging Findings and Recommendations

The OIG noted concerns with FPPE, OPPE, and provider exit review processes.

VHA requirements state that "the criteria for the FPPE process are to be defined in advance, using objective criteria accepted by the practitioner, recommended by the Service Chief and Executive Committee of the Medical Staff as part of the privileging process and approved by the Director. The process may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients."[63] The OIG found that all eight LIPs' profiles lacked evidence that they were aware of the evaluation criteria before service chiefs initiated the FPPE process. This could result in providers' lack of understanding of FPPE expectations. The Chief Medical Executive stated that providers were notified verbally but could not provide evidence of this communication.

Recommendation 3

3. The Chief Medical Executive evaluates and determines any additional reasons for noncompliance and makes certain that service chiefs define in advance, communicate, and document expectations for focused professional practice evaluations in provider profiles.

Healthcare center concurred.

Target date for completion: October 31, 2020

Healthcare center response: The Chief Medical Executive will ensure that service chiefs define in advance, communicate, and document expectations for focused professional practice evaluations in provider profiles. The Chief Medical Executive created a standardized memorandum which is to be given to new providers by the appropriate service chief within seven days of provider's clinic start date. The Chief Medical Executive will ensure continued reporting of the compliance as the number of focused professional practice evaluations with evidence of service chiefs defining in advance, communicating, and documenting expectations (numerator) compared to the total number of focused professional practice evaluations (denominator) to the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

VHA requires that "results of the FPPE must be documented in the practitioner's provider profile and reported to the Executive Committee of the Medical Staff for consideration in making the recommendation on privileges and other considerations."[64] The OIG found three of eight LIP profiles lacked evidence that FPPE results were documented. This could result in inadequate data

[63] VHA Handbook 1100.19.

[64] VHA Handbook 1100.19.

to support clinical privileging decisions. Additionally, these LIPs continued to practice without a thorough review and evaluation of their clinical competence, which could impact patient safety and quality of care. The Credentialing Supervisor stated there was no process in place to track FPPEs.

Recommendation 4

4. The Chief Medical Executive evaluates and determines any additional reasons for noncompliance and ensures service chiefs document focused professional practice evaluation results in provider profiles.

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The Chief Medical Executive will ensure that service chiefs document focused professional practice evaluation results in provider profiles. The Credentialing Supervisor will ensure that the provider folders will not be routed for signature to Chief Medical Executive until the evaluation results are in the file. The Chief Medical Executive will ensure continued reporting of the compliance as the number of providers' folders with focused professional practice evaluation results (numerator) compared the total number of focused professional practice evaluations routed for signature (denominator) to the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

VHA also requires that FPPE results are reported to the Executive Committee of the Medical Staff for consideration in LIPs' initial privileging.[65] The OIG found that three of eight documented decisions to continue initial privileges were not based on FPPE results. Failure of the Executive Committee of the Medical Staff to review FPPE outcomes may result in incomplete evidence to support the continuation of initially granted clinical privileges. This could also lead to LIPs providing care without a thorough evaluation of their competencies, which could impact quality of care and patient safety. The Credentialing Supervisor was unable to provide evidence of the FPPE results, and the Chief Medical Executive reported that the documents were lost.

Recommendation 5

5. The Chief Medical Executive evaluates and determines any additional reasons for noncompliance and makes certain that the Executive Committee of the Medical Staff meeting minutes consistently reflect the review of professional practice evaluation results in the decision to recommend continuation of initially granted privileges.

[65] VHA Handbook 1100.19.

Healthcare center concurred.

Target date for completion: September 30, 2020

Healthcare center response: The Chief Medical Executive will ensure that the Executive Committee of the Medical Staff minutes consistently reflect the review of professional practice evaluation results. Every month, the Credentialing Supervisor and the Chief Medical Executive or designee will review the number of professional practice evaluations results in the decision to recommend continuation of initially granted privileges presented to the Executive Committee of the Medical Staff (numerator) with the total number of professional practice evaluations due for review (denominator). Compliance will be reported to Quality Council quarterly. This recommendation will be considered compliant when 90 percent or greater of the professional practice evaluations completed were reported to the Executive Committee of the Medical Staff and documented in its minutes for six consecutive months.

VHA requires that reprivileging decisions are based on service- and practitioner-specific OPPE information.[66] For 6 of 16 practitioners reprivileged within the last 12 months, the OIG found that service chiefs could not demonstrate that reprivileging decisions were based upon service-specific OPPE criteria. As a result, clinical privileges were granted to LIPs without adequate data to support those decisions. This may have resulted in delivery of patient care without a systematic review and evaluation of LIP competency, which could impact quality of care and patient safety. The Chief Medical Executive stated that some services used generic forms that lacked service-specific criteria and thought those forms met the requirement.

Recommendation 6

6. The Chief Medical Executive evaluates and determines any additional reasons for noncompliance and ensures that reprivileging decisions are based on service-specific ongoing professional practice evaluation criteria.

[66] VHA Handbook 1100.19.

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The Chief Medical Executive will ensure that re-privileging decisions are based on service-specific ongoing professional practice evaluation criteria. The Chief Medical Executive will ensure continued reporting of the compliance as number of ongoing professional practice evaluations reviewed by the Chief Medical Executive which has the service specific criteria (numerator) compared to the total number of ongoing professional practice evaluations reviewed (denominator), in the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

VHA requires that LIPs are evaluated on an ongoing basis by providers with similar training and privileges.[67] The OIG found that 2 of 16 LIP profiles lacked evidence that providers with similar training and privileges completed the evaluations. This resulted in LIPs providing patient care without a thorough evaluation of their competencies, which could impact quality of care and jeopardize patient safety. The Chief Medical Executive attributed the noncompliance to a lack of staff training and the frequent rotation of staff due to the integration of the VA with DoD. The impacted providers were civilian providers working in DoD clinics, and their evaluations were completed by their ranking military department head who did not have similar training or privileges.

Recommendation 7

7. The Chief Medical Executive evaluates and determines any additional reasons for noncompliance and ensures that providers with similar training and privileges complete licensed independent practitioners' ongoing professional practice evaluations.

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

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The Chief Medical Executive will ensure that providers with similar training and privileges complete licensed independent practitioners' ongoing professional practice evaluations. The Chief Medical Executive updated the current ongoing professional practice evaluation form and signature block to reflect the titles and specialty to ensure that providers with similar training and privileges complete licensed independent practitioners' ongoing professional practice evaluations. The Chief Medical Executive will ensure continued reporting of the compliance as the number of ongoing professional practice evaluations completed by providers with similar training and privileges (numerator) compared to the total number of ongoing professional practice evaluations conducted (denominator) to the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

VHA requires that provider exit review forms, which document the review of a provider's clinical practice, are "completed within 7-calendar days of the departure of a licensed health care professional from a VA facility."[68] For the 20 providers who departed the healthcare center in the previous 12 months, the OIG found that six provider exit forms were not completed, and two forms were not completed within seven calendar days. Failure to complete a provider exit form within the specified time frame could result in delayed SLB reporting. The Chief Medical Executive stated the healthcare center does not have effective controls in place for managing the exit review process.

Recommendation 8

8. The Healthcare Center Director evaluates and determines any additional reasons for noncompliance and makes certain that the licensed healthcare professional's first- or second-line supervisor completes and signs the exit review form within seven calendar days of the professional's departure from the center.

