VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center in Dublin, Georgia

Figure 1. *Carl Vinson VA Medical Center in Dublin, Georgia (Source: https://vaww.va.gov/directory/guide/, accessed February 26, 2020)*

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Carl Vinson VA Medical Center and multiple outpatient clinics in Georgia. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

1. Quality, safety, and value

2. Medical staff privileging

3. Environment of care

4. Medication management (targeting long-term opioid therapy for pain)

5. Mental health (focusing on the suicide prevention program)

6. Care coordination (spotlighting life-sustaining treatment decisions)

7. Women's health (examining comprehensive care)

8. High-risk processes (emphasizing reusable medical equipment)

The unannounced visit was conducted during the week of March 2, 2020, at the Carl Vinson VA Medical Center and Tifton VA Clinic. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this medical center's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this medical center and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

Leadership and Organizational Risks

At the time of the OIG's visit, the medical center's leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. Organizational communications and accountability were managed through a committee reporting structure with the Executive Leadership Team overseeing several working groups. The leaders monitor patient safety and care through the Quality Leadership Team which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the medical center leaders had been working together for five weeks. The Director and Chief of Staff had served in their positions since May and September 2019, respectively. The Associate Director, permanently assigned on June 17, 2012, and the most tenured of the leaders, was detailed to another facility in November 2019. The Chief of Pharmacy served as the acting Associate Director at the time of the OIG site visit. The ADPCS, assigned in January 2020, was the newest member of the leadership team.

The OIG reviewed selected employee satisfaction survey results and concluded that the leaders had opportunities to improve employee satisfaction and staff feelings of "moral distress" at work.[1] Selected patient experience survey scores for the medical center generally reflected lower satisfaction ratings when compared to VHA averages.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[2]

The VA Office of Operational Analytics and Reporting 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.[3]

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to specific poorly performing SAIL measures. Leaders

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

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

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

also demonstrated understanding of Community Living Center (CLC) SAIL measures.[4] In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

The OIG noted opportunities for improvement in seven clinical areas reviewed and issued 17 recommendations that are directed to the Director, Chief of Staff, and ADPCS. These are briefly described below.

Quality, Safety, and Value

The medical center complied with requirements for utilization management and most patient safety elements reviewed. However, the OIG identified a deficiency with the Quality Executive Board.[5]

Medical Staff Privileging

The medical center complied with requirements for ongoing professional practice evaluation. The OIG identified deficiencies with focused professional practice evaluation and provider exit review processes.[6]

Medication Management

The OIG observed compliance with the avoidance of or documented justification for concurrent opioid and benzodiazepines therapy. The OIG found deficiencies with pain screening, aberrant behavior risk assessments, urine drug testing, informed consent, and patient follow-up but made no recommendations due to the low number of outpatients identified during the review period. The OIG also identified a concern with quality measure oversight.

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

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

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

Mental Health

The medical center complied with many of the performance elements reviewed. However, the OIG noted concerns with the completion of mandatory suicide prevention training.

Care Coordination

The medical center met expectations for the Life-Sustaining Treatment Decisions Committee and supervision of designees. However, the OIG identified a concern with life-sustaining treatment decision notes.

Women's Health

The OIG found compliance with many of the requirements for women's health, including the provision of care and most of the staffing elements reviewed. However, the OIG noted concerns with women's health primary care providers and the Women Veterans Health Committee's core membership.

High-Risk Processes

The medical center complied with some elements of expected performance for reprocessing reusable medical equipment. However, the OIG identified deficiencies with the reusable medical equipment inventory file, standard operating procedures, annual risk analysis, eyewash station checks, quality assurance monitoring, reprocessing and storage area physical inspections, and staff training.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued 17 recommendations for improvement to the Medical Center Director, Chief of Staff, and ADPCS. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this medical center. The intent is for medical center leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if not addressed, may eventually interfere with the delivery of quality health care.

Comments

The acting Veterans Integrated Service Network Director and Medical Center Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 74–75, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

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

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

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

1. Leadership and organizational risks

2. Quality, safety, and value (QSV)

3. Medical staff privileging

4. Environment of care

5. Medication management (targeting long-term opioid therapy for pain)

6. Mental health (focusing on the suicide prevention program)

7. Care coordination (spotlighting life-sustaining treatment decisions)

8. Women's health (examining comprehensive care)

9. High-risk processes (emphasizing reusable medical equipment)[3]

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

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

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

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

Methodology

The Carl Vinson VA Medical Center includes multiple outpatient clinics in Georgia. Additional details about the types of care provided by the medical center can be found in Appendixes B and C.

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

The OIG team also selected and physically inspected the Tifton VA Clinic and the following areas of the Carl Vinson VA Medical Center:

- Acute care unit
- Community living center (CLC)[5]
- Dementia care unit
- Dental clinic
- Hospice
- Main pharmacy
- Outpatient mental health
- Podiatry clinic
- Primary care clinic (Red Team)
- Same Day Surgery
- Urgent care clinic

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

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

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

The inspection examined operations from February 16, 2019, through March 5, 2020, the last day of the unannounced multiday site visit.[6] While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

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

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

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

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[6] The range represents the time period from the prior CHIP inspection to the completion of the unannounced, multiday CHIP site visit in March 2020.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA medical center. Leadership and organizational risks can affect the medical center's ability to provide care in the clinical focus areas.[7] To assess the medical center's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement

2. Employee satisfaction

3. Patient experience

4. Accreditation surveys and oversight inspections

5. Identified factors related to possible lapses in care and medical center response

6. VHA performance data (medical center)

7. VHA performance data (CLCs)

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this medical center's reported organizational structure. The medical center has a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. The Chief of Staff and ADPCS oversee patient care which requires managing service directors and chiefs of programs and practices.

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

Medical Center Director

Chief of Staff	ADPCS	Associate Director	
Associate Chief of Staff – Education Care in the Community Chief Organizational Improvement Clinical Application Coordinators Deputy Chief of Staff Diagnostic Pathology and Lab Geriatrics and Extended Care Group Practice Manager Medical Staff Office (Credentialing and Privileging) Medicine Mental Health Pharmacy Primary Care Radiology Social Work Surgery Service Women's Health Program Manager	Education Home Base Primary Care Nursing Service Recreation Therapy Respiratory Therapy Sterile Processing Service Tele-Health	Engineering Service Environmental Management Service Fiscal Service Health Administrative Service Logistics Nutrition and Food Services Police Service Privacy Officer Prosthetics & Sensory Aids Service Safety	Communication and Volunteer Services Compliance & Business Integrity Customer Service Manager Equal Employment Opportunity Quality Management

Figure 3. *Medical Center Organizational Chart*
Source: Carl Vinson VA Medical Center (received March 3, 2020)

At the time of the OIG site visit, the medical center's executive leadership team was relatively new and included four individuals who had worked together for five weeks. The Medical Center Director and Chief of Staff had worked together at the medical center since 2019. The permanent Associate Director was detailed to another facility on November 17, 2019; in the interim, the Chief of Pharmacy served as the acting Associate Director. The ADPCS was assigned to the position in January 2020, after a five-month vacancy (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	May 12, 2019
Chief of Staff	September 19, 2019
Associate Director for Patient Care Services	January 19, 2020
Associate Director	June 17, 2012 (permanent) November 18, 2019 (acting)

Source: Carl Vinson VA Medical Center Supervisory Human Resources Specialist (received March 2, 2020)

To help assess the medical center executive leaders' engagement, the OIG interviewed the Medical Center Director, Chief of Staff, ADPCS, and acting Associate Director regarding their

knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. Leaders also demonstrated understanding of CLC SAIL measures. In individual interviews, the executive leadership team members were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and patient experiences. These are discussed in greater detail below.

The Medical Center Director serves as the chairperson of the Executive Leadership Team, which has the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Team oversees multiple working groups including the Administrative Executive Board, Medical Executive Committee, and Patient Care Services Executive Committee.

