DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 12: VA Great Lakes Health Care System in Westchester, Illinois

CHIP REPORT | REPORT #20-00058-250 | SEPTEMBER 15, 2020

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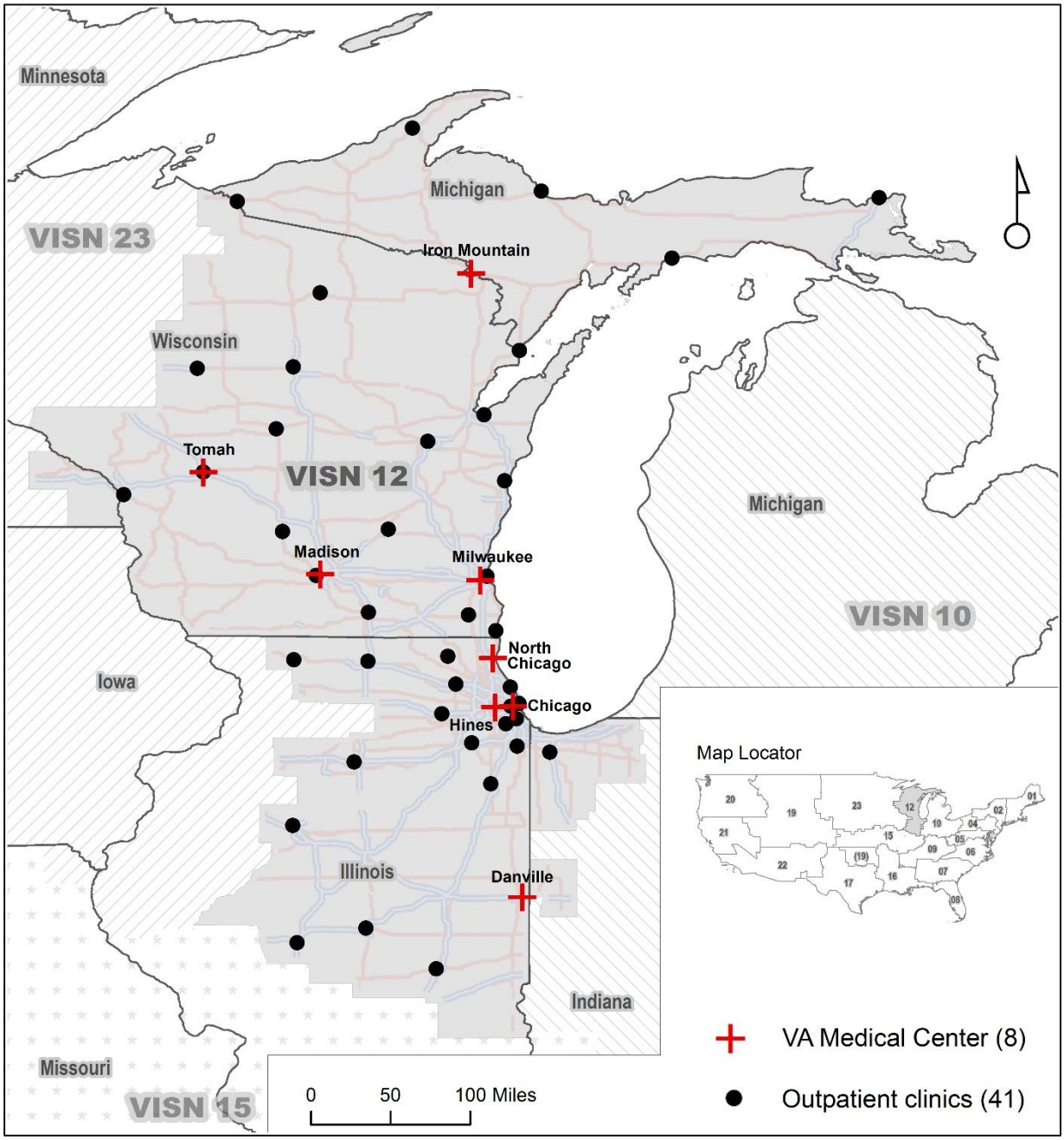

Figure 1. *VA Great Lakes Health Care System–Veterans Integrated Service Network 12 in Westchester, IL*
Source: Veterans Administration Site Tracking (VAST), December 16, 2019.

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	Chief Medical Officer
FHCC	Federal Health Care Center
FTE	full-time equivalent
FY	fiscal year
HCS	health care system
HRO	Human Resource Officer
OIG	Office of Inspector General
QMO	Quality Management Officer
QSV	quality, safety, and value
RME	reusable medical equipment
SAIL	Strategic Analytics for Improvement and Learning
SPS	Sterile Processing Services
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WVPM	women veterans program manager

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of leadership performance and oversight by the Veterans Integrated Service Network (VISN) 12: VA Great Lakes Health Care System. This inspection covers key clinical and administrative processes associated with promoting quality care.

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

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

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

The OIG conducted this unannounced visit during the week of January 27, 2020. Inspections of the following VISN 12 facilities were also performed during the weeks of January 13, 2020, and January 27, 2020:

- Captain James A. Lovell Federal Health Care Center (FHCC) (North Chicago, Illinois)
- Clement J. Zablocki VA Medical Center (VAMC) (Milwaukee, Wisconsin)
- Edward Hines, Jr. VA Hospital (Hines, Illinois)
- Jesse Brown VAMC (Chicago, Illinois)
- Oscar G. Johnson VAMC (Iron Mountain, Michigan)
- Tomah VAMC (Wisconsin)
- VA Illiana Health Care System (HCS) (Danville, Illinois)
- William S. Middleton Memorial Veterans Hospital (Madison, Wisconsin)

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient care outcomes. The findings presented in this report are a snapshot of VISN 12 and facility performance within the identified focus areas at the time of the

OIG visit. The findings in this report may help VISN leaders identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

Leadership and Organizational Risks

The VISN leadership team consists of the Network Director, Deputy Network Director, Chief Medical Officer (CMO), Quality Management Officer (QMO), and Human Resource Officer (HRO). Organizational communication and accountability are managed through a committee reporting structure, with the VISN's Executive Leadership Council overseeing the Healthcare Delivery, Healthcare Operation, Organizational & Veteran Health, and QSV Committees.

At the time of the OIG's inspection, the VISN's Deputy Director, CMO, QMO, and HRO had been working together for almost two years. On September 1, 2019, the VISN 12 Network Director was appointed as the Deputy Under Secretary for Health for Operations and Management. Two acting Network Directors served from January 3, 2019, through the time of the OIG site visit. On March 1, 2020, a permanent Network Director was appointed.

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

The OIG's evaluation of VISN access metrics and clinical vacancies did not identify any significant organizational risks. Interviewed leaders were knowledgeable about efforts taken to reduce veteran suicide in VISN 12 and shared information that highlighted efforts to develop and implement strategies for high-risk veterans.

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

The leadership team was knowledgeable within their scope of responsibility about selected SAIL and community living center (CLC) metrics and should continue to take actions to sustain and improve performance of measures contributing to quality ratings and care provided throughout the VISN. In individual interviews, the executive leadership team members were able to speak

[1] 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.)

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

However, the OIG identified that the Network Director, CMO, and QMO had opportunities to improve their oversight of facility-level QSV, medical staff privileging, medication management (specifically long-term opioid therapy for pain), mental health (focusing on the suicide prevention program), women's health (examining comprehensive care), and high-risk processes (specifically reusable medical equipment). Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

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

High-Risk Processes

The VISN did not meet many of the requirements for oversight of facility operations and management of reprocessing reusable medical equipment. The OIG noted deficiencies with VISN-led reusable medical equipment inspections.