[68] VHA Notice 2018-05.

Healthcare center concurred.

Target date for completion: September 30, 2020

Healthcare center response: The Healthcare Center Director or designee will ensure that the licensed healthcare professional's first- or second-line supervisor completes and signs the exit review form within seven calendar days of the professional's departure from the center. The Chief Medical Executive will ensure continued reporting of the compliance as the number of exit review forms completed by a first- or second-line supervisor within seven calendar days of the professional's departure (numerator) compared to the total number of professionals exiting the facility (denominator) to the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct Comprehensive Environment of Care Inspection Rounds and to resolve issues in a timely manner. The goal of the Comprehensive Environment of Care Program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[69]

The purpose of this facet of the OIG inspection was to determine whether the healthcare center maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the healthcare center met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the inpatient mental health unit where patients with active suicidal ideation or attempts are treated. Inspectors reviewed several aspects of the healthcare center's environment:

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

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

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

During its review of the environment of care, the OIG inspected the Evanston VA Clinic and the following 12 patient care areas of the healthcare center:

- Acute psychiatric unit
- CLC (Units 133/2B, 134/1B, and 134/2B)
- Dental clinic
- Emergency Department
- Intensive care unit
- Medical/surgical inpatient unit
- Pediatric clinic
- Podiatry clinic
- Post-anesthesia care unit
- Primary care clinic

The OIG reviewed relevant documents and interviewed key employees and managers.

Environment of Care Findings and Recommendations

The inspection team observed general compliance with many of the performance indicators, including requirements for the inpatient mental health unit, and logistics and accommodation for women veterans. The OIG did not note any issues with the availability of medical equipment or supplies. However, the OIG identified concerns with general safety and cleanliness at the healthcare center, and privacy and IT security at the Evanston VA Clinic.

TJC requires hospitals to maintain a clean environment, continually monitor environmental conditions, and remediate conditions not meeting this requirement.[70] Furthermore, VHA requires facilities to identify environmental deficiencies and areas for improvement during environment of care rounds, and to track them until resolved.[71] The OIG found wheelchairs with damaged

[70] TJC, Infection Prevention and Control standard IC.02.02.01, EP 1 and Environment of Care standard EC.02.06.01, EP 26.

[71] VHA Directive 1608, *Comprehensive Environment of Care Program*, February 1, 2016.

armrests in 7 of 13 patient care areas.[72] Exposed foam padding cannot be sanitized to prevent cross-contamination between patients.

The Department Head of Facility Management stated that biomedical engineering is only responsible for repairs of motorized wheelchairs and the Safe Patient Handling Nurse is responsible for all other wheelchairs.[73] The Safe Patient Handling Nurse indicated that staffing resources were limited for wheelchair maintenance—the Vocational Rehabilitation program provides one temporary employee for six months or less, and the employee must be trained before assuming responsibility for all wheelchair maintenance. The Department Head of Facility Management also reported that wheelchair damage was not detected or reported to the Safe Patient Handling Nurse due to lack of oversight during environment of care rounds.

Recommendation 9

9. The Associate Director for Facilities Support evaluates and determines any additional reasons for noncompliance and ensures that healthcare center managers repair or remove damaged wheelchairs from service.

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The Associate Director for Facilities Support and the Safe Patient Handling Coordinator ensured that all damaged wheelchairs were removed from service as of January 20, 2020. Any finding of damaged wheelchair during the environment of care rounds will be reported to Board of Directors monthly. The Associate Director for Facilities Support will ensure continued reporting of the compliance as the total number of wheelchairs that are clean and not in need of repair (numerator) compared to the total number of wheelchairs observed during environment of care rounds (denominator) to the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

As mentioned above, TJC requires hospitals to maintain a clean and safe environment, continually monitor environmental conditions, and remediate conditions not meeting this requirement.[74] In CLC 134/2B, the OIG found that the corridor and dining area floors had spills and debris, especially evident in corners and under tables; and the communal tub-shower room had fecal material on the floor. This resulted in an unclean and potentially unsafe patient care environment that may spread infection and or cause falls. The Chief of Environmental Care

[72] CLC 134/1B, CLC 134/2B, Dental Clinic, Emergency Department, Intensive Care Unit, Mental Health Inpatient Unit, and Podiatry Clinic.

[73] The Safe Patient Handling Nurse is a position within Nursing Services that reports to the Nurse Executive. Duties include oversight of maintenance for non-motorized wheelchairs.

[74] TJC, Environment of Care standard EC.02.06.01, EP 1 and 20.

stated that the department had significant staffing shortages—30 housekeepers, an evening supervisor, and an assistant department chief. CLC 134/2B had no permanently assigned staff and relied on overtime staff from other areas to provide housekeeping services.

Recommendation 10

10. The Associate Director for Facilities Support evaluates and determines any additional reasons for noncompliance and ensures that healthcare center managers maintain a safe and clean environment.

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The Associate Director for Facilities Support will ensure that the healthcare center managers maintain a safe and clean environment. New process and training, including a cleaning schedule and audit tool, for Environmental Management Staff was implemented to address deficient areas. Compliance with this recommendation will be monitored through environment of care rounds by ensuring that a corrective action is taken within fourteen days on any finding related to a safe and clean environment and the finding is closed out in Performance Logic Software. The Associate Director for Facilities Support will ensure continued reporting of the compliance as the number of findings completed or having an action plan established within fourteen days (numerator) compared to the total number of findings related to a safe and clean environment (denominator) to the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

TJC requires hospitals to respect the patient's right to privacy.[75] At the Evanston VA Clinic, the OIG noted two examination rooms adjacent to the main entrance had large storefront windows facing the sidewalk and parking lot. The windows were covered by vertical blinds with missing or damaged sections that did not provide adequate privacy for patients in the examination rooms. Staff had attempted to correct the deficiency by taping examination table paper to the windows. The Nurse Case Manager stated that staff believed the attempted corrective action was sufficient, so the situation was not reported. Also, members of the healthcare center's environment of care inspection team noted that the deficiency was not identified during routine inspections because rooms were often inaccessible due to patient activity.

Recommendation 11

11. The Associate Director for Facilities Support evaluates and determines any additional reasons for noncompliance and ensures adequate privacy is provided in patient examination rooms at the Evanston VA Clinic.

[75] TJC. Rights and Responsibility of the Individual standard RI.01.01.01, EP 7.

Healthcare center concurred.

Target date for completion: June 25, 2020

Healthcare center response: The Associate Director for Facilities Support ensured that adequate privacy is assured in patient examination rooms at the Evanston Community Based Outpatient Clinic by replacing the broken window blinds on June 25, 2020. This recommendation was considered in compliance by June 25, 2020. Compliance will be reported to the Quality Council on July 24, 2020.

VHA requires facilities to develop an approved list of individuals who are authorized access to information system areas and remove individuals from the list when access is no longer required. Facilities are also required to control physical access to the information technology room.[76] At the Evanston VA Clinic, the OIG found that a posted list of authorized individuals included staff who were no longer employed by the facility or whose position did not justify unescorted access. Also, the room key was kept in an unlocked, easily accessed desk drawer. This could have resulted in unauthorized access to personally identifiable information. The Information System Security Officer stated that the existence of over 100 information technology rooms made it difficult to oversee maintenance of lists posted in each room. Furthermore, due to lack of oversight and attention to detail by the Information System Security Officer, education on information technology room key security had not been provided to clinic staff.