These leaders monitor patient safety and care through the Quality Leadership Team. The Quality Leadership Team is responsible for tracking and trending quality of care and patient outcomes and reports to the Executive Leadership Team (see figure 4).
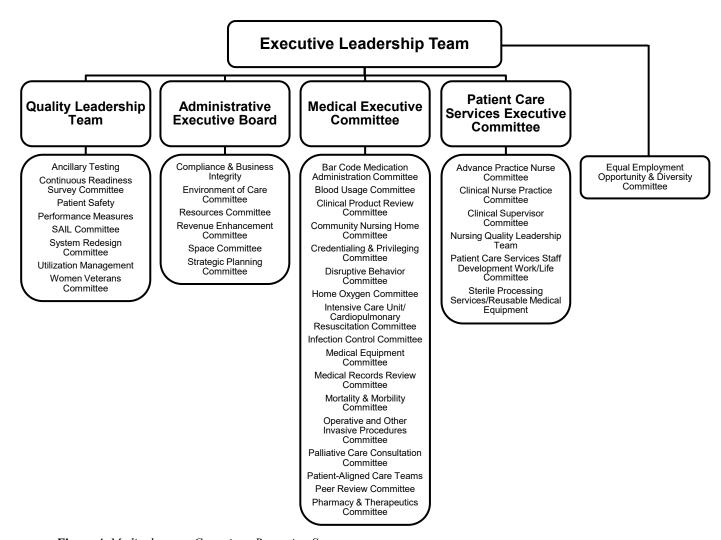
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Executive Leadership Team

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Quality Leadership Team        Administrative Executive Board        Medical Executive Committee        Patient Care Services Executive Committee

Equal Employment Opportunity & Diversity Committee
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Quality Leadership Team
- Ancillary Testing
- Continuous Readiness Survey Committee
- Patient Safety
- Performance Measures
- SAIL Committee
- System Redesign Committee
- Utilization Management
- Women Veterans Committee

Administrative Executive Board
- Compliance & Business Integrity
- Environment of Care Committee
- Resources Committee
- Revenue Enhancement Committee
- Space Committee
- Strategic Planning Committee

Medical Executive Committee
- Bar Code Medication Administration Committee
- Blood Usage Committee
- Clinical Product Review Committee
- Community Nursing Home Committee
- Credentialing & Privileging Committee
- Disruptive Behavior Committee
- Home Oxygen Committee
- Intensive Care Unit/ Cardiopulmonary Resuscitation Committee
- Infection Control Committee
- Medical Equipment Committee
- Medical Records Review Committee
- Mortality & Morbility Committee
- Operative and Other Invasive Procedures Committee
- Palliative Care Consultation Committee
- Patient-Aligned Care Teams
- Peer Review Committee
- Pharmacy & Therapeutics Committee

Patient Care Services Executive Committee
- Advance Practice Nurse Committee
- Clinical Nurse Practice Committee
- Clinical Supervisor Committee
- Nursing Quality Leadership Team
- Patient Care Services Staff Development Work/Life Committee
- Sterile Processing Services/Reusable Medical Equipment

Equal Employment Opportunity & Diversity Committee

Figure 4. Medical center Committee Reporting Structure
Source: Carl Vinson VA Medical Center (received March 5, 2020)

Employee Satisfaction

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

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of

October 1, 2018, through September 30, 2019.[8] Table 2 provides relevant survey results for VHA, the medical center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center average for the selected survey leadership questions was similar to or lower than the VHA average.[9] The ADPCS scores were lower than the VHA and medical center average; the Chief of Staff scores were similar to or better than those for VHA and the medical center; and the Director and Associate Director scores were consistently higher than those for VHA and the medical center.[10]

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite[11]*	0–100 where higher scores are more favorable	72.6	66.2	87.1	72.5	55.5	73.0
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.4	3.3	4.0	3.7	3.0	3.7

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

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

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

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: My organization's senior leaders maintain high standards of honesty and integrity.	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.4	4.1	3.8	3.3	3.9
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.6	4.1	3.9	3.3	4.1

Source: VA All Employee Survey (accessed February 3, 2020)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[12] Note that the medical center average for the selected survey questions was less favorable than the VHA average. Most of the Director, Chief of Staff, and Associate Director averages were better than those for VHA and the medical center.[13] Opportunities appear to exist to improve employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing).

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.6	4.7	4.1	3.1	3.9

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

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) –5 (Strongly Agree)	3.7	3.6	4.1	3.8	3.5	3.8
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.4	1.5	1.6	1.3	2.3	1.7

Source: VA All Employee Survey (accessed February 3, 2020)

Patient Experience

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

VHA also collects SHEP survey data from Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG reviewed responses to four relevant survey questions that

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

reflect patients' attitudes toward their healthcare experiences (see table 4). For this medical center, the patient survey results generally reflected lower care ratings than the VHA average.

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.3	69.3
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	74.5
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	69.9
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.	77.9	68.3

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

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

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients' experiences by gender (see tables 5–7), including those for Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG noted that the inpatient survey results for male respondents were similar to the corresponding VHA averages, while the remaining results were lower than the VHA averages. The OIG also noted that the patient-centered medical home

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

results for female respondents were generally better than the corresponding VHA averages, while the specialty care results were consistently lower than the VHA averages. Medical center leaders appeared to be actively engaged with male and female patients (for example, conducting whole health town hall meetings); however, the scores reflect opportunities for medical center leaders to improve veteran experiences in the patient-centered medical home and specialty care settings.

Table 5. Inpatient Survey Results on Experiences by Gender
(October 1, 2018, through September 30, 2019)

Questions	Scoring	VHA[16]		Medical center[17]	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	82.8	85.6	—[18]
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.8	83.1	85.6	—
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	68.7	61.8	69.5	—

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed February 3, 2020)

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

[17] The medical center averages are based on 89–91 male respondents depending on the question.

[18] The SHEP inpatient composite percentages are weighted to reflect the numbers of patients at different locations and respondent characteristics (i.e., age, gender). Weighted response percentages cannot be derived from the N (number of results) for fewer than 30 respondents at a location. Introduction page of VISN Patient Experience FY report. http://vaww.car.rtp.med.va.gov/programs/shep/shepReportsOuthQLImp.aspx. (The website was accessed on March 10, 2020, but is not accessible by the public).

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

Questions	Scoring	VHA[19]		Medical center[20]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.2	43.3	42.3	55.0
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.9	49.7	53.2	52.5
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.6	65.7	65.5	64.8

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed February 3, 2020)

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

[20] The medical center averages are based on 420–1,404 male and 70–129 female respondents, depending on the question.

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

Questions	Scoring	VHA[21]		Medical center[22]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.5	44.7	40.1	35.9
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	55.0	52.3	34.4
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	70.4	70.1	63.2	58.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed February 3, 2020)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[23] Table 8 summarizes the relevant medical center inspections most recently performed by the OIG and The Joint Commission (TJC).[24] At the time of the OIG visit, the medical center had open/active

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

[22] The medical center averages are based on 312–922 male and 20–50 female respondents, depending on the question.

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

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

recommendations for improvement that were issued for the previous comprehensive healthcare inspection conducted in February 2019. Of note, the prior report was published on November 12, 2019 (less than four months prior to the OIG visit), and the Chief of QSV provided action plans demonstrating continued work to address the open recommendations.

The OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[25]

On January 21, 2020, the Long Term Care Institute conducted an inspection of the medical center's CLC.[26] At the time of the OIG's site visit, 14 recommendations remained open. The Chief of QSV reported that because the CLC survey was conducted less than two months prior, development of the action plans to address open recommendations was still in progress. The Chief of QSV submitted action plans to the OIG after the site visit; these demonstrated that the facility was actively addressing the open recommendations.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the Carl Vinson VA Medical Center Dublin, Georgia*, Report No.18-04682-256, November 12, 2019)	February 2019	22	8[27]

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

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

[27] As of November 2020, five recommendations from the FY 2019 CHIP inspection remained open.

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
TJC Hospital Accreditation	August 2019	34	0
TJC Behavioral Health Care Accreditation		13	0
TJC Home Care Accreditation		3	0

Source: OIG and TJC (inspection/survey results verified with the Chief of Quality, Safety, and Value on March 12, 2020)

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

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

Table 9 lists the reported patient safety events from February 16, 2019 (the prior OIG comprehensive healthcare inspection), through March 2, 2020.[28] The Patient Safety and Risk Managers provided details for two sentinel events, one of which resulted in a death. The managers provided evidence that the medical center completed a review of contributing factors and released two issue briefs in response to the event resulting in a patient's death.

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[28] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Carl Vinson VA Medical Center is a medium complexity (2) affiliated system as described in Appendix C.)