Conclusion

The OIG conducted a detailed inspection across seven key areas and subsequently issued four recommendations for improvement to the Network Director. The number of recommendations should not be used, however, as a gauge for the overall quality provided within this VISN. The intent is for VISN leaders to use these recommendations as a road map to help improve operations and clinical care throughout the network of assigned facilities. The recommendations address systems issues as well as other less-critical findings that, if not addressed, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendix G, page 48, and the responses within the body of the report for the full text of the Network Director's 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 this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to evaluate leadership performance and oversight by the Veterans Integrated Service Network (VISN) 12: VA Great Lakes Health Care System. This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so that informed decisions can be made to improve care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[1] Investments in a culture of safety and continuous quality improvement, in concert with robust leadership and communication, significantly contribute to positive patient outcomes in healthcare organizations.[2]

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

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

[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.

Methodology

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

The inspection examined operations from July 10, 2017, through January 31, 2020, the last day of the unannounced week-long site visit.[3]

Inspections of the following VISN 12 facilities were also performed during the weeks of January 13, 2020, and January 27, 2020:

- Captain James A. Lovell Federal Health Care Center (FHCC) (North Chicago, Illinois)
- Clement J. Zablocki VA Medical Center (VAMC) (Milwaukee, Wisconsin)
- Edward Hines, Jr. VA Hospital (Hines, Illinois)
- Jesse Brown VAMC (Chicago, Illinois)
- Oscar G. Johnson VAMC (Iron Mountain, Michigan)
- Tomah VAMC (Wisconsin)
- VA Illiana Health Care System (HCS) (Danville, Illinois)
- William S. Middleton Memorial Veterans Hospital (Madison, Wisconsin)

While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leadership, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[3] The range represents the time from the last CHIP inspection of all VISN 12 facilities to the completion of the unannounced week-long CHIP site visit on January 31, 2020. (See Appendix D.)

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the ability to provide care in the clinical focus areas.[4] To assess the VISN's risks, the OIG considered the following indicators:

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

Additionally, the OIG briefed VISN managers on identified trends in noncompliance for facility CHIP reviews performed during the weeks of January 13, 2020, and January 27, 2020.

Executive Leadership Position Stability and Engagement

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

VISN 12 is responsible for oversight of eight medical centers and 41 outpatient clinics. According to data from the VA National Center for Veterans Analysis and Statistics, VISN 12 had a veteran population of 828,237 within its borders at the end of fiscal year (FY) 2019.

VISN 12 has a leadership team consisting of the Network Director, Deputy Network Director, Chief Medical Officer (CMO), Quality Management Officer (QMO), and Human Resource

[4] L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on February 2, 2017.)

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

Officer (HRO). The CMO is responsible for overseeing facility-level patient care programs. Figure 2 illustrates the VISN's reported organizational structure.

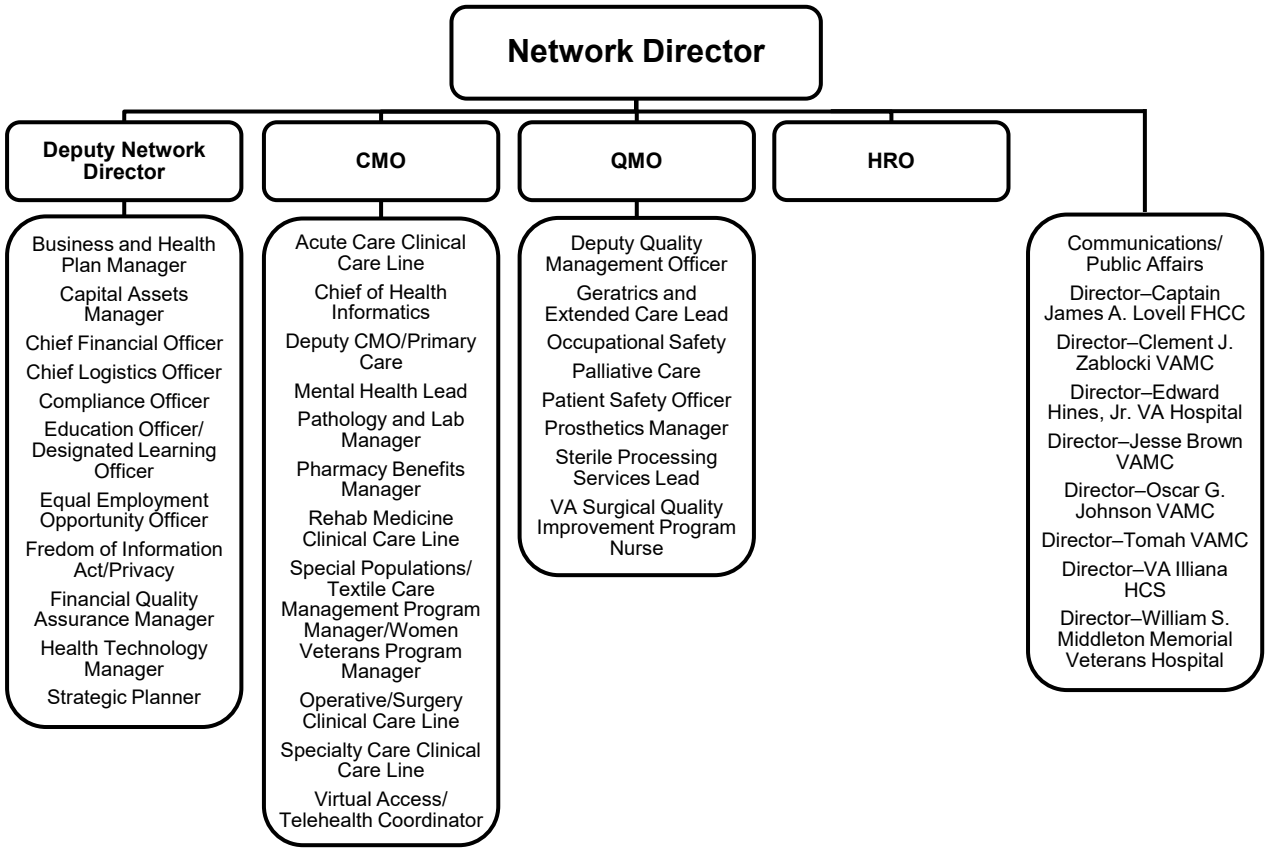

Figure 2. *VISN 12 Organizational Chart*[6]
Source: VA Great Lakes Health Care System–VISN 12 (received January 27, 2020)

At the time of the OIG site visit, the executive team was led by an acting Network Director, Deputy Network Director,[7] CMO, QMO, and HRO. The previous Network Director had served as the acting Deputy Under Secretary for Health for Operations and Management since January 3, 2019, and was permanently assigned to that position on September 1, 2019. Two acting Network Directors served from January 3, 2019, through the time of the OIG site visit (see table 1).[8] Although the VISN had two acting Directors in the year before the OIG site visit, the

[6] For this VISN, the Network Director is responsible for the directors of the Captain James A Lovell FHCC, Clement J. Zablocki VAMC, Edward Hines, Jr. VA Hospital, Jesse Brown VAMC, Oscar G. Johnson VAMC, Tomah VAMC, VA Illiana HCS, and William S. Middleton Memorial Veterans Hospital.

[7] During the OIG visit, the permanently-assigned Deputy Director was serving as the acting Medical Center Director at the Jesse Brown VAMC.

[8] A permanent Network Director was appointed on March 1, 2020.