Recommendation 12

12. The Associate Director for Facilities Support evaluates and determines any additional reasons for noncompliance and ensures the information technology room at the Evanston VA Clinic is secure and restricted to authorized personnel.

Healthcare center concurred.

Target date for completion: July 31, 2020

Healthcare center response: The Associate Director for Facilities Support in collaboration with the Information Security Officer will ensure the information technology room at Evanston Community Based Outpatient Clinic is secure and restricted to authorized personnel. Access to the information technology room will be changed to keycard access which is connected to the staff identification card. Access will only be granted to appropriate employees by the Information Security Officer. The key card locks have been ordered by Facilities Support. This recommendation will be considered in compliance by July 31, 2020 when Facilities Support installs the lock to the information technology room at the Evanston Community Based Outpatient Clinic. Compliance will be reported to the Quality Council.

[76] VHA Handbook 6500, Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program, March 10, 2015.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[77] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[78] Long-term opioid use is of particular concern in the veteran population where there is a high incidence of posttraumatic stress disorder, major depressive disorder, alcohol use, substance abuse, and suicide attempts.[79] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[80]

VHA requires routine assessments of pain and the completion of an opioid risk assessment before initiating patients on long-term opioid therapy and recommends against the therapy for patients with untreated substance use disorders. VHA also recommends avoiding drugs capable of inducing fatal interactions, such as opioids with benzodiazepines.[81] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[82] To achieve VHA's vision of providing patient-driven healthcare, providers are also required to obtain informed consent from patients and to provide education about the risks, benefits, and alternatives prior to initiating long-term opioid therapy.[83] VHA recommends evaluating patients receiving continued opioid therapy for improvement of pain and opioid-related adverse events at least every three months and more frequently as doses increase.[84]

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

- Completion of initial screening for pain
- Assessment of aberrant behavior risk
- Avoidance of concurrent therapy with benzodiazepines
- Completion of urine drug testing with intervention, when indicated

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

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

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

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

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

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

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

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

- Documentation of informed consent
- Timely follow-up with patients included required elements

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures include, but are not limited to, adherence to published clinical practice guidelines, timeliness of treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment, patient satisfaction, and quality of life.[85] The OIG examined the following indicators for program oversight and evaluation:

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

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

Medication Management Findings and Recommendations

The OIG noted concerns with the provision of pain management using long-term opioid therapy and program oversight and evaluation.

VHA and VA/DoD Clinical Practice Guidelines outline specific guidance for the provision of pain management using long-term opioid therapy.[86] In two of three records, the OIG did not find evidence of initial pain screening, aberrant behavior risk assessment that included a history of substance abuse and aberrant drug-related behaviors, or documented informed consent prior to initiating long-term opioid therapy.[87] Although the healthcare center did not meet the requirements above, these findings did not rise to the level of a recommendation due to the small study population.

VHA requires the facility to have a multidisciplinary pain management committee to provide oversight, coordination, and at least yearly monitoring of pain management activities and processes.[88] The OIG determined that the facility established a pain management committee;

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

[86] VHA Directive 2009-053; *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*; VHA Directive 1005.

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

[88] VHA Directive 2009-053.

however, the committee did not monitor the quality of pain assessment and effectiveness of pain management interventions. This resulted in lack of oversight, coordination, and monitoring of pain management strategies to ensure compliance with evidence-based standards of care. The Pharmacy Chief stated that the Pain Management Committee was unaware of the monitoring requirements.

Recommendation 13

13. The Healthcare Center Director evaluates and determines any additional reasons for noncompliance and ensures the Pain Management Committee monitors the quality of pain assessments and the effectiveness of pain management interventions.

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The Chief Medical Executive will ensure that the Pain Management Committee monitors the quality of pain assessments and the effectiveness of pain management interventions. The Pain Management Committee meeting minutes will be reviewed by the Chief Medical Executive to ensure they are monitoring the quality of pain assessments and the effectiveness of pain management interventions. The Pain Management Committee monitoring the quality of pain assessments and the effectiveness of pain management interventions documented will be the numerator and the number of Pain Management Committee meetings will be the denominator. This recommendation will be considered compliant when Pain Management Committee minutes have 90 percent or greater documentation of the quality of pain assessments and effectiveness of pain management for six consecutive months. Compliance will be reported to the Quality Council quarterly.

Mental Health: Suicide Prevention Program

In 2017, suicide was the 10th leading cause of death, with approximately 47,000 lives lost across the United States.[89] The suicide rate was 1.5 times greater for veterans than for non-veteran adults and estimated to represent approximately 22 percent of all suicide deaths in the United States.[90] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[91]

VHA has identified suicide prevention as a top priority and implemented various evidence-based approaches to reduce the veteran suicide rate. In addition to expanded mental health services and community outreach, VHA has developed comprehensive screening and assessment processes to identify at-risk patients.[92]

VHA requires that each healthcare center and very large CBOC have a full-time suicide prevention coordinator (SPC) to track and follow up with high-risk veterans, develop a process for responding to referrals from hotlines such as the Veteran Crisis Line, and conduct community outreach activities.[93] The OIG examined various requirements related to SPCs:

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

VHA also requires that any patient determined to be at high risk for suicide be added to the facility high-risk list and have a High Risk for Suicide (HRS) Patient Record Flag (PRF) placed in his or her electronic health record "as soon as possible but no later than 1 business day after

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

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

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

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

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

such determination by the SPC."[94] According to VHA, "Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death…The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions."[95] The HRS PRF is reviewed at least every 90 days and depending on changes to the suicide risk status, will remain active or be removed.[96] Additionally, VHA requires designated high-risk patients to have a completed suicide safety plan and four face-to-face visits with an acceptable provider within the first 30 days of designation.[97]

The OIG noted that from July 1, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA required that "Any patient determined to be High Risk for Suicide [by the licensed independent provider] must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination."[98] However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management changed the requirement for the HRS PRF placement to be "as soon as possible but no later than 1 business day after determination by the SPC."[99] VHA further provided additional clarifying information:

- The "SPC exclusively controls the HRS-PRF and must limit their use to patients who meet the criteria of being placed on the facility high-risk suicide list."
- "The time frame of placing the flag begins once the SPC makes the determination that an HRS-PRF is warranted."
- The SPC's determination process "may be beyond 24 hours after a referral, due to case consultation and review."[100]

The OIG is concerned that the updated requirement may result in delayed placement of the HRS PRF for at-risk patients. Without defined time frames for SPC determination that the HRS PRF is warranted, patients identified as at-risk for suicide could have flags placed in his or her chart several days after referral. For example, the current requirement would allow for a patient to be

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

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

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

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

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

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

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

identified as high risk for suicide and referred to the SPC on Monday, the SPC to assess the patient for risk and determine the need for an HRS PRF on the following Friday, and the SPC to place an HRS PRF on the subsequent Monday (a week after referral).