**Table 9. Summary of Selected Organizational
Risk Factors
(February 16, 2019, through March 2, 2020)**

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

*Source: Carl Vinson VA Medical Center's Patient Safety and
Risk Managers (received March 2, 2020)*

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 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2019. Of note, figure 5 uses blue and green data points to indicate high performance for the medical center (for example, in the areas of complications, call responsiveness, and mental health (MH) population (popu) coverage). Metrics that need improvement are denoted in orange and red (for example, rating
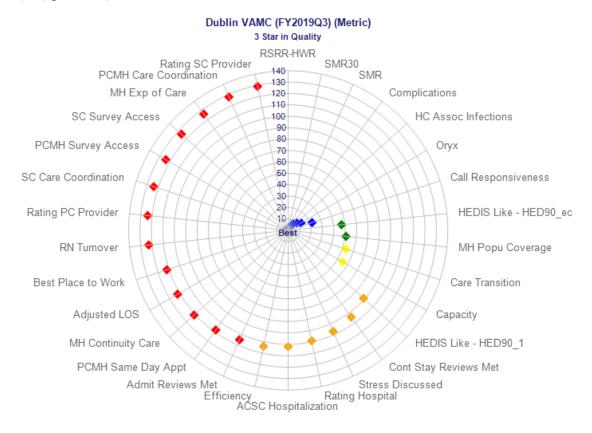
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[29] The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

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

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

[32] VHA Support Service Center, *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.)

(of) hospital, MH continuity (of) care, registered nurse (RN) turnover, and rating (of) specialty care (SC) provider.[33]

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

Veterans Health Administration Performance Data for Community Living Centers

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

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

Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource to review quality measures and health inspection results.[34]

Figure 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2019. Figure 6 uses blue and green data points to indicate high performance for the medical center (for example, in the areas of physical restraints–long-stay (LS), outpatient emergency department (ED) visit–short-stay (SS), and catheter in bladder (LS)). Metrics that need improvement are denoted in orange and red (for example, improvement in function (SS), moderate-severe pain (SS), and ability to move independently worsened (LS)).[35]
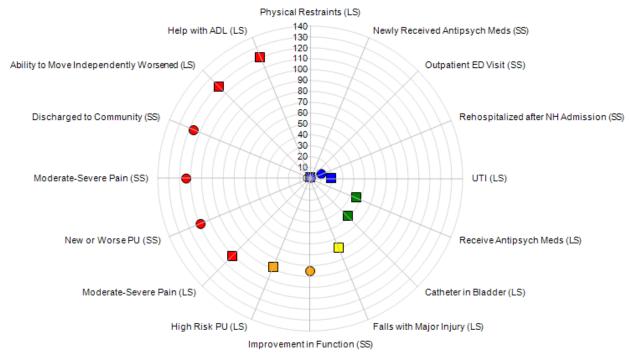

Figure 6. *Medical Center CLC Quality Measure Rankings (as of September 30, 2019)*
LS = Long-Stay Measure   SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

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

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

Leadership and Organizational Risks Conclusion

The medical center's executive leadership team had vacancies in three of the four key positions since the previous February 2019 OIG CHIP inspection. At the time of OIG's on-site visit, the positions were permanently filled; however, the Associate Director was detailed to another facility. Selected survey items related to employees' satisfaction with the medical center executive leaders revealed opportunities to improve employee satisfaction and "moral distress" at work. Patient satisfaction survey results generally reflected lower scores than VHA averages. Further, the OIG found that scores for male and female respondents highlighted opportunities for executive leaders to improve veterans' satisfaction. The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. In individual interviews, the executive leaders were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve employee satisfaction and patient experiences. In addition, the executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.[36] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and to maintain Joint Commission accreditation.[37] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[38]

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

- o Review of aggregated QSV data

- o Recommendation and implementation of improvement actions

- o Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the medical center's processes for conducting protected peer reviews of clinical care.[39] Protected peer reviews, when conducted systematically and credibly, reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[40] The OIG team examined the completion of the following elements:

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

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

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

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

[40] VHA Directive 1190.

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

- o Peer review of all applicable deaths within 24 hours of admission to the hospital

- o Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[41]

- o Completion of final reviews within 120 calendar days

- o Implementation of improvement actions recommended by the Peer Review Committee

- o Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Next, the inspection team assessed the medical center's utilization management (UM) program, a key component of VHA's framework for quality, safety, and value, which provides vital tools for managing the quality and the efficient use of resources.[42] It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[43] Inspectors reviewed several aspects of the UM program:

- o Completion of at least 80 percent of all required inpatient reviews

- o Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database

- o Interdisciplinary review of UM data

- o Implementation and monitoring of improvement actions recommended by the interdisciplinary UM group

Finally, the OIG reviewers assessed the medical center's reports of patient safety incidents with related root cause analyses.[44] Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual

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[41] VHA Directive 1190.

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

[43] VHA Directive 1117(2).

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

causes of harm to patients throughout the medical center.[45] The medical center was assessed for its performance on several dimensions:

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

- o Inclusion of required content in root cause analyses

- o Submission of completed root cause analyses to the National Center for Patient Safety within 45 days

- o Provision of feedback about root cause analysis actions to reporting employees

- o Submission of annual patient safety report to medical center leaders

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents.[47]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for most patient safety elements reviewed. The OIG identified a deficiency with the interdisciplinary review of UM data; however, no additional recommendation was issued because the medical center is actively addressing improvement actions from the previous 2019 CHIP inspection. The OIG also identified a weakness in Quality Executive Board processes.

TJC requires that the medical center's governing body provides structure and resources to support quality and safety. TJC also requires leaders to use and review data to evaluate performance and make improvements. Analyzing data helps leaders understand performance patterns and trends so that effectiveness of improvements can be sustained, measured, and integrated into quality and safety processes.[48] The OIG reviewed Quality Executive Board (also known as the Quality Leadership Team) minutes from March 13, 2019, through February 12, 2020, and noted a lack of evidence that action items were developed in response to identified problems or opportunities for improvement. This may have prevented quality care and patient safety process improvements at the medical center.[49] The Chief of QSV stated that most of the

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[45] VHA Handbook 1050.01.

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

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

[48] TJC. Rationale for Leadership standards LD.01.03.01, 03.02.01, and 03.05.01, Leadership Introduction to Operations standards LD.03.07.01 through LD.04.03.11, and Performance Improvement standard PI.03.01.01.

[49] TJC standards LD.01.03.01, 03.02.01, 03.05.01, 03.07.01—04.03.11; and PI.03.01.01.

meeting attendees were QSV staff; therefore, problems were resolved prior to the next meeting. The Chief also reported that documentation of resolved problems and monitoring were not required in the minutes but had plans to improve meeting minute documentation across the medical center.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures specific action items are developed and documented in the Quality Executive Board minutes when problems or opportunities for improvement are identified.

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Medical Center Director ensures that the improvement action recommended in the Quality Executive Board are fully implemented and monitored. In March 2020, the Quality Executive Board modified the template for minutes to reflect conclusion, action, recommendation and follow-up. The compliance will be monitored and reported by the Chief of Quality to the Quality Executive Board monthly.

This recommendation will be considered compliant when ninety percent or greater of the number of Quality Executive Board Meeting minutes reflect the monitoring of improvement actions. This will be the numerator. The denominator will be the number of minutes that are audited for six consecutive months.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[50]

Clinical privileges need to be specific and based on the individual practitioner's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[51]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance." The FPPE process occurs when a provider is hired at the facility and granted initial privileges and before any new clinical privileges are granted. Additionally, VA facilities must continuously monitor the performance of their providers. VHA requirements state that "the on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered."[52] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[53]
  - Clear documentation of the results and time frames
  - Evaluation by another provider with similar training and privileges
- OPPEs
  - Application of criteria specific to the service or section
  - Use of minimum criteria for selected specialty LIPs[54]
  - Evaluation by another provider with similar training and privileges

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

[51] VHA Handbook 1100.19.

[52] VHA Handbook 1100.19.

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

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

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

Further, VA must put processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former licensed practitioner's clinical practice, VA has an obligation to notify state licensing boards (SLBs) and to subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[55] Further, "VA medical facility Directors must designate an individual, and backup, to be responsible for the SLB reporting process. This individual will be the subject matter expert (SME) for the facility…and ensure oversight of the exit review process, including receipt, review, and maintenance of the Provider Exit Review Forms."[56] The OIG reviewers assessed whether the medical center's staff

- Designated an individual and backup responsible for the SLB reporting process,

- Completed forms within the required time frame and with required oversight, and

- Reported results to SLBs when indicated.

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

- One solo/few practitioner who underwent initial or reprivileging during the previous 12 months[57]

- Seven LIPs hired within 18 months before the site visit

- Twelve LIPs privileged within 12 months before the visit

- Seven LIPs who left the medical center in 12 months before the visit

Medical Staff Privileging Findings and Recommendations

The medical center met many of the selected elements of expected performance for OPPE. The OIG identified deficiencies with FPPE and provider exit review processes.