VISN's executive leadership team appeared stable with the Deputy Network Director, CMO, QMO, and HRO serving together for almost two years.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network Director	September 1, 2019 (acting)
Deputy Network Director	February 18, 2018
Chief Medical Officer	June 2, 2013
Quality Management/Nursing Officer	January 21, 2018
Human Resource Officer	February 22, 2015

Source: VA Great Lakes Health Care System (received April 4, 2020)

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

The executive leaders were sufficiently knowledgeable within their scopes of responsibilities about VHA data and factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. In individual interviews, the executive leadership team members were generally able to speak in depth about actions taken during the previous 12 months to maintain or improve performance, as well as employee satisfaction, and patient survey results. These are discussed in greater detail below.

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

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

The Network Director serves as the chairperson of the Executive Leadership Council, which has oversight of the Healthcare Delivery, Healthcare Operation, Organizational & Veteran Health, and Quality Safety & Value Committees. See figure 3.

Figure 3. *VISN 12 Committee Reporting Structure*
Source: VA Great Lakes Health Care System (received January 27, 2020)

Employee Satisfaction

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

To assess employee attitudes toward VISN leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2018, through September 30, 2019.[9] Table 2 summarizes employee attitudes as expressed in VHA's All Employee Survey for VHA, the VISN office, and VISN leaders. The OIG found the VISN office and leaders' averages for the selected survey leadership questions were generally higher than the VHA averages.[10] However, opportunities appear to exist for the CMO and HRO to model servant leadership. VISN leaders reported sharing the AES results with staff and noted that employee workgroups were created to identify goals for improvement in the coming year.

[9] Ratings are based on responses by employees who report to or are aligned under the Network Director, Deputy Network Director, CMO, QMO, and HRO.

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

Table 2. Survey Results on Employee Attitudes toward VISN 12 Leadership (October 1, 2018, through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	VISN 12 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average	HRO Average
All Employee Survey: *Servant Leader Index Composite*[11]	0–100 where HIGHER scores are more favorable	72.6	75.1	72.3	83.7	65.6	88.1	52.3
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	3.7	3.8	4.2	3.9	3.9	3.2
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.8	3.6	4.2	3.8	4.1	3.5
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.8	3.9	4.2	3.9	3.9	3.3

Source: VA All Employee Survey (accessed December 23, 2019, and January 27, 2020)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Employee workplace attitudes within the VISN office were generally better

[11] According to the 2019 VA All Employee Survey Questions by Organizational Health Framework, Servant Leader Index "is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others' contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others' needs before their own."

than those for VHA employees collectively. However, opportunities appear to exist for the leaders—except the QMO—to improve staff's feeling of "moral distress" in the workplace.

Table 3. Survey Results on Employee Attitudes toward the VISN 12 Workplace (October 1, 2018, through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	VISN 12 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average	HRO Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	4.1	3.5	4.6	4.1	4.5	3.8
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	3.8	3.9	4.1	3.7	4.1	3.1
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	1.3	1.8	1.9	1.8	0.9	1.7

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

Patient Experience

To assess patient attitudes toward their healthcare experiences, the OIG reviewed patient experience survey results that relate to the period of October 1, 2018, through

September 30, 2019. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for VISN 12 and compares the results to the overall VHA averages.[12]

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 VISN and facility leaders (see table 4). The VISN averages for each of the selected survey questions were similar to or higher than the VHA averages, indicating that VISN 12 patients are more satisfied compared to VHA patients in general.

VISN leaders acknowledged lower-than-average inpatient scores for the "willingness to recommend the hospital to friends or family" survey question at Jesse Brown and Tomah VAMCs. However, VISN-wide outpatient scores for Patient-Centered Medical Home satisfaction were consistently higher than the VHA average, and those for specialty care were generally similar to or better than the VHA average. To improve overall patient satisfaction, the VISN's Veteran Experience Group developed several programs to assist facilities and tied results to facility directors' performance plans.[13] The Tomah VAMC also implemented VHA's Whole Health program.[14] VISN 12 facility scores for the selected questions are presented in Appendix C.

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

[13] VISN 12 programs include use of the "Choose VA" badges, the Green Glove Toolkit, the Standard Phone Greeting, the "My Life My Story" program, and a dedicated staff member to manage patient experience initiatives.

[14] Whole Health is a recent VHA approach to health care that is a collaboration between providers and patients to focus on a personalized health plan that uses complementary therapies along with conventional medical care. https://www.va.gov/wholehealth/. (This website was accessed on April 7, 2020.)

Table 4. Survey Results on Patient Attitudes within VISN 12 (October 1, 2018, through September 30, 2019)

Questions	Scoring	VHA Average	VISN 12 Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.3	71.6
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	87.6
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	84.5
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	82.2

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

Access to Care

A VA priority is achieving and maintaining an optimal workforce to ensure timely access to the best care and benefits for our nation's veterans. VHA has a goal of providing patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[15] VHA has utilized various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates.[16] Wait time measures

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

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

based on "create date" have the advantage of not relying upon the accuracy of the "preferred date" entered into the scheduling system and are particularly applicable for new primary care patients where the care is not initiated by referral, or consultation, that includes a "clinically indicated date." The disadvantage to "create date" metrics is that wait times do not account for specific patient requests/availability. Wait time measures based on patient preferred dates consider patient preferences but rely upon appointment schedulers accurately recording the patients' wishes into the scheduling software.[17]

When patients could not be offered appointments within 30 days of clinically indicated or preferred dates, patients became eligible to receive non-VA (community) care through the VA Choice program—eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.[18] However, with the passage of the VA MISSION Act of 2018 on June 6, 2018, and subsequent enactment on June 6, 2019, eligibility criteria for obtaining care in the community now include average drive times and appointment wait times:[19]

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

To examine access to primary and mental health care within VISN 12, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics for the most recently completed quarter. Tables 5 and 6 provide wait time statistics for completed primary care and mental health appointments from July 1, 2019, through September 30, 2019.

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

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

[19] VA Office of Public Affairs Media Relations, *Fact Sheet: Veteran Community Care – Eligibility, VA MISSION Act of 2018*, April 2019. https://www.missionact.va.gov/library/files/MISSION-Act-Veteran-Community-Care-Eligibility-Fact-Sheet.pdf. (This website was accessed on June 27, 2019.)

Table 5. Primary Care Appointment Wait Times[20]
(July 1, 2019, through September 30, 2019)

Facility	New Patient Appointments	Average New Patient Wait from Create Date
VA Great Lakes Health Care System – VISN 12	5,146	12.0
Captain James A. Lovell FHCC (North Chicago, IL)	529	9.0
Clement J. Zablocki VAMC (Milwaukee, WI)	997	10.5
Edward Hines, Jr. VA Hospital (IL)	859	14.6
Jesse Brown VAMC (Chicago, IL)	902	14.9
Oscar G. Johnson VAMC (Iron Mountain, MI)	364	13.3
Tomah VAMC (WI)	214	13.3
VA Illiana HCS (Danville, IL)	695	9.4
William S. Middleton Memorial Veterans Hospital (Madison, WI)	586	11.0

Source: VHA Support Service Center (accessed December 23, 2019)
Note: The OIG did not assess VA's data for accuracy or completeness.

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

Table 6. Mental Health Appointment Wait Times[21] (July 1, 2019, through September 30, 2019)

Facility	New Patient Appointments	Average New Patient Wait from Create Date
VA Great Lakes Health Care System – VISN 12	2,197	11.3
Capt. James A Lovell FHCC (North Chicago, IL)	535	8.4
Clement J. Zablocki VAMC (Milwaukee, WI)	390	14.9
Edward Hines, Jr. VA Hospital (IL)	405	9.3
Jesse Brown VAMC (Chicago, IL)	310	9.6
Oscar G. Johnson VAMC (Iron Mountain, MI)	113	14.8
Tomah VAMC (WI)	95	10.7
VA Illiana HCS (Danville, IL)	206	12.0
William S. Middleton Memorial Veterans Hospital (Madison, WI)	143	17.2

Source: VHA Support Service Center (accessed December 23, 2019)
Note: The OIG did not assess VA's data for accuracy or completeness.