On March 27, 2020, VHA also updated existing policy requirements to allow the review of an HRS PRF to "occur no earlier than 10 days before and no later than 10 days after the 90-day due date."[101]

Inspectors examined the completion of several requirements:

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

All VHA employees must complete suicide risk and intervention training within 90 days of entering their position. Clinical staff (including physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and Vet Center counselors) must complete Suicide Risk Management Training for Clinicians, and nonclinical staff must complete Operation S.A.V.E. training.[102] VHA also requires that all staff receive annual refresher training.[103] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[104]

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

- Relevant documents;
- The electronic health records of 37 outpatients whose electronic health records were flagged as high risk for suicide from July 1, 2018, to June 30, 2019; and

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

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

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

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

- Staff training records.

Mental Health Findings and Recommendations

The healthcare center complied with requirements for a designated SPC, no-show appointment follow-up, and suicide safety plans.

However, the OIG found deficiencies. With VHA's original requirement that was in place when these patients received care—that "Any patient determined to be High Risk for Suicide must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"[105]—the OIG estimated that 46 percent of HRS PRFs were placed within one business day of referral to the SPC.[106] Based on the current updated requirement that the SPC be responsible for determining placement of the HRS PRF(without a defined timeframe for doing so)[107], the OIG further calculated that the average time from referral to HRS PRF placement for the patients reviewed was 3 days (the observed range was 0–8 days).

Further, the OIG noted concerns with reviewing HRS PRFs within the required time frame. VHA required that all patients with an HRS PRF be reevaluated at least every 90 days and there is documented justification for continuing or discontinuing the flag.[108] The OIG estimated that 24 percent of patients with an HRS PRF were reevaluated at least every 90 days.[109] However, based upon the updated requirement that HRS PRFs be reviewed up to 10 days prior to or after the due date for reevaluation, the OIG found that 36 of 37 patients (97 percent) were reviewed within the expected time frame (observed range was 87–104 days).[110]

Additionally, the OIG noted concerns with completion of suicide prevention training. VHA requires that all employees complete suicide risk and intervention training within 90 days of starting their position and annual refresher training thereafter.[111] The OIG found that 11 of 19 clinical and nonclinical staff did not complete annual refresher training as required. Lack of training could prevent staff from providing optimal treatment to veterans who are at risk for suicide. The SPC was given an opportunity to provide a reason for noncompliance, but no explanation was offered.

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

[106] The OIG estimated that 95 percent of the time, the true compliance rate is between 30.0 and 62.2 percent, which is statistically significantly below the 90 percent benchmark.

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

[108] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk For Suicide*, July 18, 2008. *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide*.

[109] The OIG estimated that 95 percent of the time, the true compliance rate is between 11.1 and 38.7 percent, which is statistically significantly below the 90 percent benchmark.

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

[111] VHA Directive 1071.

Recommendation 14

14. The Healthcare Center Director determines the reasons for noncompliance and ensures clinical and nonclinical staff complete annual suicide prevention refresher training.

Healthcare center concurred.

Target date for completion: October 31, 2020

Healthcare center response: The Healthcare Center Director ensures that the suicide prevention training is assigned to all staff in Talent Management System upon hire by the Chief of Education Department/designee. After the initial training, all staff will complete the refresher training annually during Suicide Prevention Month in September of each year, placing all staff on the same training schedule. Supervisors will ensure staff complete the required training by September 30th each year. This recommendation will be considered in compliance when the Suicide Prevention Coordinator reports 90 percent or greater compliance in the number of staff completed the training timely (numerator) compared to the total number of staff required to complete the training (denominator) in the Quality Council in October of 2020.

Care Coordination: Life-Sustaining Treatment Decisions

Life-sustaining treatments (LSTs) are intended to extend the life of a patient expected to die soon without medical intervention. Life-sustaining treatments may include artificial nutrition, hydration, and mechanical ventilation. VHA issued the Life-Sustaining Treatment Decisions (LSTD) handbook to standardize practices related to discussing and documenting goals of care and LSTD. Per VHA, the goal is to encourage personalized, proactive, patient-driven treatment plans for veterans with serious illness by "…eliciting, documenting, and honoring patients' values, goals, and preferences."[112]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.[113] Implementation requirements included initiating conversations about the goals of care. A goals of care conversation is a discussion between a healthcare provider and a patient or surrogate to help define the patient's values, goals, and preferences for care and, based on the discussion, make choices about starting, limiting, or ceasing LSTs.[114] VHA requires practitioners to initiate goals of care conversations with high-risk patients—including hospice patients or their surrogates—within a time frame that meets the medical needs of the patient or at the time of a triggering event.[115]

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

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

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

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

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

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

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

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

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

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

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

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[116] Inspectors examined if the healthcare center established an LSTD committee that was comprised of a multidisciplinary membership, which included representation from Ethics Consultation Service, and reviewed proposed LST plans.

To determine whether the healthcare center complied with the OIG-selected requirements related to LSTD for hospice patients, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 39 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

Care Coordination Findings and Recommendations

The healthcare center generally complied with requirements for the LSTD committee, supervision of designees, and timely documentation of LSTD notes. Additionally, with VHA's

[116] VHA Handbook 1004.03(1).

original requirements that were in place when these patients received care,[117] the OIG estimated that

- 58 percent of patients' LST progress notes addressed identification of a surrogate if the patient loses decision-making capacity,[118]
- 53 percent of patients' LST progress notes addressed previous advance directive(s), state-authorized portable orders, and/or LST notes, and[119]
- 55 percent of patients' LST progress notes addressed the patient's or surrogate's understanding of the patient's condition.[120]

However, VHA recently dropped requirements for the documentation of these elements in the LST progress note.[121] The OIG remains concerned that this change could result in practitioners not addressing these important goals of care conversation elements.

[117] VHA Handbook 1004.03(1).

[118] The OIG estimated that 95 percent of the time, the true compliance rate is between 41.9 and 73.7 percent, which is statistically significantly below the 90 percent benchmark.

[119] The OIG estimated that 95 percent of the time, the true compliance rate is between 36.6 and 68.6 percent, which is statistically significantly below the 90 percent benchmark.

[120] The OIG estimated that 95 percent of the time, the true compliance rate is between 39.0 and 71.1 percent, which is statistically significantly below the 90 percent benchmark.

[121] VHA Handbook 1004.03(1).

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[122] 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.[123] 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."[124] 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."[125]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment. Facilities must, therefore, ensure availability of appropriate resources, services, and staffing ratios.[126] VHA also requires delivery of quality care to all women veterans accessing VA emergency services. In addition, VHA requires facilities to establish a multidisciplinary women veteran health committee that "develops and implements a Women's Health Program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans."[127]

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

- Provision of care requirements

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[122] 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.)

[123] 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.)

[124] 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.)

[125] 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.)

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

[127] VHA Directive 1330.01(3).

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

Women's Health Findings and Recommendations

The healthcare center complied with requirements for each of the selected staffing elements reviewed. However, the OIG identified weaknesses with Primary Care Mental Health Integration services, CBOC-designated women's health primary care providers, and Women Veterans Health Committee processes.

VHA requires all sites that have primary care to provide integrated mental health services for women veterans.[128] The OIG determined that CBOC clinicians did not provide integrated mental health services, which could prevent development of gender-specific prevention strategies. The Women's Health Medical Director reported that staffing shortage of mental health providers affected the ability to meet the requirement.

[128] VHA Directive 1330.01(3).