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

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

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

VHA requires criteria for the FPPE process "to be defined in advance, using objective criteria accepted by the practitioner."[58] In the seven practitioner profiles reviewed, the OIG did not find evidence that LIPs were aware of the evaluation criteria before service chiefs initiated the FPPE process. This could result in LIPs misunderstanding FPPE expectations. The Supervisory Program Specialist stated that new FPPE/OPPE objective criteria, time frame, and method of measuring competency were developed and implemented in December 2019.

Recommendation 2

2. The Chief of Staff determines the reasons for noncompliance and ensures clinical managers define in advance, communicate, and document expectations for focused professional practice evaluations in practitioner profiles.

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Chief of Staff will ensure that service chiefs define in advance, communicate, and document expectations for Focused Professional Practice Evaluations in provider profiles. The Chief of Staff created a standardized memorandum which is given to new providers by the Medical Staff Office with the New Provider packet. The numerator is the number of FPPEs that includes the evaluation criteria defined in advance and the denominator is the number of FPPEs completed. This will be considered compliant when 90 percent or greater of FPPE forms contain the evaluation criteria defined in advance for six consecutive months.

VHA requires that all LIPs new to the facility have FPPEs completed, "documented in the practitioner's provider profile and reported to the Executive Committee of the Medical Staff."[59] FPPEs may include "periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients." VHA also requires that FPPEs are time-limited.[60] Time limitations help ensure an efficient process by preventing undefined or indefinite evaluation of providers. The OIG found that FPPE time frames were clearly defined in four of seven profiles reviewed. This left the remaining three LIPs unclear about the time frame for their evaluation period. The Supervisory Program Specialist stated that the service chiefs missed clearly documenting the time frames as reason for noncompliance.

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[58] VHA Handbook 1100.19.

[59] VHA Handbook 1100.19.

[60] VHA Handbook 1100.19.

Recommendation 3

3. The Chief of Staff determines the reasons for noncompliance and makes certain that all focused professional practice evaluations include defined time frames.

> Medical center concurred.
>
> Target date for completion: February 28, 2021
>
> Medical center response: The Chief of Staff has evaluated the reasons for noncompliance and has found no further reasons for noncompliance. The Chief of Staff will ensure FPPE/OPPE forms contain the timeframe. This will be monitored by the Medical Staff Office. The numerator will be the number of FPPE/OPPE forms with the timeframe documented and the denominator will be the number of FPPE/OPPE performed monthly. This will be considered compliant when 90 percent or greater of FPPE/OPPE forms contain the timeframe documentation for six consecutive months. Compliance will be reported to the Medical Executive Board chaired by the Chief of Staff.

VHA requires a provider exit review form, which documents the review of a provider's clinical practice, to "be completed within 7 calendar days of the departure of a licensed health care professional from a VA facility."[61] For the seven providers that departed the medical center in the previous 12 months, the OIG found that four exit review forms were completed within the required time frame. Of the remainder, one provider exit form was not completed at all, and two forms were not completed within seven calendar days. This could have resulted in delayed reporting of potential substandard care to SLBs. The Supervisory Program Specialist explained that one exit review form was not completed due to the first-line supervisor's position change, one was signed but not dated, and one was not completed within the required time frame.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that provider exit review forms are completed within seven calendar days of licensed healthcare professionals' departure from the medical center.

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[61] VHA Notice 2018-05.

Medical center concurred.

Target date for completion: February 28, 2021

Medical center response: The Chief of Staff has evaluated the reasons for noncompliance and has found no further reasons for noncompliance. The Chief of Staff will ensure completion of the exit form within seven calendar days of the provider's departure from the Medical Center and it will be monitored by the Medical Staff Office. The numerator will be the number of first or second-line supervisors who completed the exit forms within seven calendar days of the provider's departure and the denominator will be the number of identified providers who departed the medical center each month. This will be considered compliant when 90 percent or greater of exit reviews have been completed within seven days of the provider's departure from the Medical Center for six consecutive months. Compliance will be reported to the Medical Executive Board chaired by the Chief of Staff.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct Comprehensive Environment of Care Inspection Rounds and to resolve issues in a timely manner. The goal of the Comprehensive Environment of Care Program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[62]

The purpose of this facet of the OIG inspection was to determine whether the medical center maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the medical center met requirements in selected areas that are often associated with higher risks of harm to patients.[63] Inspectors reviewed several aspects of the medical center's environment:

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

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

[63] The medical center did not have an inpatient mental health unit.

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

- Acute care unit

- CLC

- Dementia care unit

- Dental clinic

- Hospice

- Main pharmacy

- Outpatient mental health

- Podiatry clinic

- Primary care clinic (Red Team)

- Same Day Surgery

- Urgent care clinic

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

Environment of Care Findings and Recommendations

Generally, the medical center met the above requirements. The inspection team observed general compliance with requirements for privacy in areas across the medical center and did not note any issues with the availability of medical equipment and supplies. The OIG made no recommendations.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[64] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[65] Long-term opioid use is of particular concern in the veteran population where there is a high incidence of posttraumatic stress disorder, major depressive disorder, alcohol use, substance abuse, and suicide attempts.[66] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[67]

VHA requires routine assessments of pain and the completion of an opioid risk assessment before initiating patients on long-term opioid therapy and recommends against the therapy for patients with untreated substance use disorders. VHA also recommends avoiding drugs capable of inducing fatal interactions, such as opioids with benzodiazepines.[68] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[69] To achieve VHA's vision of providing patient-driven healthcare, providers are also required to obtain informed consent from patients and to provide education about the risks, benefits, and alternatives prior to initiating long-term opioid therapy.[70] VHA recommends evaluating patients receiving continued opioid therapy for improvement of pain and opioid-related adverse events at least every three months and more frequently as doses increase.[71]

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

- Completion of initial screening for pain

- Assessment of aberrant behavior risk

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

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

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

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

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

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

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

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

- Avoidance of concurrent therapy with benzodiazepines

- Completion of urine drug testing with intervention, when indicated

- Documentation of informed consent

- Timely follow-up with patients included required elements

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures include, but are not limited to, adherence to published clinical practice guidelines, timeliness of treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment, patient satisfaction, and quality of life.[72] The OIG examined the following indicators for program oversight and evaluation:

- Performance of pain management committee activities

- Monitoring of quality measures

- Following the quality improvement process

The OIG interviewed key employees and managers and reviewed relevant documents and the electronic health records of 15 selected outpatients who had newly-dispensed (no VA dispensing in previous six months) long-term opioids for pain, daily or intermittently for 90 or more calendar days through VA from July 1, 2018, through June 30, 2019. The team considered whether providers acted in accordance with guidelines for the provision of pain management and the medical center's oversight process for evaluating pain management outcomes and quality.

Medication Management Findings and Recommendations

The medical center did not address most of the indicators of expected performance. The OIG found deficiencies with pain screening, aberrant behavior risk assessments, urine drug testing, informed consent, patient follow-up, and quality measure oversight.

VHA requires all elements of pain management to be documented in the patient record, including completion of initial screening for pain prior to long-term opioid therapy.[73] The OIG determined that providers conducted pain screening for 87 percent of patients based on electronic health records reviewed.[74] Consistent screening and recognition reduces "suffering and improves quality of life for Veterans experiencing acute and chronic pain."[75] The acting Chief of Primary

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

[73] VHA Directive 2009-053.

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

[75] VHA Directive 2009-053.

Care reported that providers believed repeat screening was not required when a patient switched long-term opioid therapy from a non-VA provider to a VA provider.

VA/DoD clinical practice guidelines recommend completion of an aberrant behavior risk assessment that includes a history of substance abuse, psychological disease, and aberrant drug-related behaviors prior to initiating long-term opioid therapy.[76] The OIG determined that providers assessed substance abuse history for 33 percent of patients reviewed. Additionally, the OIG determined that providers assessed for psychological disease in 47 percent and aberrant drug-related behaviors in 87 percent of patients reviewed.[77] This may have resulted in providers prescribing opioids for some patients who were at high risk for misuse. The Chief of Primary Care and the Associate Chief of Primary Care reportedly believed that screening completed by licensed practical nurses prior to the provider appointment met requirements.

VA/DoD clinical practice guidelines also recommend that providers "obtain UDT [urine drug testing] prior to initiating or continuing LOT [long-term opioid therapy] and periodically thereafter."[78] The OIG determined that providers conducted initial urine drug testing in 80 percent of patients, based on electronic health records reviewed.[79] This resulted in providers' inability to identify whether the remaining 20 percent of patients had a substance use disorder, were at risk for drug diversion, or were adhering to the prescribed medication regimen. The Chief of Primary Care stated that providers made unintentional omissions since there was no documentation template in the electronic health record system.