Data from July 1, 2019, through September 30, 2019, show that VISN facilities scheduled primary care and mental health appointments within the 20-day MISSION Act standard. To keep wait times under 20 days, the VISN used a clinical resource hub that assigned gap providers to primary care clinics at medical centers and community-based outpatient clinics in need of back-up. To maintain mental health access, the VISN also placed a telehealth hub at the Jesse Brown VAMC. The telehealth hub allows specialty staff and services to be provided closer to the veteran's home. Veterans are able to connect with medical center healthcare specialists from their respective community clinic. Providers perform exams, make diagnoses, and manage care virtually for patients across the VISN.

Clinical Vacancies

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

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

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

To assess the extent of clinical vacancies across VISN 12 facilities, the OIG held discussions with the HRO and reviewed the total number of vacancies by facility, position, service/section, and full-time equivalent (FTE) employees. Upon closer inspection, the OIG found the following approximated clinical vacancies across VISN 12:

- 389 nurse FTEs
- 167 physician FTEs
- 98 social worker FTEs
- 59 psychologist FTEs
- 40 nurse practitioner FTEs
- 14 physician assistant FTEs
- 7 physical therapist FTEs

Table 7 provides the clinical vacancy rates for these professions and the total vacancy rates across the VISN as of January 28, 2020.

Table 7. Reported Vacancy Rates for VISN 12 Facilities (as of January 28, 2020)

Facility	Clinical Vacancies	Clinical Vacancy Rate	Total Vacancy Rate
VA Great Lakes Health Care System – VISN 12	761	11%	28%
Captain James A. Lovell FHCC (North Chicago, IL)	85	13%	12%
Clement J. Zablocki VAMC (Milwaukee, WI)	132	8%	10%
Edward Hines, Jr. VA Hospital (IL)	96	8%	10%
Jesse Brown VAMC (Chicago, IL)	130	12%	13%
Oscar G. Johnson VAMC (Iron Mountain, MI)	30	18%	10%
Tomah VAMC (WI)	85	16%	13%
VA Illiana HCS (Danville, IL)	93	19%	15%
William S. Middleton Memorial Veterans Hospital (Madison, WI)	111	9%	11%

Source: VISN 12 Human Resource Officer (received January 28, 2020)

Given the potential opportunities to improve mental health wait times at William S. Middleton Memorial Veterans Hospital, the OIG reviewed the number of mental health clinical vacancies at the medical center and found five psychiatrist FTEs were vacant. Clinical staffing is likely a contributing factor to the 17.2-day mental health wait times at this medical center.

Regarding staffing vacancies in general, the HRO reported nurse recruitment and retention as a significant issue for patient safety and staff satisfaction and described recent VISN efforts to recruit and retain nurses. The VISN sponsored nursing career fairs at the Clement J. Zablocki VAMC (January 2020) and the Tomah VAMC (February 2020) and publicized these events on local radio and popular websites. To make nurse retention and engagement an organizational priority, facilities instituted "stay interviews" between newly hired nurses and facility supervisors at the 30-day, 90-day, and 1-year marks.[23]

VISN Efforts to Reduce Veteran Suicide

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

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

[23] VA policy on trainee recruitment events notes that "stay interviews are a strategic and systematic approach for supervisors to make employee retention and engagement an organizational priority. Stay interviews are intended to be an informal discussion around a set of recommended questions to uncover problems, concerns, and opportunities for employees before they decide to leave VA employment." *VA-Trainee Recruitment Events (VA-TRE): Facility Policy Factsheet.* https://www.va.gov/OAA/docs/VA-TRE_Facility_Participation_Policy_FactSheet.pdf. (The website was accessed on April 9, 2020.)

[24] The Centers for Disease Control and Prevention, *CDC Vitalsigns™,* June 2018. (The website was accessed on March 10, 2020.)

[25] Office of Mental Health and Suicide Prevention, U.S. Department of Veterans Affairs, *Suicide Prevention*. February 5, 2019. https://www.mentalhealth.va.gov/suicide_prevention/. (The website was accessed on April 12, 2019.)

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

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

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

The OIG found that VISN 12 leaders appeared engaged and supportive of facilities' efforts to prevent veteran suicides and noted the following:

- VISN 12 scored among the best VISNs for the SAIL mental health population coverage metric for July 1, 2019–September 30, 2019[30]
- The VISN had the highest mental health provider-to-patient ratio in VHA (more than 9 providers per 1000 patients)
- The VISN's collaboration with Cermak Health Care Services and Cook County Jail ensured a smooth transition for veterans and increased access to VHA medical and mental health services
- VHA approved VISN 12 participation in the Suicide Prevention 2.0 Pilot. The project provides funding for an increase in non-clinical staffing to perform community outreach projects

VISN leaders cited that resources and funding for VHA suicide prevention efforts were satisfactory; however, they suggested that increased resources for coordination with local outreach programs could help identify and assist at-risk veterans who are not enrolled in the VHA system.

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders respond to identified problems. At the time of OIG's visit, one recommendation remained open from the 2018 CHIP review of the William S. Middleton Memorial Veterans Hospital; however, the OIG subsequently closed that recommendation based upon the VISN-submitted update in January 2020. The remaining

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

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

[30] Mental Health Population Coverage metrics include measures of percentage of different classes of patients and the percentages that are receiving the appropriate mental health treatments for specific conditions.

22 open recommendations were made in recently published reports. VISN and facility leaders had closed all other recommendations for improvement listed in Appendix D.[31]

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[32]

Figure 4 illustrates the VISN's quality of care and efficiency metric rankings and performance as of June 30, 2019. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of mental health (MH) population (popu) coverage, best place to work, standardized mortality ratio (SMR), and rating (of) hospital). Metrics that need improvement are denoted in orange and red (for example, capacity, complications, ambulatory care sensitive conditions (ACSC) hospitalization, and hospital-wide readmission (RSRR-HWR)).[33]

[31] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations.