Recommendation 15

15. The Healthcare Center Director evaluates and determines any additional reasons for noncompliance and ensures that clinicians at community-based outpatient clinics provide integrated mental health services for women veterans.

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The Healthcare Center Director will ensure that clinicians at community-based outpatient clinics provide integrated mental health services for women Veterans. The Chief Medical Executive reevaluated the staffing and ensured adequate coverage at community-based outpatient clinics to provide integrated mental health services for women Veterans. The Chief Medical Executive will ensure continued reporting of the compliance as the number of days providing integrated mental health services for women Veterans at each community-based outpatient clinic (numerator) compared to the total number of days per month (denominator) to the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

VHA requires that each CBOC have at least two designated women's health primary care providers (WH-PCPs) or arrangements for leave coverage when CBOCs have only one designated WH-PCP.[129] The OIG found that three CBOCs reviewed had only one designated WH-PCP and no plans for leave coverage, which could limit the clinics' ability to offer comprehensive women's healthcare services. The Women's Health Medical Director cited a lack of incentive for providers to undergo the additional training for the WH-PCP designation and overall provider retention as reasons for noncompliance.

Recommendation 16

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

[129] VHA Directive 1330.01(3).

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The Healthcare Center Director will ensure that each community-based outpatient clinic has arrangements for leave coverage when clinics have only one provider. The Chief Medical Executive has developed a contingency plan for staffing in the case of absences to ensure access to care for women veterans. The Clinical Director for Primary Care or designee will conduct a monthly audit for effectiveness of the contingency plan. The Clinical Director for Primary Care will ensure continued reporting of the compliance as the number of days with leave coverage for each community-based outpatient clinic (numerator) compared to the total number of days per month (denominator) to the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

VHA requires that the Women Veterans Health Committee meets quarterly, reports to executive leaders, and has a core membership that includes a women veterans program manager, women's health medical director, "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership."[130]

The OIG reviewed the Women Veterans Health Committee minutes for June 2019 through November 2019 and found that representatives from laboratory, quality management, business office/non-VA medical care, and executive leadership did not attend the quarterly meetings. This resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans.

The Women Veterans Program Manager was new to the role and followed the past practice of the committee charter and meeting format; however, the charter did not specify the required core membership. The Women Veterans Program Manager cited unawareness of the laboratory representative requirement. A member from quality management was not assigned to attend until November 2019, and the representative from the business office/non-VA medical care office was unable to attend due to heavy workload. Additionally, the Women Veterans Program Manager reported to the Chief Medical Executive and believed this reporting structure met the intent of the executive leader membership requirement.

[130] VHA Directive 1330.01(3).

Recommendation 17

17. The Healthcare Center Director evaluates and determines any additional reasons for noncompliance and makes certain that required members are assigned and consistently attend Women Veterans Health Committee meetings.

Healthcare center concurred. Target date for completion: December 31, 2020 Healthcare center response: The Healthcare Center Director will ensure that required members are assigned and consistently attend Women Veterans Health Committee meetings. The Women Veteran Health Committee charter was updated to include all the required core members. The Chief Medical Executive will ensure continued reporting of the compliance as the number of Women Veteran Health Committee minutes attendance sheet reflecting required member attendance (numerator) compared to the total number of meetings conducted (denominator) to the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

VHA requires the facility to collect and track quality assurance data related to appropriate and timely follow-up care of abnormal breast cancer screening results, cervical screening results, customer satisfaction initiatives and outcomes, and women veterans' appointment wait times.[131] The OIG found that healthcare center staff did not collect and track the required quality assurance data. This could prevent the healthcare center leaders from identifying practice improvement opportunities, ensuring corresponding actions are implemented, and regularly measuring the effectiveness of those actions. The Women's Health Medical Director reported that some cervical cancer screening data were tracked for the Women's Health Medical Director's clinic, but the data were not tracked for all primary care clinics. None of the data were reported to the Women Veterans Health Committee. The Women's Health Medical Director cited staffing constraints and increased provider workload as reasons for noncompliance.

Recommendation 18

18. The Chief Medical Executive evaluates and determines any additional reasons for noncompliance and ensures the Women's Health Medical Director collects, tracks, and reports quality assurance data.

[131] VHA Directive 1330.01(3).

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The Chief Medical Executive will ensure that Women Veterans Health Program Manager collects, tracks, and reports quality assurance data in Women Veterans Health Committee meetings. The reporting of quality assurance data was started in February 2020 in the quarterly Women Veterans Health Committee meetings. The Chief Medical Executive will ensure continued reporting of the compliance as the number of committee meetings where the Women's Health Medical Director collects, tracks, and reports quality assurance data (numerator) compared to the total number of meetings conducted (denominator) in the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have a Sterile Processing Services (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment…"[132] The goal of SPS is to "...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[133] To ensure this, VHA requires facilities to conduct the following activities:

- Maintain a current inventory list of all RME
- Have standard operating procedures (SOPs) that are based on current manufacturer's guidelines and reviewed at least triennially
- Use CensiTrac® Instrument Tracking System for tracking reprocessed instruments[134]
- Perform annual risk analysis and report results to the VISN SPS Management Board
- Monitor data for reprocessing and storing RME
- Conduct annual airflow/ventilation system inspections[135]

VHA requires strict controls that closely monitor climate, storage, and sterilization parameters and additionally requires that quality assurance documentation of this monitoring be maintained for a minimum of three years.[136] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[137]

In addition, RME reprocessing areas must be clean, restricted, and airflow-controlled. All areas where RME reprocessing occurs must have safety data sheets, an unobstructed eyewash station, personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[138]

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

[133] 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.)

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

[135] VHA Directive 1116(2).

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

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

[138] VHA Directive 1116(2).

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued annual and essential staff competency assessments, and monthly continuing education. This ensures that staff have sufficient aptitude, knowledge, and skills to effectively and safely reprocess and sterilize RME.[139]

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

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

[139] VHA Directive 1116(2).

- Completion of staff training, competency, and continuing education
  - Required training completed in a timely manner
  - Competency assessments performed
  - Monthly continuing education received

High-Risk Processes Findings and Recommendations

The healthcare center complied with quality assurance monitoring and most of the reprocessing and storage area physical inspection requirements. However, the OIG identified deficiencies with administrative processes; equipment storage; and staff training, competency, and continuing education.

VHA requires that facilities "have standard operating procedures (SOPs) based on manufacturer's guidelines that establishes a documented and systematic approach to critical and semi-critical RME processes."[140] VHA also requires that "all SOPs are kept up-to-date, reviewed at least every 3 years, and updated when there is a change in process or a change in manufacturer's IFU [instructions for use]."[141] The OIG found that the SOP for a colonoscope did not align with the manufacturer's IFU. This could cause inadequate disinfection and reprocessing of RME. The Chief of SPS reported lack of oversight and increased workload as contributing factors for noncompliance.

Recommendation 19

19. The VA Chief Nurse Executive evaluates and determines any additional reasons for noncompliance and makes certain that the Chief of Sterile Processing Services aligns standard operating procedures with manufacturers' guidelines and instructions for use.

[140] VHA Directive 1116(2).
[141] VHA Directive 1116(2).