VHA requires providers to obtain and document informed consent prior to initiating long-term opioid therapy. VHA also recommends that informed consent conversations cover the risks and benefits of opioid therapy, as well as alternative therapies.[80] The OIG determined that providers documented informed consent prior to initiating long-term opioid therapy in 20 percent of the patients reviewed.[81] The remaining patients, therefore, were potentially receiving treatment without knowledge of the associated risks, including opioid dependence, tolerance, addiction, and fatal overdose. The acting Chief of Pharmacy and the Pain & Palliative Care Services Pharmacist stated that providers used chronic pain agreements they believed met informed

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[76] *Pain Management, Opioid Safety, VA Educational Guide (2014)*, July 2014. https://www.va.gov/PAINMANAGEMENT/docs/OSI_1_Tookit_Provider_AD_Educational_Guide_7_17.pdf. (The website was accessed on December 4, 2019.) Examples of aberrant drug related behaviors include "lost prescriptions, multiple requests for early refills, unauthorized dose escalation, apparent intoxication, frequent accidents." *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain.*

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

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

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

[80] VHA Directive 1005.

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

consent requirements. The chiefs also reported that providers believed informed consent was not necessary when a patient switched care from a non-VA provider to a VA provider.

VA/DoD clinical practice guidelines recommend providers follow up with patients within three months after initiating long-term opioid therapy.[82] The OIG determined that providers followed up with 47 percent of patients within three months of initiating long-term opioid therapy.[83] For the remaining patients, failure to conduct follow-up visits may result in missed opportunities to assess adherence to the therapy plan, effectiveness of treatment, or risks of continued opioid therapy. The Chief of Primary Care and the Associate Chief of Primary Care explained that providers were aware of the requirement but used business days instead of calendar days to schedule follow-up appointments. The chiefs also explained that patient follow-up appointment time is often limited, which resulted in providers focusing on the chief complaint rather than additional chronic issues.

The OIG made no recommendations related to pain screening, aberrant behavior risk assessments, urine drug testing, informed consent, or patient follow-up due to the low number of identified outpatients who had newly-dispensed long-term opioids for pain during the review period.

VHA requires facilities to have a multidisciplinary pain management committee to provide oversight of pain management activities and processes, which includes monitoring the "quality of pain assessment and effectiveness of pain management interventions."[84] The OIG reviewed Pain Committee (a subcommittee of the Pharmacy & Therapeutics Committee) minutes from August 28, 2019, through February 26, 2020, and found no indication that the committee evaluated the quality of pain assessment or the effectiveness of pain management interventions. This resulted in the inability to identify deficiencies or provide recommendations for improvement to medical center leaders. The Chief of Primary Care and the Pain & Palliative Care Pharmacist did not provide a reason for noncompliance and reported that the committee reviewed other long-term opioid therapy metrics.

Recommendation 5

5. The Chief of Staff determines the reasons for noncompliance and makes certain that the Pain Committee monitors the quality of pain assessment and the effectiveness of pain management interventions.

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

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

[84] VHA Directive 2009-053.

Medical center concurred.

Target date for completion: April 30, 2021

Medical center response: The Chief of Staff has determined the reasons for noncompliance and has found no additional reasons for noncompliance. The Chief of Staff has directed the Pain Committee to evaluate the quality of pain assessments and effectiveness of the pain management interventions.

Twenty (20) records will be reviewed monthly by the Pain Committee to ensure that the quality of pain assessment and effectiveness of pain management interventions are documented, if less than twenty records are available a 100% review of all charts pulled will be completed. The numerator will be the number of patient records with documentation of appropriate pain assessment and management of interventions for effectiveness and the denominator will be the number of eligible patients who require pain assessment and management of interventions for effectiveness.

This recommendation will be considered compliant when 90 percent or greater of the charts reviewed include the above elements for six (6) consecutive months. Compliance will be reported monthly to the Medical Executive Board.

Mental Health: Suicide Prevention Program

In 2017, suicide was the 10th leading cause of death, with approximately 47,000 lives lost across the United States.[85] The suicide rate was 1.5 times greater for veterans than for non-veteran adults and estimated to represent approximately 22 percent of all suicide deaths in the United States.[86] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[87]

VHA has identified suicide prevention as a top priority and implemented various evidence-based approaches to reduce the veteran suicide rate. In addition to expanded mental health services and community outreach, VHA has developed comprehensive screening and assessment processes to identify at-risk patients.[88]

VHA requires that each medical center and very large CBOC have a full-time suicide prevention coordinator (SPC) to track and follow up with high-risk veterans, develop a process for responding to referrals from hotlines such as the Veteran Crisis Line, and conduct community outreach activities.[89] The OIG examined various requirements related to SPCs:

- Assignment of a full-time SPC

- Tracking and follow-up of high-risk veterans

    o   Patients' completion of four appointments within the required time frame

    o   Safety plan completion within the required time frame

    o   Mental health teams' contacts with patients for missed appointments

- Provision of suicide prevention training for nonclinical employees at new employee orientation

- Completion of at least five outreach activities per month

VHA also requires that any patient determined to be at high risk for suicide be added to the facility high-risk list and have a High Risk for Suicide (HRS) Patient Record Flag (PRF) placed

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

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

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

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

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

in his or her electronic health record "as soon as possible but no later than 1 business day after such determination by the SPC."[90] According to VHA, "Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death…The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions."[91] The HRS PRF is reviewed at least every 90 days and depending on changes to the suicide risk status, will remain active or be removed.[92] Additionally, VHA requires designated high-risk patients to have a completed suicide safety plan and four face-to-face visits with an acceptable provider within the first 30 days of designation.[93]

The OIG noted that from July 1, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA required that "Any patient determined to be High Risk for Suicide [by the licensed independent provider] must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination."[94] However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management changed the requirement for the HRS PRF placement to be "as soon as possible but no later than 1 business day after determination by the SPC."[95] VHA further provided additional clarifying information:

- The "SPC exclusively controls the HRS-PRF and must limit their use to patients who meet the criteria of being placed on the facility high-risk suicide list."

- "The time frame of placing the flag begins once the SPC makes the determination that an HRS-PRF is warranted."

- The SPC's determination process "may be beyond 24 hours after a referral, due to case consultation and review."[96]

The OIG is concerned that the updated requirement may result in delayed placement of HRS PRFs for at-risk patients. Without defined time frames for SPC determination that the HRS PRF

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

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

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

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

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

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

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

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

On March 27, 2020, VHA also updated existing policy requirements to allow the review of an HRS PRF to "occur no earlier than 10 days before and no later than 10 days after the 90-day due date."[97]

Inspectors examined the completion of several requirements:

- Review of HRS PRFs within the required time frame

- Completion of at least four mental health visits within 30 days of HRS PRF placement

- Appropriate follow-up for no-show high-risk appointments

- Completion of suicide safety plans with the required elements within the required time frame

All VHA employees must complete suicide risk and intervention training within 90 days of entering their position. Clinical staff (including physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and Vet Center counselors) must complete Suicide Risk Management Training for Clinicians, and nonclinical staff must complete Operation S.A.V.E. training.[98] VHA also requires that all staff receive annual refresher training.[99] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[100]

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

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

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

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

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

- Relevant documents;

- The electronic health records of 40 outpatients whose electronic health records were flagged as high risk for suicide from July 1, 2018, to June 30, 2019; and

- Staff training records.

Mental Health Findings and Recommendations

The medical center complied with requirements associated with timely appointment and safety plan completion, and patient follow-up for missed appointments. At the time of the site visit, the OIG noted the medical center did not have a full-time SPC; however, the interim Deputy Director of Mental Health reported that an SPC candidate had been selected and would be entering on duty in March 2020. Therefore, the OIG made no recommendation.

Additionally, the OIG noted concerns with suicide prevention training.

VHA requires that all nonclinical employees receive Operation S.A.V.E. training during new employee orientation.[101] The OIG found that the training provided at new employee orientation was not the required Operation S.A.V.E. training. Lack of nationally required training could prevent nonclinical staff from consistently recognizing and intervening for a veteran in suicidal crisis.[102] The Lead Educator, Nursing Education reportedly believed that a S.A.V.E. training video from a third-party vendor met requirements.

Recommendation 6

6. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that nonclinical staff receive the required Operation S.A.V.E. training during new employee orientation.