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

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

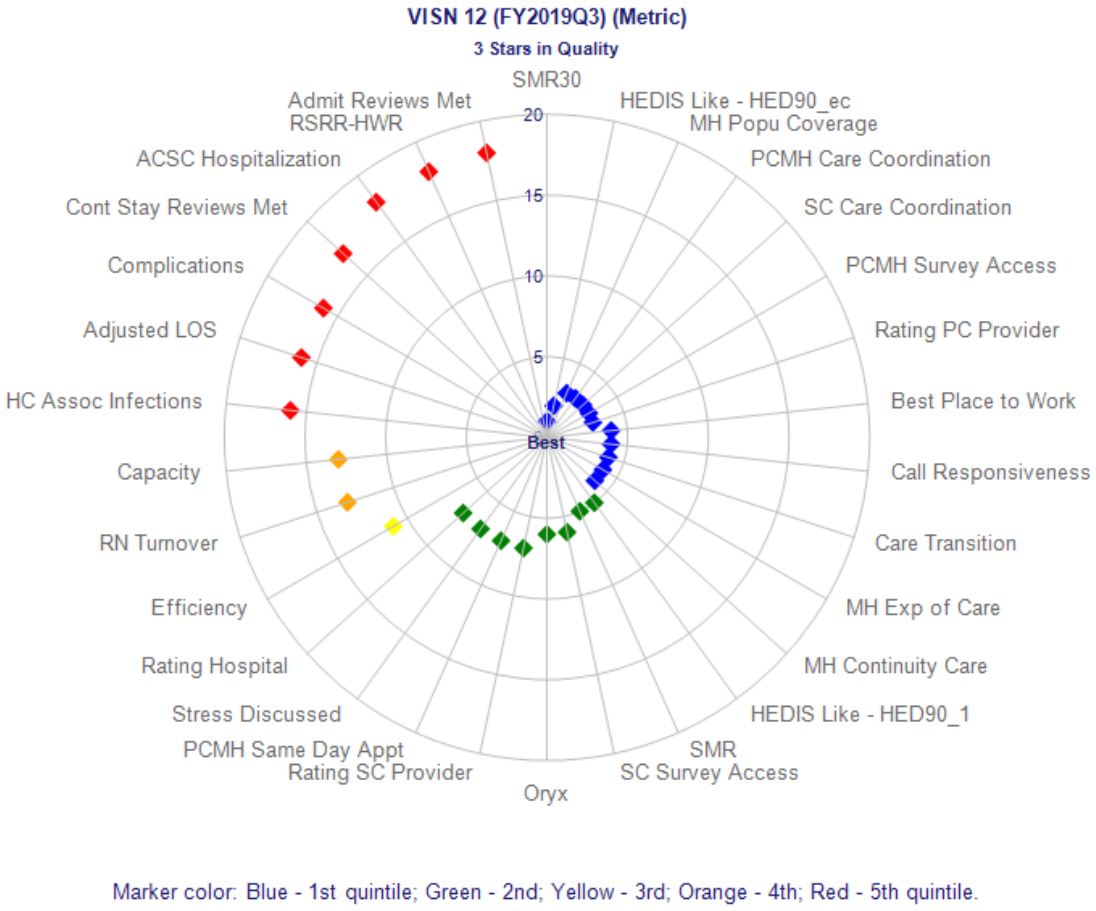

Figure 4. *Facility Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

VISN leaders acknowledged several performance measures were in the fifth quintile for the third quarter of FY 2019 and had identified efforts to improve care and performance. For admit reviews met—a review within 24 hours of admission to determine the appropriateness of an admission to a specific level of care—the VISN developed an FY 2020 plan with performance goals. The VISN also supported a utilization management training summit at the William S. Middleton Memorial Veterans Hospital on September 11–12, 2019, to share best practices in medical necessity documentation, interrater reliability, and physician education on appropriate levels of care.

As shown in figure 4 above, hospital-wide readmission (RSRR-HWR) rates presented an opportunity for improvement within the VISN. According to the CMO, facility chiefs of staff worked to address the measure with a focus on improved congestive heart failure treatment, documentation, and increased utilization of Patient Aligned Care Team intensive case management.

Effective primary care is associated with lower hospitalizations due to ambulatory care sensitive conditions (ACSC) (for example, hypertension, congestive heart failure, and pneumonia).[34] The CMO acknowledged that opportunities for improvement existed; and, on February 22, 2019, the VISN formed an ACSC workgroup to identify unique factors, strategies, and barriers impacting ACSC improvement efforts. Major conditions like congestive heart failure, chronic obstructive pulmonary disease, pneumonia, and urinary tract infections were identified for improvement actions such as intensive case management, increased availability of follow-up appointments, and shared lessons learned across facilities.

The SAIL Value Model also includes "SAIL CLC," which is a tool to summarize and compare the performance of community living centers (CLCs) in the VA. The SAIL model leverages much of the same data used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare*.[35] The SAIL CLC provides a single resource to review quality measures and health inspection results.

The SAIL CLC includes a radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 5 illustrates the VISN's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2019. The figure uses blue and green data points to indicate high performance (for example, in the areas of physical restraints–long-stay (LS), high-risk pressure ulcer (PU)–LS, urinary tract infections (UTI)–LS, and improvement in function–short-stay (SS)). Measures that need improvement are denoted in orange (for example, falls with major injury–LS and new or worse PU–SS).[36]

Fiscal year 2019 third quarter (April 1, 2019–June 30, 2019) SAIL CLC data and quality scores showed opportunities for improvement in the quality metrics for the Iron Mountain and Milwaukee CLCs and improvement for the unannounced survey score at the Danville CLC. Recent VISN efforts focused care on improving the assessment and reevaluation of patients receiving antipsychotic and pain medications and helped improve the FY 2019 fourth quarter overall quality scores for Milwaukee and Iron Mountain.

[34] ACSC hospitalizations reported on SAIL is a risk adjusted rate of ACSC hospitalizations per 1,000 patients, measured as the Observed to Expected ratio (actual number of hospitalizations due to ACSC divided by the predicted number of hospitalizations due to ACSC) multiplied by the VA national rate per 1,000 patients. See https://www.va.gov/QUALITYOFCARE/measure-up/SAIL_definitions.asp. (The website was accessed on April 10, 2020.)

[35] According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, August 22, 2019, "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

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

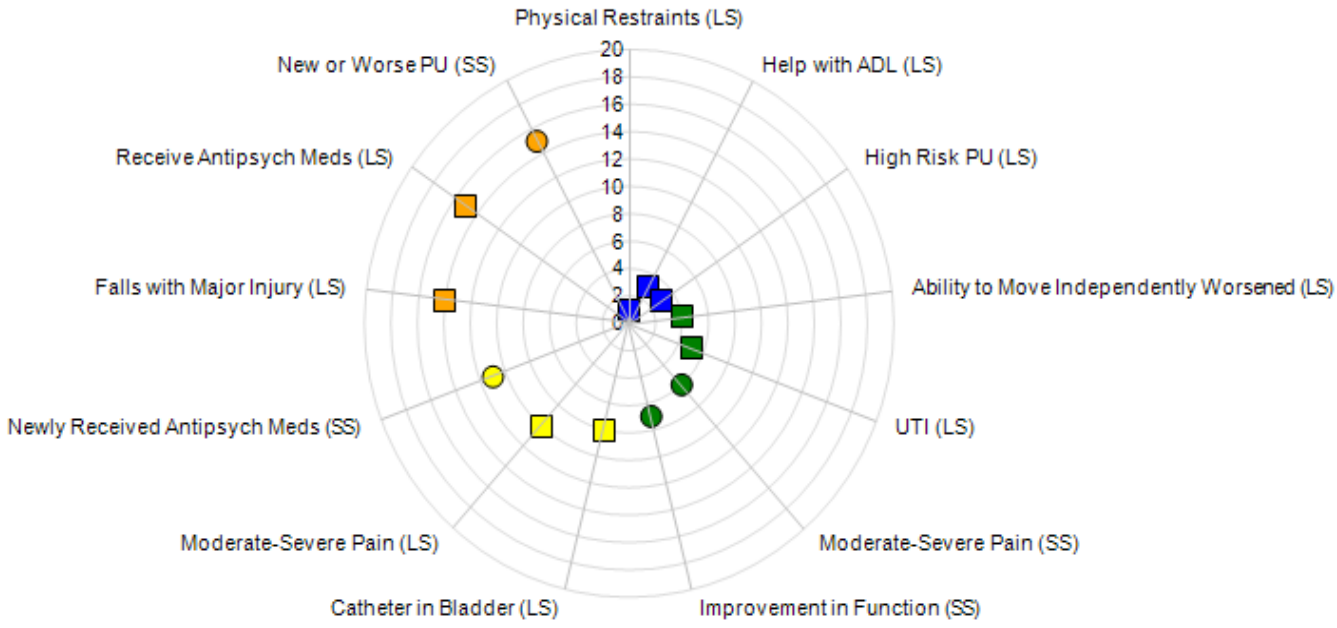

Figure 5. *CLC Quality Measure Rankings (as of June 30, 2019)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