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The VA Chief Nurse Executive will ensure that facility's Sterile Processing Services' standard operating procedures are in alignment with manufacturer's guidelines and instructions for use by reviewing all standard operating procedures and updating the ones which are not in alignment with manufacturer's guidelines. The VA Chief Nurse Executive will ensure continued reporting of the progress in compliance as the number of standard operating procedures in alignment with manufacturer's guidelines and instructions for use (numerator) compared to the total number of standard operating procedures guidelines and instructions for use (denominator) in the Quality Council. This recommendation will be considered in compliance as of December 31, 2020 when 90 percent or greater Sterile Processing Services' standard operating procedures are in alignment with manufacturer's guidelines and instructions for use.

Additionally, VHA requires that facilities deploy CensiTrac®, an instrument tracking system.[142] The Chief of SPS reported that five percent of the healthcare center's instruments were not entered into CensiTrac®. Not using CensiTrac® may result in potential veteran harm through noncompliant record control processes. The Chief of SPS reported inadequate staffing and designated space for the computer equipment as reasons for noncompliance.[143]

Recommendation 20

20. The VA Chief Nurse Executive evaluates and determines any additional reasons for noncompliance and ensures that the Chief of Sterile Processing Services enters all equipment into the CensiTrac® Instrument Tracking System.

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The VA Chief Nurse Executive will ensure that the Chief of Sterile Processing Services enters all equipment into the CensiTrac® Instrument Tracking System. This recommendation will be considered compliant when the remaining five percent reusable medical equipment has been entered in the CensiTrac® system. The compliance will be reported to the Quality Council.

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

[143] Initially, there was a delay with installation of CensiTrac® computer equipment due to a lack of adequate designated space in SPS. The healthcare system obtained approval to rearrange SPS to accommodate the equipment and completed the install in March 2019.

VHA also requires that the SPS Chief performs an annual risk analysis and reports the results to the VISN SPS Management Board.[144] The OIG found that a risk analysis was performed but not reported to the VISN SPS Management Board. Failure to report analysis results can delay or prevent the identification of potential problems or process failures. According to the Chief of SPS, the VISN SPS Management Board had been inactive for approximately a year, so the results could not be reported.

Recommendation 21

21. The VA Chief Nurse Executive evaluates and determines any additional reasons for noncompliance and makes certain that the Chief of Sterile Processing Services consistently reports the annual risk analysis to the Veterans Integrated Service Network Sterile Processing Services Management Board.

Healthcare center concurred.

Target date for completion: February 27, 2020

Healthcare center response: The VA Chief Nurse Executive ensured that the Chief of Sterile Processing Services sent the annual sterile processing risk analysis to VISN 12 for reporting purposes at the VISN Sterile Processing Services Management Board. The risk analysis dated February 27, 2020 was forwarded to VISN 12 on February 27, 2020. This recommendation is considered in compliance as of February 27, 2020.

VHA requires airflow checks at minimum annually and "after repair of the heating, ventilation and air-conditioning (HVAC) system, extended shut-down or equipment replacement."[145] The OIG found that healthcare center staff failed to conduct annual airflow testing for the endoscope storage and operating room sterile storage rooms. Failure to evaluate and maintain air-quality standards could result in exposure to airborne contaminants.[146] The Assistant Department Head of Facilities Management Division stated that the rooms were not included on the preventative maintenance schedule due to lack of oversight.

Recommendation 22

22. The Associate Director for Facilities Support evaluates and determines any additional reasons for noncompliance and ensures that Sterile Processing Services staff conduct annual airflow testing in all areas where reusable medical equipment is reprocessed or stored.

[144] VHA Directive 1116(2).

[145] VHA Directive 1116(2).

[146] Centers for Disease Control and Prevention, *Guidelines for Environmental Infection Control in Health-Care Facilities, July 2019.* https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf. (The website was accessed on February 6, 2020.)

Healthcare center concurred.

Target date for completion: September 30, 2020

Healthcare center response: The Associate Director for Facilities Support ensured that all rooms where reusable medical equipment is stored or reprocessed has been added to their list of annual air flow testing as of May 31, 2020. The Associate Director for Facilities Support will ensure reporting of compliance as the number of reusable medical equipment storage/reprocessing rooms where annual airflow testing is conducted (numerator) compared to the total number of reusable medical equipment storage/reprocessing rooms (denominator). This recommendation will be considered in compliance when 90 percent or greater compliance with annual airflow testing in reusable medical equipment storage/reprocessing rooms is reported in the Quality Council by September 2020.

According to VHA, facilities must conduct and maintain written records of weekly function testing of eyewash stations.[147] The OIG found no evidence of weekly testing in the prep/assembly room. This could potentially result in staff injury if the eyewash station is unavailable in an emergency. The Chief of SPS cited lack of oversight as the reason for noncompliance.

Recommendation 23

23. The Associate Director for Facilities Support evaluates and determines any additional reasons for noncompliance and ensures that the Chief of Engineering Service or designee conduct and maintain the record of weekly eyewash station function testing.

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The Associate Director for Facilities Support will ensure that eye wash station function tests are conducted and recorded weekly by the leadership in each area. The Associate Director for Facilities Support will ensure continued reporting of compliance as the number of eye wash station in compliance with weekly testing and documentation (numerator) compared to the total number of eye wash stations in the facility (denominator) in the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

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

According to VHA, the Chief of SPS must "develop, implement and enforce a written daily cleaning schedule for all SPS areas."[148] The OIG found no evidence that a cleaning schedule was maintained or followed for SPS. Environmental cleaning prevents infections by decreasing the presence of microorganisms.[149] The Chief of SPS asked the Chief of Environmental Care to provide a reason for not following the cleaning schedule, but none was offered.

Recommendation 24

24. The Associate Director for Facilities Support determines the reasons for noncompliance and makes certain the Environmental Management Supervisor develop, implement, and enforce a written cleaning schedule for all Sterile Processing Services areas.

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The Associate Director for Facilities Support will ensure that the Environmental Management Supervisors develop, implement, and enforce a written cleaning schedule for all Sterile Processing Services areas. The Environmental Management Supervisors have created and implemented a new 'cleaning schedule' and audit checklist for all Sterile Processing Services areas. The Associate Director for Facilities Support will ensure continued reporting of compliance as the number of days in compliance with the new cleaning schedule (numerator) compared to the total number of days per month (denominator) in the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

Additionally, VHA requires that high-level disinfected endoscopes "are to be hung so that no part of the scope touches the bottom of the cabinet and in sufficient space for storage of multiple endoscopes without touching."[150] The OIG found that two high-level disinfected endoscopes were touching other scopes. Improper storage of endoscopes increases the risk of contamination or damage to the equipment. The Chief of SPS stated the noncompliance was potentially due to lack of attention to detail by SPS and clinical staff.

[148] VHA Directive 1116(2).

[149] "Environmental Cleaning in Sterile Processing Areas," OR Manager, 30, no. 9 (September 2014): 20-25. http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=103889374&site=ehost-live. (The website was accessed on May 4, 2020.)

[150] VHA Directive 1116(2).

Recommendation 25

25. The VA Chief Nurse Executive evaluates and determines any additional reasons for noncompliance and ensures that endoscopes are properly stored by Sterile Processing Services and clinical staff.