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[101] VHA DUSHOM Memorandum, *Suicide Awareness Training*, April 11, 2017.
[102] VHA Directive 1071.

Medical center concurred.

Target date for completion: April 30, 2021

Medical center response: The Chief of Staff has reviewed and determined the reasons for noncompliance of completion of suicide risk training. It was determined that the Suicide Prevention Team did not use the required Operation S.A.V.E. training during New Employee Orientation. The Suicide Prevention Coordinator will obtain a Talent Management System report for all new and current employees who received the S.A.V.E. training video in lieu of National Face to Face training prior to this calendar year and coordinate with the Education service to ensure all new employees receive the national training. The training will begin September 2020. The numerator will be the number of nonclinical staff who attended New Employee Orientation and completed the required face to face teaching session (Operation S.A.V.E. training) and the denominator is all medical center nonclinical staff who attended New Employee Orientation.

The compliance list will be monitored for six (6) consecutive months with expectation of 90 percent compliance for training within six months. Compliance will be reported monthly by the Suicide Prevention Coordinator at the Quality Executive Board.

Care Coordination: Life-Sustaining Treatment Decisions

Life-sustaining treatments (LSTs) are intended to extend the life of a patient expected to die soon without medical intervention. LSTs may include artificial nutrition, hydration, and mechanical ventilation. VHA issued the life-sustaining treatment decisions (LSTD) handbook to standardize practices related to discussing and documenting goals of care and LSTD. Per VHA, the goal is to encourage personalized, proactive, patient-driven treatment plans for veterans with serious illness by "…eliciting, documenting, and honoring patients' values, goals, and preferences."[103]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.[104] Implementation requirements included initiating conversations about the goals of care. A goals of care conversation is a discussion between a healthcare provider and a patient or surrogate to help define the patient's values, goals, and preferences for care and, based on the discussion, make choices about starting, limiting, or ceasing LSTs.[105] VHA requires practitioners to initiate goals of care conversations with high-risk patients—including hospice patients or their surrogates—within a time frame that meets the medical needs of the patient or at the time of a triggering event.[106]

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

- Decision-making capacity,

- Identification of a surrogate if the patient loses decision-making capacity,

- Patient or surrogate understanding of the patient's condition,

- Goals of care,

- Plan of care for the use of LST, including whether cardiopulmonary resuscitation will be attempted in the event of cardiac arrest, and

- Informed consent for the LST plan.

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

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

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

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

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

- Decision-making capacity,

- Goal(s) of care,

- Plan of care for the use of LST, and

- Informed consent for the LST plan.

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

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

- Completion of LSTD notes

- Timely documentation of LSTD

- Inclusion of required elements in LSTD documentation

- Completion of LSTD note/orders by an authorized provider or delegation to a designee met all requirements

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[107] Inspectors examined if the medical center established an LSTD committee that was comprised of a multidisciplinary membership, which included representation from Ethics Consultation Service, and reviewed proposed LST plans.

To determine whether the medical center complied with the OIG-selected requirements related to LSTD for hospice patients, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 22 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

Care Coordination Findings and Recommendations

The OIG found the medical center complied with requirements for the LSTD committee and supervision of designees. With VHA's original requirements that were in place when these

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[107] VHA Handbook 1004.03(1).

patients received care, the OIG determined that 85 percent of patients' LST progress notes addressed previous advance directive(s), state-authorized portable orders, and/or LST notes.[108] However, VHA recently deleted requirements for the documentation of these elements in the LST progress note. The OIG remains concerned that this change could result in practitioners not addressing these important goals of care conversation elements. The OIG also identified that LSTD notes were not documented in a timely manner.

VHA requires that providers complete a goals of care conversation with hospice patients and document life-sustaining treatment decisions before entering a referral to VA or non-VA hospice.[109] The OIG determined that providers completed goals of care conversations prior to hospice referrals for 85 percent of patients, based on electronic health records reviewed.[110] Failure to provide timely goals of care conversations may hinder providers' ability to honor the patient's self-determined preferences, autonomy, or wishes prior to or during a life-threatening clinical event. The Chief of Geriatrics and Extended Care indicated that providers may have selected the wrong title or template during the transition to the new LSTD note.

Recommendation 7

7. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures providers complete and document goals of care conversations prior to hospice referrals.

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

[109] VHA Handbook 1004.03(1).

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

Medical center concurred.

Target date for completion: March 31, 2021

Medical center response: The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the facility educates providers on the Goals of Care Conversations and Life Sustaining Treatment Decisions Note completion and will implement a hard stop on the Hospice Referral that will inform the referring provider of the need to have a Goals of Care/Life Sustaining Treatment Decision note in CPRS prior to placing the hospice referral.

Twenty (20) records will be reviewed monthly by the Chief of Geriatrics & Extended Care or designee to ensure providers document Goals of Care Conversations and Life Sustaining Treatment Decisions. If less than twenty records are available, a 100 percent review of all charts pulled will be completed. The numerator will be the number of patient records with documentation of appropriate Goals of Care Conversations and Life Sustaining Treatment Decisions and the denominator will be the number of patients with a Hospice referral.

This recommendation will be considered compliant when 90 percent or greater of the charts reviewed include the above elements for six (6) consecutive months. Compliance will be reported monthly to the Medical Executive Board.

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[111] 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.[112] To help the VA better understand the needs of the growing women's veteran population, efforts have been made by VHA to identify and address the urgent needs "by examining health care use, preferences, and the barriers Women Veterans face in access to VA care."[113] Additionally, a VA report in 2016 on suicide among veterans pointed out concerning trends in suicide among women veterans and discussed "the importance of understanding suicide risk among women veterans and developing gender-tailored suicide prevention strategies."[114]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment. Facilities must, therefore, ensure availability of appropriate resources, services, and staffing ratios.[115] VHA also requires delivery of quality care to all women veterans accessing VA emergency services. In addition, VHA requires facilities to establish a multidisciplinary women veteran health committee that "develops and implements a Women's Health Program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans."[116]

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

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[111] 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.)

[112] 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.)

[113] 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.)

[114] 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.)

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

[116] VHA Directive 1330.01(3).

- Provision of care requirements

  o Designated Women's Health Patient Aligned Care Team established

  o Primary Care Mental Health Integration services available

  o Gynecologic care coverage available 24/7

  o Gynecology care accessible

  o Facility women's health primary care providers designated

  o CBOC women's health primary care providers designated

  o Emergency contraception accessible

- Oversight of program and monitoring of performance improvement data

  o Women Veterans Health Committee established

    - Quarterly meetings held

    - Core members attend

    - Quality assurance data collected and tracked

    - Reports made to clinical executive leaders

- Assignment of required staff

  o Women Veterans Program Manager

  o Women's Health Medical Director or clinical champion

  o Maternity Care Coordinator

  o Women's health clinical liaison at each CBOC

Women's Health Findings and Recommendations

The medical center complied with requirements for most of the provision of care indicators and selected staffing elements reviewed. However, the OIG identified weaknesses with designated women's health primary care providers and the Women Veterans Health Committee core membership.

Specifically, VHA requires each CBOC to have at least two designated women's health primary care providers (WH-PCPs) or arrangements for leave coverage when CBOCs have only one designated provider.[117] The OIG found that three of six CBOCs had two designated WH-PCPs. Inadequate staffing of WH-PCPs may limit the system's ability to provide comprehensive

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[117] VHA Directive 1330.01(3).

healthcare services to women veterans.[118] The Women Veterans Program Manager was reportedly aware of the requirement but stated that limited ability to hire providers, high turnover rates, slow recruitment processes, rurality, and staff training contributed to noncompliance.

Recommendation 8

8. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that each community-based outpatient clinic has at least two designated women's health primary care providers or arrangements for leave coverage when there is only one designated provider.

Medical center concurred.

Target date for completion: February 28, 2021

Medical center response: The Medical Center Director will ensure that each community-based outpatient clinic has arrangements for leave coverage when clinics have only one provider. The Women's Health Medical Director has developed a standard operating procedure for coverage in the case of absences to ensure access to care for women veterans. The Women's Health Medical Director or designee will conduct a monthly audit for effectiveness of the standard operating procedure.

The Women's Health Medical Director will ensure continued reporting of the compliance as the number of days without coverage for each community-based outpatient clinic (denominator) compared to the total number of days with alternative coverage provided per month (numerator) to the Quality Executive Board monthly. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation.