Observed Trends in Noncompliance

During CHIP inspections of the VISN 12 facilities performed during the weeks of January 13, 2020, and January 27, 2020, the OIG noted trends in noncompliance for the following areas:

- QSV
  - Documentation and implementation of action items when problems or opportunities for improvement are identified
  - Interdisciplinary review of utilization management data
- Medical staff privileging
  - Use of service-specific criteria in ongoing professional practice evaluations
  - Completion of professional practice evaluations by providers with similar training and privileges
  - Review of professional practice evaluations by the Medical Executive Committee in the decision to recommend new or continuing privileges
  - Timely completion of provider exit review forms

- Medication management (specifically long-term opioid therapy for pain)
  - Assessment of aberrant behavior risk
  - Documentation of informed consent
  - Completion of urine drug testing
  - Follow-up with patients
  - Monitoring of the quality of pain assessments and effectiveness of pain management interventions by facility pain committees
- Mental health (focusing on the suicide prevention program)
  - Initial and annual suicide prevention training for staff
- Women's health (examining comprehensive care)
  - Attendance by required members of women veterans health committees
  - Designation of community-based outpatient clinic women's health primary care providers
- High-risk processes (specifically reusable medical equipment)
  - Alignment of standard operating procedures with manufacturer's guidelines
  - Staff completion of competency assessments and monthly continuing education
  - Reporting of annual risk analysis results to the VISN Sterile Processing Services Management Board

In response to these trends, the Network Director noted that VISN staff would follow up with responsible facility directors, chiefs of staff, associate directors for patient care services, associate directors, and a chief nurse executive.

Leadership and Organizational Risks Conclusion

Although the VISN had two acting Network Directors in the year prior to this OIG site visit, the VISN's executive leadership team appeared stable with the Deputy Network Director, CMO, QMO, and HRO serving together for almost two years. Since the OIG site visit, VHA leaders appointed a permanent Network Director on March 1, 2020.

Most of the selected survey scores related to employees' satisfaction with the VISN executive team leaders were above VHA averages; however, the executive leadership team's averages for the "moral distress" survey question consistently fell below VHA averages and VISN leaders should consider this an opportunity for improvement. In review of patient experience survey data, the OIG noted VISN averages for each of the selected survey questions were consistently better than VHA averages. The VISN has an opportunity to provide assistance to and oversight of the Jesse Brown VAMC, Tomah VAMC, and VA Illiana HCS to evaluate and improve

satisfaction scores for inpatient and specialty care. The VISN leaders appeared actively engaged with employees and patients and were working to sustain and further improve employee and patient engagement and satisfaction.

The executive team leaders seemed to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as utilization management training, improving hospital-wide readmission rates, and creating an ACSC workgroup to improve case management and follow-up care).

The OIG's review of access metrics and clinical vacancies did not identify any substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and CLC metrics but should continue to take actions to sustain and improve performance of measures. Further, the OIG identified that the Network Director, CMO, and QMO had opportunities to improve their oversight of facility-level QSV, medical staff privileging, medication management, mental health, women's health, and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.[37] 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.[38] Designated leaders are directly accountable for program integration and communication within their level of responsibility. Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[39]

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

- Written utilization management plan[40]
- Annual utilization management program summary reviews[41]
- Collection, analysis, and action, as appropriate, in response to VISN peer review data[42]
    - Monitoring of facility outlier data and communication of follow-up actions communicated to the Network Director and System/VAMC Director
    - Submission of quarterly VISN peer review data analysis reports to the Office of Quality, Safety, and Value
- Quarterly reporting of institutional disclosures for each facility[43]

Quality, Safety, and Value Findings and Recommendations

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

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

Medical Staff Credentialing

VHA has defined procedures for the credentialing of medical staff—"the systematic process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training and experience, and current competence and health status."[44] When certain actions are taken against one of a provider's licenses, the Chief of Human Resources Management Service, or Regional Counsel, must determine whether the provider meets licensure requirements for VA employment.[45] Further, physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued, and/or placed on probational status, or denied upon application, must not be appointed without a through documented review" by Regional Counsel and concurrence and approval of the appointment by the VISN CMO. The Deputy Under Secretary for Health for Operations and Management is responsible for ensuring that VISN directors maintain an appropriate credentialing and privileging process consistent with VHA policy, which includes VISN CMO oversight of facility processes.[46]

The OIG inspection team reviewed VISN facility physicians hired after January 1, 2018.[47] When reports from the National Practitioner Data Bank and/or Federation of State Medical Boards appear to confirm that a physician has a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined evidence of the

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

Medical Staff Credentialing Findings and Recommendations

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

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

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

[46] VHA Handbook 1100.19.

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

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires that veterans, their families, visitors, and employees in VHA healthcare facilities be provided a safe, clean, and functional environment of care in accordance with applicable Joint Commission Environment of Care standards, federal regulatory requirements, and applicable VA and VHA requirements.[48] The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.[49] VHA also provides policy, mandatory procedures, and operational requirements for implementing an effective VHA supply chain management program at VA medical facilities, which includes VISN-level oversight responsibility.[50]

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

- Establishment of policy that maintains a comprehensive environment of care program at the VISN level
- Establishment of a VISN Emergency Management Committee[51]
    - Met at least quarterly
    - Documented an annual review within the previous 12 months of the VISN's
        - Emergency Operations Plan
        - Continuity of Operations Plan
        - Hazards Vulnerability Analysis
    - Conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leaders for review and approval
- Assessment of inventory management programs through a quality control review once per FY

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

[49] VHA Directive 1608.

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

[51] VHA Directive 0320.01.

Environment of Care Findings and Recommendations

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

Medication Management: Long-Term Opioid Therapy for Pain

VHA has established pain management as a national priority. The VHA National Pain Management Strategy was initiated in November 1998, with its main objective being to "develop a comprehensive, multicultural, integrated, system-wide approach to pain management that reduces pain and suffering and improves quality of life for Veterans experiencing acute and chronic pain associated with a wide range of injuries and illnesses, including terminal illness."[52]

The VHA National Pain Management Program Office is responsible for policy development, coordination, oversight, and monitoring of the VHA National Pain Management Strategy. VHA requires VISNs to implement the Pain Management Strategy throughout VISN facilities. VHA also requires a VISN-level pain management point of contact (POC) to annually describe the progress in implementing the Pain Management Strategy to the VISN Director and establish a VISN pain committee to develop timelines for achieving and maintaining pain management standards. In addition, VHA requires that VISNs have at least one Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited tertiary, interdisciplinary pain care program.[53]

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

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

Medication Management Findings and Recommendations

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

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

[53] VHA Directive 2009-053. According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities (CARF) "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[54] 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.[55] To help the VA better understand the needs of the growing women veterans population, VHA has made efforts to examine "health care use, preferences, and the barriers Women Veterans face in access to VA care."[56] Additionally, a 2016 VA report 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."[57]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in all VA medical facilities.[58] VHA also requires that VISNs appoint a lead women veterans program manager (WVPM) to serve as the VISN representative on women veterans' issues and identify gaps through VISN-wide needs assessments, site visits, surveys, and/or other means, including conducting yearly site visits at each VISN facility.[59]

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

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

[54] 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.)

[55] 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.)

[56] 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.)

[57] 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.)