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The VA Chief Nurse Executive will ensure that endoscopes are properly stored by Sterile Processing Services and clinical staff. Additional storage equipment was purchased and will be installed by June 30, 2020. Quality checks are being completed by a Quality Management Specialist on a weekly basis to ensure proper storage. The VA Chief Nurse Executive will ensure continued reporting of the compliance as the number of quality checks ensuring that endoscopes are properly stored (numerator) compared to the total number of quality checks conducted per month (denominator) in the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

VHA requires that "competency evaluation will be conducted and documented listing all critical action steps, validation methods and results. Each critical action step will be validated."[151] SPS staff must complete competency assessments for RME reprocessing.[152] The OIG found that all 10 SPS staff reviewed had incomplete competency assessments for reprocessing equipment. This could result in improper processing of the RME and compromise patient safety. The Chief of SPS reported a lack of effective oversight as the reason for noncompliance.

Recommendation 26

26. The VA Chief Nurse Executive evaluates and determines any additional reasons for noncompliance and ensures that Sterile Processing Services staff properly complete competency assessments for reprocessing reusable medical equipment.

[151] VHA DUSHOM Memorandum, *Competency Assessment for Employees Reprocessing Critical and Semi-critical Reusable Medical Equipment*, April 11, 2017.

[152] VHA Directive 1116(2).

Healthcare center concurred.

Target date for completion: December 31, 2020

Healthcare center response: The VA Chief Nurse Executive will ensure that Sterile Processing Service staff properly complete competency assessments for reprocessing reusable medical equipment. To ensure sustainment of this recommendation, a new orientation plan was implemented to ensure that all new employees also complete the competency assessments for reprocessing reusable medical equipment. A database has been created to monitor staff for re-competency needs. The VA Chief Nurse Executive will report compliance as the number of Sterile Processing Services staff properly completing competency assessments for reprocessing reusable medical equipment (numerator) compared to the total number of completed competency assessments for reprocessing reusable medical equipment (denominator) in the Quality Council. This recommendation will be considered compliant when 90 percent or greater of current Sterile Processing Service staff properly complete competency assessments for reprocessing reusable medical equipment.

In addition, VHA requires SPS staff to receive monthly "in-service education sessions focusing on the technical aspects of SPS...including an attendance roster, clear objectives of the training and a brief description of the content to be covered."[153] The OIG found no evidence of monthly continuing education for 6 of 10 selected SPS staff between October 2019 and December 2019. This could result in a potential knowledge gap in the technical aspects of reprocessing duties. The Chief of SPS reported that insufficient staffing, increased workload, and lack of oversight contributed to noncompliance.

Recommendation 27

27. The VA Chief Nurse Executive evaluates and determines any additional reasons for noncompliance and makes certain that Sterile Processing Services staff receive monthly continuing education.

[153] VHA Directive 1116(2).

Healthcare center concurred.

Target date for completion: September 30, 2020

Healthcare center response: The VA Chief Nurse Executive and the Chief of Sterile Processing Services will ensure Sterile Processing Service staff receive monthly continuing education. The VA Chief Nurse Executive will ensure continued reporting of the compliance as the number of Sterile Processing Services staff completing monthly continuing education (numerator) compared to the total number of Sterile Processing Services staff required to complete monthly continuing education (denominator) in the Quality Council quarterly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

Healthcare Processes	Requirements	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Factors related to possible lapses in care and healthcare center response • VHA performance data (facility or system) • VHA performance data for CLCs	Twenty-seven OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the Director, Chief Medical Executive, Associate Director for Facilities Support, and VA Chief Nurse Executive. See details below.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• None	• Improvement action items recommended by the Quality Council are fully implemented, monitored. • Patient Flow Committee meeting minutes reflect documentation, implementation, and evaluation of action items.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• Service chiefs define in advance, and communicate the criteria for focused professional provider evaluations in provider profiles. • Focused Professional Practice Evaluation results are documented in provider profiles. • Executive Committee of the Medical Staff review professional practice evaluation results in the decision to recommend continuation of initially granted privileges. • Reprivileging decisions are based on service-specific ongoing professional practice evaluation data. • Providers with similar training and privileges complete ongoing professional practice evaluations.	• Provider exit review forms are completed within seven calendar days of licensed healthcare professionals' departure from the healthcare center.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Healthcare center
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Accommodation and privacy for women veterans
	  ○ Logistics
	• Inpatient mental health unit
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Accommodation for women veterans
	  ○ Logistics
	• Community-based outpatient clinic
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Privacy for women veterans
	  ○ Logistics
		• Healthcare center managers remove or repair damaged wheelchairs.
		• Healthcare center managers maintain a safe and clean environment.
		• Adequate privacy is provided in patient examination rooms.
			• Information technology room is secure, and access is restricted to authorized personnel.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• Pain Management Committee monitors the quality of pain assessments and effectiveness of pain management interventions.	• None
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements	• None	• Clinical and nonclinical staff complete annual suicide prevention refresher training.
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• None	• None
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• Community-based outpatient clinics provide integrated mental health services for women veterans. • Each community-based outpatient clinic has at least two designated women's health primary care providers or arrangements for leave coverage.	• Required members are assigned and consistently attend Women Veterans Health Committee meetings. • Women's health quality assurance data are collected, tracked, and reported.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Data monitoring • Physical inspection • Staff training	• Annual airflow testing is conducted in all areas where reusable medical equipment is reprocessed or stored. • Endoscopes are stored properly by Sterile Processing Services and clinical staff.	• Standard operating procedures align with current manufacturers' instructions for use. • All equipment is entered into the CensiTrac® Instrument Tracking System. • Sterile Processing Services Chief reports the annual risk analysis to the VISN Sterile Processing Services Management Board. • Written records of weekly eyewash function testing are maintained. • A written cleaning schedule for the Sterile Processing Services is developed, implemented, and enforced. • Sterile Processing Services staff properly complete competency assessments for reprocessing reusable medical equipment. • Sterile Processing Services staff receive monthly continuing education.

Appendix B: Healthcare Center Profile

The table below provides general background information for this mid-high complexity (1c) affiliated[1] healthcare center reporting to VISN 12.[2]

Table B.1. Profile for Captain James A. Lovell Federal Health Care Center (556) (October 1, 2016, through September 30, 2019)

Profile Element	Healthcare Center Data FY 2017[3]	Healthcare Center Data FY 2018[4]	Healthcare Center Data FY 2019[5]
Total medical care budget in dollars	$423,078,254	$447,973,896	$443,361,075
Number of:			
• Unique patients	76,244	78,215	77,932
• Outpatient visits	419,340	407,654	400,797
• Unique employees[6]	2,203	2,119	2,231
Type and number of operating beds:			
• Community living center	134	134	134
• Domiciliary	125	125	125
• Medicine	32	32	32
• Mental health	52	52	52
• Residential rehabilitation	18	18	18
• Surgery	4	4	4
Average daily census:			
• Community living center	115	100	102
• Domiciliary	80	85	84
• Medicine	23	25	27
• Mental health	16	27	24
• Residential rehabilitation	16	13	14

[1] Associated with a medical residency program.

[2] The VHA medical centers are classified according to a facility complexity model; a designation of "1c" indicates a facility with "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs."

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

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

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

[6] Unique employees involved in direct medical care (cost center 7000).