VHA requires that the Women Veterans Health Committee meets quarterly, reports to executive leaders, and has a core membership. That membership includes a women veterans program manager; a women's health medical director; "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care; and a member from executive leadership."[119] The OIG reviewed the committee minutes from July 10, 2019, through December 18, 2019, and found inconsistent representation from primary care, medical and/or surgical subspecialties, social work, and business office/non-VA medical care. This resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out

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[118] VHA Directive 1330.01(3).
[119] VHA Directive 1330.01(3).

improvements for quality care.[120] The Women Veterans Program Manager stated scheduling conflicts, inability to hold assigned disciplines accountable for poor attendance, temporary leadership, lack of committee appointments by leaders, and vacant positions as factors that contributed to noncompliance.

Recommendation 9

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

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Medical Center Director will ensure that required members are assigned and consistently attend Women Veterans Health Committee meetings. The Women Veterans Health Committee charter was updated to include all the required core members. The Chief Medical Executive will ensure continued reporting of the compliance as the number of Women Veterans Health Committee minutes attendance sheet that reflects the required member attendance (the numerator) compared to the total number of meetings conducted (the denominator) to the Quality Executive Board quarterly. The monitoring and auditing will continue until 90 percent compliance has been reached for two consecutive quarters.

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[120] VHA Directive 1330.01(3).

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have a Sterile Processing Service (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment…"[121] The goal of SPS is to "...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[122] To ensure this, VHA requires facilities to conduct the following activities:

- Maintain a current inventory list of all RME

- Have standard operating procedures (SOPs) that are based on current manufacturer's guidelines and reviewed at least triennially

- Use CensiTrac® Instrument Tracking System for tracking reprocessed instruments[123]

- Perform annual risk analysis and report results to the VISN SPS Management Board

- Monitor data for reprocessing and storing RME

- Conduct annual airflow/ventilation system inspections[124]

VHA requires strict controls that closely monitor climate, storage, and sterilization parameters and additionally requires that quality assurance documentation of this monitoring be maintained for a minimum of three years.[125] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[126]

In addition, RME reprocessing areas must be clean, restricted, and airflow controlled. All areas where RME reprocessing occurs must have safety data sheets, an unobstructed eyewash station,

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

[122] 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.)

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

[124] VHA Directive 1116(2).

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

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

personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[127]

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued annual and essential staff competency assessments, and monthly continuing education. This ensures that staff have sufficient aptitude, knowledge, and skills to effectively and safely reprocess and sterilize RME.[128]

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

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

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[127] VHA Directive 1116(2).
[128] VHA Directive 1116(2).

- o Eating or drinking in the area prohibited

- o Equipment properly stored

- o Required temperature and humidity maintained

- Completion of staff training, competency, and continuing education

- o Required training completed in a timely manner

- o Competency assessments performed

- o Monthly continuing education received

High-Risk Processes Findings and Recommendations

The OIG found the medical center complied with some elements of expected performance for reprocessing RME. However, the OIG identified deficiencies with administrative processes, quality assurance monitoring, reprocessing and storage area physical inspections, and staff training.

VHA requires that "The Chief, SPS, must maintain a file (electronic or paper copy) for all reusable devices. This file must contain the manufacturer's IFU [instructions for use] for the proper method of sterilization for each item."[129] The OIG found that the medical center did not maintain a current inventory file for reusable medical devices. This resulted in the potential for loss of reusable devices and lack of "staff awareness when significant changes are made to [the] manufacturer's IFU."[130] The ADPCS stated that lack of consistent leadership and an SPS RME coordinator and the inability to recruit qualified staff contributed to noncompliance.

Recommendation 10

10. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that the Sterile Processing Services Chief maintains an accurate file for all reusable medical equipment that includes the current manufacturers' instructions for use.

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[129] VHA Directive 1116(2).
[130] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Associate Director for Patient Care Services evaluated and determined any additional reasons for noncompliance and makes certain that the Sterile Processing Services Acting Chief maintains an accurate file for all reusable devices that includes the current manufacturer's instructions for use.

The Associate Director for Patient Care Services or designee will verify the file of reusable equipment and the current manufacturer's instructions is accurate. Review will be shared monthly during SPS staff meeting. Minutes of staff meeting will be presented to Quality Executive Board monthly for six (6) months.

Additionally, VHA requires that facilities "must have standard operating procedures (SOPs) based on manufacturer's guidelines that establishes a documented and systematic approach to critical and semi-critical RME processes." [131] VHA also requires that "all SOPs are kept up-to-date, reviewed at least every 3 years and updated when there is a change in process or a change in manufacturer's IFU [instructions for use]."[132] The OIG found that the SOPs for the colonoscope and tonometer did not align with the manufacturers' IFU.[133] In addition, the corresponding SOPs had not been reviewed every three years. Failure to follow the manufacturer's instructions could result in inadequate reprocessing, damage to the scope, and significant safety risks for patients.[134] The ADPCS stated that lack of consistent leadership and an SPS RME coordinator and the inability to recruit qualified staff contributed to noncompliance.

Recommendation 11

11. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that standard operating procedures align with the manufacturers' instructions for use, are reviewed at least every three years, and are updated when there is a change.

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[131] VHA Directive 1116(2).

[132] VHA Directive 1116(2).

[133] A tonometer is an instrument used to measure the fluid pressure inside the eye.

[134] VHA Directive 1116(2).

> Medical center concurred.
>
> Target date for completion: March 31, 2021
>
> Medical center response: The Associate Director for Patient Care Services reviewed and determined that Sterile Processing Service SOP did not contain all the required elements. As a result, the Sterile Processing Service SOPs were modified and updated by the Reusable Medical Equipment Coordinator, based on current manufacture guidelines and instructions for use, including the SOP for "Olympus Evis Exera Videoscopes" and "Goldman Tonometer Prism" which was revised on July 7, 2020 and August 28, 2020. The Acting Assistant Sterile Processing Service Chief will ensure that monitoring occurs, and that Sterile Processing Service SOPs align with current manufacturers' guidelines and instructions for use. Updated SOPs were discussed with SPS staff during huddle and monthly meeting. This will be accomplished by monitoring five (5) SOPs each month until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of the Sterile Processing Service SOPs reviewed that contain current manufacturers' guidelines and instructions for use and the denominator is five of the number of Sterile Processing Service SOPs reviewed. Results will be reported to the Quality Executive Board.

VHA also requires the SPS Chief to perform an annual risk analysis and report the results to the VISN SPS Management Board.[135] The OIG found that the FY 2019 annual risk analysis was performed; however, the medical center could not provide evidence that the results were reported to the VISN SPS Management Board. This may have impeded the identification of potential process failures or medical center preparedness for managing those failures.[136] The acting Chief of SPS and ADPCS stated that the acting Chief had too many collateral duties and failed to report the results to the VISN.

Recommendation 12

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

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[135] VHA Directive 1116(2).
[136] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Associate Director for Patient Care Services ensured that the annual sterile processing risk analysis was sent to VISN 7 for reporting purposes at the VISN Sterile Processing Services Management Board. The risk analysis dated June 22, 2020 was forwarded to VISN 7 on June 22, 2020. This recommendation is considered in compliance as of June 22, 2020.

According to VHA, facilities must maintain written records of weekly function testing of eyewash stations.[137] The OIG found no evidence of weekly function testing of eyewash stations in SPS areas. This could potentially result in staff injury if the eyewash station is unavailable or not operating properly in an emergency.[138] The ADPCS cited a failure in communication of responsibility for weekly testing as the reason for noncompliance.

Recommendation 13

13. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that written records of weekly eyewash station testing are maintained.

Medical Center concurred.

Target date for completion: March 31, 2021

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

According to VHA, "liquid disinfectant solutions must be tested to ensure the minimum effective concentration (MEC) of the active ingredients is accurate. For VA medical facilities using automated HLD [high-level disinfectant] equipment, the manufacturer's IFU must be followed to correctly test the MEC." [139] Testing should occur prior to each reprocessing cycle, and results

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[137] VHA Directive 7704(1).

[138] VHA Directive 1116(2).

[139] VHA Directive 1116(2).

must be documented and kept for 3 years.[140] The OIG did not find that the medical center completed and documented MEC testing of the solutions used in the automated HLD equipment. This resulted in potentially inadequate disinfection of reusable devices. The acting Chief of SPS was reportedly unaware that MEC results needed to be documented, as printouts from the automated endoscope reprocessor showed that equipment passed post-disinfectant checks.

Recommendation 14

14. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and certifies that Sterile Processing Services staff complete and document liquid disinfectant solution testing to ensure the minimum effective concentration of the active ingredient is achieved.