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

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

- Execution of interdisciplinary comprehensive strategic planning for women's health at the VISN level
- Provision of quarterly program updates to executive leaders
- Monthly calls held with facility WVPMs and women's health medical directors
- Completion of annual site visits
  - Needs assessment conducted
  - Progress toward implementation of recommended interventions tracked
- Assessments of staff education gaps
  - Development of educational programs and/or resources when needs identified
- Availability of VISN-level support staff for implementing performance improvement projects
- Analysis of women veterans access and satisfaction data
  - Improvement actions implemented when recommended
- Tracking of maternity care data[60]

Women's Health Findings and Recommendations

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

[60] VHA Handbook 1330.03, *Maternity Health Care and Coordination*, October 5, 2012.

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. The goal of Sterile Processing Services (SPS) is to "...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[61]

VHA requires VISNs to appoint and maintain a VISN SPS Management Board charged with oversight of SPS and all reprocessing of critical and semi-critical RME at VISN facilities.[62] VHA also requires VISNs to conduct facility inspections using the RME Inspection Tool, provide the results to VISN leadership for review by a VISN-level committee or board, and post the results to the RME SharePoint site within 30 days of the completed inspection. VISN SPS leads must ensure corrective action plans are developed within 30 days of the completed inspections and track the action plans until all items are closed.[63]

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

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

High-Risk Processes Findings and Recommendations

The VISN did not meet many of the requirements for oversight of facility operations and management of reprocessing RME. The OIG noted that although the VISN had established an SPS Management Board, the board did not hold monthly meetings as outlined in their committee charter. Additionally, the OIG identified deficiencies with VISN-led facility inspections.

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[61] 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.)

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

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

VHA requires that VISN-led RME inspections are conducted by the SPS Management Board at facilities within the jurisdiction of the network.[64] The OIG did not find evidence of VISN-led RME inspections at each facility in FY 2019. Lack of required inspections could prevent identification of significant RME-related issues warranting intervention. Inspections were completed at the Clement J. Zablocki VAMC; Milo C. Huempfner VA Outpatient Clinic; Edward Hines, Jr. VA Hospital; and Jesse Brown VAMC in FY 2019. The acting VISN SPS Lead and Deputy QMO told the OIG that because of frequent details to the Edward Hines, Jr. VA Hospital, the previous VISN SPS Lead received an extension from the VHA National Program Office for Sterile Processing (NPOSP) to complete the Oscar G. Johnson VAMC, Tomah VAMC, VA Illiana HCS, and William S. Middleton Memorial Veterans Hospital inspections by the end of October 2019 (early FY 2020). Further, the VISN had scheduled an inspection at the Captain James A. Lovell FHCC for June 2019; however, the NPOSP conducted a review during the week of June 18, 2019.[65] The Deputy QMO reported that the NPOSP review was substantial and led to multiple findings. Given the scope of the NPOSP review, the VISN chose to postpone their review and instead conducted follow-up "spot" checks at the Captain James A. Lovell FHCC in September 2019 and January 2020 with continued monitoring of the findings and action plans.

Recommendation 1

1. The Network Director evaluates and determines the reasons for noncompliance and ensures that the Sterile Processing Services Management Board conducts Veterans Integrated Service Network-led facility reusable medical equipment inspections.

[64] VHA Directive 1116(2).

[65] Captain James A. Lovell FHCC is a partnership between the U. S. Department of Veterans Affairs and the Department of Defense (DoD), integrating all medical care into a fully integrated federal health care facility with a single combined VA and Navy mission. https://www.lovell.fhcc.va.gov/about/index.asp. (The website was accessed on March 19, 2020.) According to VHA Director 1116(2), the VHA National Program Office for Sterile Processing (NPOSP) is a distinct program office under the VHA DUSHOM. The NPOSP is "responsible for establishing policy regarding reprocessing of critical and semi-critical RME."

VISN concurred.

Target date for completion: September 30, 2020

VISN response: The Network Director evaluated and determined that one reason for prior non-compliance may be attributed to VISN resources, it was determined VISN 12 would benefit from a dedicated Full-time employee (FTE) for SPS. The VISN has now appointed a full time SPS Lead to enable increased auditing, oversight and development of staff (previously there was .25 dedicated FTE).

All VISN 12 FY20 Reusable Medical Equipment facility inspections have been scheduled and communicated to each facility. Six of eight have been completed as of 8/1/2020 and the remaining two will be completed by the end of August 2020. These required audits have been added as a standing agenda item for tracking purposes to the VISN 12 SPS Management Board and are also tracked through the VISN 12 Quality Safety Value council.

VHA mandates that VISN-led facility RME inspection results are provided to VISN leadership for review.[66] The OIG noted that the former VISN SPS Lead reported RME audit plans in February 2019 and RME summary data to the Quality Council in November 2019 but did not provide individual inspection results to executive leaders. A lack of communication to VISN leadership about RME inspection findings could impede the allocation of resources toward remediating identified issues at each facility. The acting VISN SPS Lead and Deputy QMO reported being uninvolved with the SPS program until December 2019 and therefore were unable to comment on the lack of reporting to executive leaders. The acting VISN SPS Lead and Deputy QMO also stated that the former VISN SPS Lead's frequent details to the Edward Hines, Jr. VA Hospital may have been a factor in the noncompliance.

Recommendation 2

2. The Network Director evaluates and determines any additional reasons for noncompliance and ensures that Veterans Integrated Service Network-led facility reusable medical equipment inspection results are provided to executive leaders.

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

VISN concurred.

Target date for completion: September 30, 2020

VISN response: The Network Director evaluated and determined that one reason for prior non-compliance may be attributed to VISN resources, it was determined VISN 12 would benefit from a dedicated FTE for SPS. The VISN has now appointed a full time SPS Lead (previously there was .25 dedicated FTE).

All VISN 12 FY20 Reusable Medical Equipment facility inspection results will be provided to VISN executive leadership within 30 days of completion of individual facility audits. Currently six of eight of the facility audits have been completed. Four of the six reports were reported to VISN executive leadership within 30 days of completion and the remaining two will be completed within the required time frame. VISN Action Items are utilized to track facility completion of associated deficiencies. Dates of completion of audits and associated VISN action item will be reported and tracked through VISN 12 SPS Management Committee minutes as a standing agenda item.

VHA necessitates that VISN-led inspection results are posted to the RME SharePoint site within 30 days of completion.[67] The OIG did not find evidence that inspection results were posted to the RME SharePoint site in a timely manner for the Edward Hines, Jr. VA Hospital, Jesse Brown VAMC, Oscar G. Johnson VAMC, or VA Illiana HCS. Not posting results timely could delay or prevent opportunities to mitigate identified issues. Of note, the acting VISN SPS Lead (prior to the VISN appointment) reportedly conducted the VA Illiana Health Care System inspection in October 2019 because the former VISN SPS Lead was unavailable. However, the former VISN SPS Lead did not post the results. After becoming aware of the omission, the acting VISN SPS Lead posted the results to the RME SharePoint site in January 2020. As stated earlier, the acting Lead and Deputy QMO were reportedly not involved in SPS oversight during the time of the inspections.

Recommendation 3

3. The Network Director determines the reasons for noncompliance and ensures that Veterans Integrated Service Network-led facility reusable medical equipment inspection results are posted within the required time frame.

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

VISN concurred.

Target date for completion: September 30, 2020

VISN response: The Network Director evaluated and determined that one reason for prior non-compliance may be attributed to VISN resources, it was determined VISN 12 would benefit from a dedicated FTE for SPS. The VISN has now appointed a full time SPS Lead (previously there was .25 dedicated FTE).

All VISN FY20 Reusable Medical Equipment facility inspection results will be completed and uploaded to the NPOSP SharePoint within 30 days of completion of the audit. Dates of completion and upload will be reported and tracked through VISN 12 SPS Management Committee minutes as a standing agenda item.