Profile Element	Healthcare Center Data FY 2017[3]	Healthcare Center Data FY 2018[4]	Healthcare Center Data FY 2019[5]
• Surgery	2	2	1

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

Appendix C: VA Outpatient Clinic Profiles[1]

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Evanston, IL	556GA	3,005	1,713	Dermatology Gastroenterology Nephrology	EKG	Nutrition Pharmacy Weight management
McHenry, IL	556GC	9,899	3,894	Dermatology Gastroenterology Nephrology Podiatry	EKG	Nutrition Pharmacy Weight management

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

[2] The definition of an "encounter" can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. An encounter is a "professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

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

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

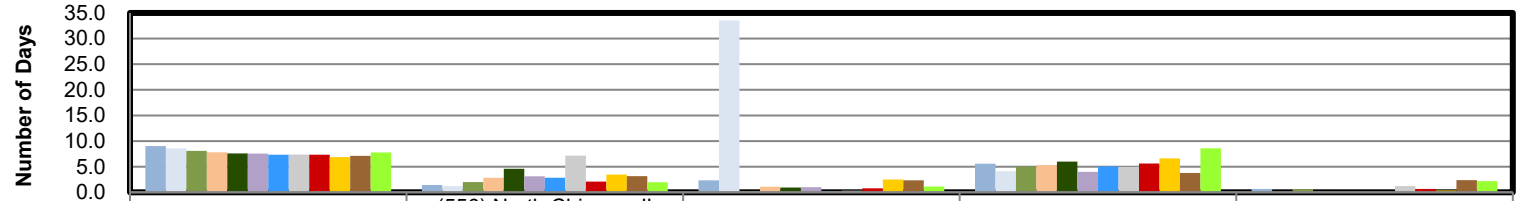
[5] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Kenosha, WI	556GD	4,645	2,924	Gastroenterology Nephrology Podiatry	EKG	Nutrition Pharmacy Weight management

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

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

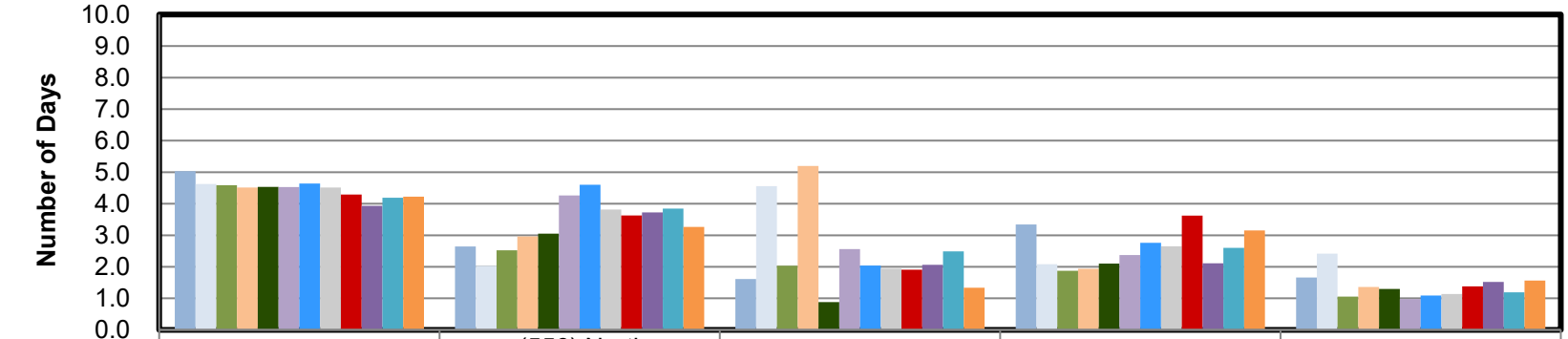
Quarterly New Primary Care Patient Average Wait Time in Days



	VHA Total	(556) North Chicago, IL (Captain James A. Lovell)	(556GA) Evanston, IL	(556GC) McHenry, IL	(556GD) Kenosha, WI
JAN-FY19	9.0	1.4	2.4	5.6	0.7
FEB-FY19	8.5	1.2	33.5	4.1	0.0
MAR-FY19	8.1	2.0	0.2	5.0	0.6
APR-FY19	7.8	2.8	1.1	5.3	0.1
MAY-FY19	7.6	4.6	0.9	6.0	0.0
JUN-FY19	7.6	3.1	1.0	4.0	0.0
JUL-FY19	7.3	2.8	0.3	5.1	0.0
AUG-FY19	7.4	7.2	0.3	5.0	1.2
SEP-FY19	7.3	2.1	0.8	5.6	0.7
OCT-FY20	6.9	3.5	2.5	6.6	0.4
NOV-FY20	7.1	3.2	2.3	3.8	2.4
DEC-FY20	7.8	2.0	1.1	8.6	2.2

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the healthcare center's explanation for the increased wait times for the (556GA) Evanston, IL, CBOC.
Data Definition: "The average number of calendar days between a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Note that prior to FY15, this metric was calculated using the earliest possible create date.

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



	VHA Total	(556) North Chicago, IL (Captain James A. Lovell)	(556GA) Evanston, IL	(556GC) McHenry, IL	(556GD) Kenosha, WI
JAN-FY19	5.0	2.6	1.6	3.3	1.7
FEB-FY19	4.6	2.0	4.6	2.1	2.4
MAR-FY19	4.6	2.5	2.0	1.9	1.1
APR-FY19	4.5	3.0	5.2	1.9	1.4
MAY-FY19	4.5	3.1	0.9	2.1	1.3
JUN-FY19	4.5	4.3	2.6	2.4	1.0
JUL-FY19	4.6	4.6	2.0	2.8	1.1
AUG-FY19	4.5	3.8	1.9	2.7	1.1
SEP-FY19	4.3	3.6	1.9	3.6	1.4
OCT-FY20	3.9	3.7	2.1	2.1	1.5
NOV-FY20	4.2	3.8	2.5	2.6	1.2
DEC-FY20	4.2	3.3	1.3	3.2	1.6

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

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

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

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

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

Source: VHA Support Service Center

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

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

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

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 2, 2020

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

Subj: Comprehensive Healthcare Inspection of the Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois

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

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

1. I have reviewed the Comprehensive Healthcare Inspection of the Captain James A. Lovell Federal Health Care Center draft report.
2. I concur with the findings and recommendations proposed.
3. I concur with the submitted action plans from the facility.
4. I would like to thank the OIG inspection team for a thorough review of the Captain James A. Lovell Federal Health Care Center.

(Original signed by:)

Victoria P. Brahm, MSN, RN, VHA-CM
Director, VA Great Lakes Health Care System (10N12)

Appendix H: Healthcare Center Director Comments

Department of Veterans Affairs Memorandum

Date: July 14, 2020

From: Director, Captain James A. Lovell Federal Health Care Center (556/00)

Subj: Comprehensive Healthcare Inspection of the Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois

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

1. I have reviewed and concur with the findings and recommendations from the Office of Inspector General's Comprehensive Healthcare Inspection Program report for the Captain James A. Lovell Federal Health Care Center, North Chicago, IL
2. Corrective action plans have been established, with some having already been implemented and/or completed.
3. I would like to thank the Officer of Inspector General CHIP Survey team for their professionalism and constructive feedback to our employees during our review. This review provides the opportunity to continue improving care to our active duty military, military family, and Veterans.

(Original signed by:)

Robert G. Buckley, MD, MPH, FACEP

Medical Center Director

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