Additionally, VHA requires that facilities develop corrective action plans within 30 days of each completed inspection and the VISN SPS Lead tracks the action plans until closure.[68] The OIG did not find evidence of action plans for RME inspections at the Oscar G. Johnson VAMC, Tomah VAMC, VA Illiana HCS, or William S. Middleton Memorial Veterans Hospital.[69] Lack of timely action plan development could delay corrective measures to prevent untoward events. The acting VISN SPS Lead was unable to provide a reason for noncompliance and stated that those site visits were completed in FY 2019 during the former VISN SPS Lead's tenure.

Recommendation 4

4. The Network Director determines the reasons for noncompliance and ensures that Veterans Integrated Service Network-led reusable medical equipment facility inspection corrective action plans are developed and tracked until closure.

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

[69] The Captain James A. Lovell FHCC was inspected by the National Program Office for Sterile Processing during the week of June 18, 2019, with action plans submitted to that program. The VISN chose to postpone their review and instead lead "spot" checks at the facility.

VISN concurred.

Target date for completion: September 30, 2020

VISN response: The Network Director evaluated and determined that one reason for prior non-compliance may be attributed to VISN resources, it was determined VISN 12 would benefit from a dedicated FTE for SPS. The VISN has now appointed a full time SPS Lead (previously there was .25 dedicated FTE).

All VISN FY20 Reusable Medical Equipment facility inspection corrective action plans will be completed and provided to the respective facility via VISN action items within 30 days of completion of the audit. Dates of completion and action items will be reported and tracked through VISN 12 SPS Management Committee minutes as a standing agenda item.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

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

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Comprehensive Care	• Appointment of a lead women veteran program manager • Establishment of a multidisciplinary team for comprehensive care • Execution of interdisciplinary comprehensive strategic planning for women's health • Provision of quarterly program updates to executive leaders • Monthly calls held with facility women veterans program managers and women's health medical directors • Completion of annual site visits • Assessments to identify staff education gaps • Availability of VISN-level support staff for implementing performance improvement projects • Analysis of women veterans access and satisfaction data • Tracking of maternity care data	• None	• None
High-Risk Processes: Reusable Medical Equipment	• Establishment of a VISN SPS Management Board • VISN-led inspection at each facility	• VISN-led facility RME inspections are conducted.	• VISN-led facility RME inspection results are provided to executive leaders. • VISN-led facility RME inspection results are posted within the required time frame. • RME facility inspection corrective action plans are developed and tracked until closure.

Appendix B: VISN 12 Profile

The table below provides general background information for VISN 12.

Table B.1. Profile for VISN 12
(October 1, 2016, through September 30, 2019)

Profile Element	VISN Data FY 2017[1]	VISN Data FY 2018[2]	VISN Data FY 2019[3]
Total medical care budget	$3,203,105,462	$3,392,349,055	$3,467,518,621
Number of:			
• Unique patients	343,028	342,821	342,073
• Outpatient visits	4,077,643	4,038,950	4,057,126
• Unique employees[4]	13,474	13,944	14,213
Type and number of operating beds:			
• Community living center	942	942	940
• Domiciliary	447	457	442
• Hospital	845	847	851
• Residential rehabilitation	49	49	49
Average daily census:			
• Community living center	624	609	609
• Domiciliary	313	319	315
• Hospital	564	546	551
• Residential rehabilitation	39	33	37

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

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

Appendix C: Survey Results

Table C.1. Survey Results on Patient Attitudes within VISN 12 (October 1, 2018, through September 30, 2019)

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	VHA	68.3
		VISN 12	71.6
		Chicago, IL	63.5
		Danville, IL	68.5
		Hines, IL	67.2
		Iron Mountain, MI	81.5
		Madison, WI	84.3
		Milwaukee, WI	72.2
		North Chicago, IL	76.3
		Tomah, WI	62.2
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	84.9
		VISN 12	87.6
		Chicago, IL	87.4
		Danville, IL	89.2
		Hines, IL	85.7
		Iron Mountain, MI	87.8
		Madison, WI	94.4
		Milwaukee, WI	86.5
		North Chicago, IL	85.9
		Tomah, WI	75.0

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	77.3
		VISN 12	84.5
		Chicago, IL	81.3
		Danville, IL	82.6
		Hines, IL	85.4
		Iron Mountain, MI	85.8
		Madison, WI	83.6
		Milwaukee, WI	88.5
		North Chicago, IL	82.5
		Tomah, WI	82.2
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	78.0
		VISN 12	82.2
		Chicago, IL	77.2
		Danville, IL	76.7
		Hines, IL	82.6
		Iron Mountain, MI	85.3
		Madison, WI	86.2
		Milwaukee, WI	85.3
		North Chicago, IL	82.1
		Tomah, WI	82.6

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

Appendix D: Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Comprehensive Healthcare Inspection Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin, Report No. 17-01854-115, March 14, 2018	July 2017	0	10	0	0
Comprehensive Healthcare Inspection Program Review of the Tomah VA Medical Center, Wisconsin, Report No. 17-05400-246, August 9, 2018	November 2017	0	2	0	0
Comprehensive Healthcare Inspection Program Review of the VA Illiana Health Care System, Danville, Illinois, Report No. 17-05424-142, March 28, 2018	December 2017	0	7	0	0
Comprehensive Healthcare Inspection Program Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois, Report No. 18-01143-302, September 27, 2018	June 2018	0	5	0	0
Concerns Related to the Management of a Patient's Medication at Three VA Medical Centers and Inaccurate Response to a Congressional Inquiry at the VA Illiana Health Care System; Orlando, Florida; Indianapolis, Indiana; Danville, Illinois; Report No. 18-02056-54, January 16, 2019	n/a	0	8	0	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Comprehensive Healthcare Inspection Program Review of the William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin, Report No. 18-01147-47, December 20, 2018	August 2018	0	4	0	1
Review of Opioid Monitoring and Allegations Related to Opioid Prescribing Practices and Other Concerns at the Tomah VA Medical Center, *Wisconsin*, Report No. 18-05872-103, March 28, 2019	September 2018	0	1	0	0
Comprehensive Healthcare Inspection Program Review of the Edward Hines, Jr. VA Hospital, Hines, Illinois, Report No. 18-04676-142, June 18, 2019	November 2018	0	10	0	4
Alleged Delay in Surgical Care, Lack of Resident Oversight, and Improper Physician Pay at the Edward Hines, Jr. VA Hospital, Hines, Illinois, Report No. 19-00004-187, August 8, 2019	November 2018	0	2	0	2
Comprehensive Healthcare Inspection Program Review of the Jesse Brown VA Medical Center, Chicago, Illinois, Report No. 18-04673-138, June 18, 2019	November 2018	0	11	0	11
Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan, Report No. 18-04669-125, May 28, 2019	November 2018	0	9	0	5

Source: Inspection/survey results verified with the Quality Management Health System Specialist on January 27, 2020

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

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

[1] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated on 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: August 13, 2020

From: Director, VA Great Lakes Health Care System–VISN 12 (10N12)

Subj: Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 12: VA Great Lakes Health Care System in Westchester, Illinois

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

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

1. Thank you for the opportunity to review the draft of the Office of Inspector General report from the Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 12: VA Great Lakes Health Care System in Westchester, Illinois.
2. I have reviewed the four recommendations and concur with the findings and submitted action plans. They will be implemented and monitored through satisfactory completion.
3. I would like to thank the OIG Inspection team for a thorough review of Veterans Integrated Service Network 12: VA Great Lakes Health Care System in Westchester, Illinois.

(Original signed by:)

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

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

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