Medical center concurred.

Target date for completion: March 31, 2021

Medical center response: The Associate Director for Patient Care Services has evaluated and determined reasons for noncompliance and instructed SPS staff to certify liquid disinfectant solution meets minimum effective concentration. The daily results are kept in a log.

The Associate Director for Patient Care Services or designee will ensure continued reporting of compliance of the minimum effective concentration for the liquid disinfectant solution.

The numerator will be the number of daily uses of liquid disinfectant solution and the denominator is the number of times the minimum effective concentration is tested. This recommendation will be considered compliant when there are six consecutive monthly reports of data showing 90 percent or greater compliance with this recommendation. This data will be reported to the Quality Executive Board monthly.

Despite VHA's requirement for annual airflow testing, the OIG found that medical center staff failed to conduct the testing in the Gastroenterology SPS storage room during FY 2019.[141] Failure to evaluate and maintain air quality standards can lead to the spread of healthcare-associated infections.[142] The Chief of Engineering stated that the storage room was not on the list for testing.

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[140] VHA Directive 1116(2).

[141] VHA Directive 1116(2).

[142] Centers for Disease Control and Prevention, *Guidelines for Environmental Infection Control in Health-Care Facilities, July 2019.* https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf. (The website was accessed on August 15, 2019.)

Recommendation 15

15. The Associate Director for Patient Care Services determines the reasons for noncompliance and makes certain that annual airflow testing is conducted in the Gastroenterology Sterile Processing Services storage room.

> Medical center concurred.
>
> Target date for completion: November 30, 2020
>
> Medical center response: The Associate Director for Patient Care Services determined the Annual Air Flow test was completed; however, the testing results were not shared with SPS staff. A preventive maintenance workorder will be placed to the Heating, Ventilation, and Air Conditioning shop for a yearly reminder to provide results of testing to SPS staff.

VHA requires that "eating, drinking, or the storage of food items (including beverages) are not permitted in SPS where the processes of decontamination, sterilization or clean/sterile storage are performed."[143] The OIG found a coffee beverage in the SPS preparation area. Eating and drinking in SPS areas increases the likelihood of contamination and compromised package integrity of reprocessed items. The acting Chief of SPS stated that a new employee from the dental clinic had not been educated about the guidelines in clean/sterile storage rooms.

Recommendation 16

16. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and verifies that eating, drinking, and food item storage is prohibited where the processes of decontamination, sterilization, or clean and sterile storage are performed.

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[143] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: March 31, 2021

Medical center response: The Associate Director for Patient Care Services evaluated additional reasons for noncompliance. A review of the findings, including discussions with staff was completed. It was confirmed that there were no specific issues other than a new employee from the dental clinic had not been educated about the guidelines in clean/sterile storage rooms. The Acting Assistant Sterile Processing Service Chief met with staff member immediately to ensure staff did not have food or drinks in the clean/sterile room. A sign was placed on the door to remind staff of restrictions. The Acting Assistant Sterile Processing Service Chief once again addressed food/drink issues in the staff huddle. August 31, 2020 the issue of food/drink was addressed in staff huddle, education provided. Random weekly rounding for six (6) months will be performed by a Quality Management designee and reported monthly to Quality Executive Board for six (6) consecutive months.

VHA requires documented competency assessments for employees who reprocess critical and semi-critical reusable medical equipment. The competency assessment must be documented with all critical action steps, two validation methods, and evaluation of proficiency.[144] Although the medical center staff completed the required competency assessments, the OIG found that assessments for five SPS employees who reprocessed colonoscopes and tonometers did not include all critical action steps nor was a two-validation method used, thereby rendering the competencies invalid. Failure to properly assess staff competency could compromise patient safety. The acting Chief of SPS indicated unawareness of the requirements.

Recommendation 17

17. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that Sterile Processing Services staff receive properly completed competency assessments for reprocessing reusable medical equipment.

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

Medical center concurred.

Target date for completion: March 31, 2021

Medical center response: Associate Director for Patient Care Services ensures that all Sterilization Processing Service Medical Service Technicians complete their annual competency assessments. Acting Assistant Sterile Processing Service Chief is monitoring the competency completion through competency tracker tool. Monthly audit of staff competency completion is conducted by the Sterile Processing Service Supervisor.

This recommendation will be considered compliant when the monthly audit of staff Competency assessments shows a ninety percent or greater compliance for Competency Assessment to include all critical steps and a two-validation method for six consecutive months. Numerator is the number of Sterile Processing Services employees completed annual competency training; denominator is the number of Sterile Processing Services employees requiring Annual Competency Assessment. Compliance will be reported by the Acting Assistant Sterile Processing Service Chief monthly to the Quality Executive Board and quarterly to the Reusable Medical Equipment Committee.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• None	• Quality Executive Board improvement actions are developed and documented in meeting minutes.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• Clinical managers define in advance, communicate, and document expectations for focused professional practice evaluations in practitioner profiles. • Focused professional practice evaluation time frames are clearly documented.	• Exit review forms are completed within seven calendar days of licensed healthcare professionals' departure from the medical center.

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• None	• Pain Committee monitors the quality of pain assessment and the effectiveness of pain management interventions.
Mental Health: Suicide Prevention Program	• Designated suicide prevention coordinator • Tracking and follow-up of high-risk veterans • Provision of suicide prevention care • Completion of suicide prevention training requirements	• None	• Suicide prevention training is conducted for nonclinical staff during new employee orientation.
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• Providers complete and document goals of care conversations prior to hospice referrals.	• None
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• Each CBOC has at least two designated women's health primary care providers or arrangements for leave coverage when there is only one designated provider.	• Core members are assigned to and consistently attend Women Veterans Health Committee meetings.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Quality assurance monitoring • Physical inspection • Staff training	• High-level disinfectant solution minimum effective concentration is tested and documented as required. • Annual airflow testing is conducted in the Gastroenterology SPS storage room. • Eating, drinking, and food item storage is prohibited in areas where the processes of decontamination, sterilization, or clean and sterile storage are performed.	• An accurate file for all reusable medical equipment that includes the current manufacturers' instructions for use is maintained. • Standard operating procedures align with the manufacturers' instructions for use, are reviewed at least every three years, and are updated when there is a change. • Annual risk analysis results are reported to the VISN SPS Management Board. • Written records of weekly eyewash station testing are maintained. • SPS staff receive properly completed competency assessments for reprocessing reusable medical equipment.

Appendix B: Medical Center Profile

The table below provides general background information for this medium complexity (2) affiliated[1] medical center reporting to VISN 7.[2]

Table B.1. Profile for Carl Vinson VA Medical Center (557)
(October 1, 2016, through September 30, 2019)

Profile Element	Medical Center Data FY 2017[3]	Medical Center Data FY 2018[4]	Medical Center Data FY 2019[5]
Total medical care budget	$284,673,313	$329,297,508	$280,593,113
Number of:			
• Unique patients	37,318	36,991	38,412
• Outpatient visits	378,296	392,987	416,022
• Unique employees[6]	1,115	1,230	1,267
Type and number of operating beds:			
• Community living center	147	147	147
• Domiciliary	145	145	145
• Medicine	30	30	30
• Surgery	4	4	4
Average daily census:			
• Community living center	140	121	133
• Domiciliary	74	74	104
• Medicine	4	3	3
• Surgery	–	–	–

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

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[1] Associated with a medical residency program.

[2] The VHA medical centers are classified according to a facility complexity model; a designation of "2" indicates a facility with "Facilities with medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs"

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

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

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

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

Appendix C: VA Outpatient Clinic Profiles[1]

The VA outpatient clinics in communities within the catchment area of the medical center provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table C.1 provides information relative to each of the clinics.

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Macon, GA	557GA	17,760	13,109	Dermatology Endocrinology Eye General surgery Infectious disease	n/a	Nutrition Pharmacy Social work Weight management
Albany, GA	557GB	8,316	7,921	Dermatology Endocrinology Eye Podiatry	n/a	Pharmacy Prosthetics Social work

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

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

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

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Milledgeville, GA	557GC	3,306	1,877	Dermatology Endocrinology	n/a	Pharmacy Social work Weight management
Brunswick, GA	557GE	6,891	5,090	Dermatology Endocrinology Eye Podiatry	n/a	Pharmacy Social work Weight management
Tifton, GA	557GF	7,238	5,133	Dermatology Eye	n/a	Nutrition Pharmacy Social work Weight management
Kathleen, GA	557HA	5,860	4,351	Dermatology Endocrinology Infectious disease	n/a	Nutrition Pharmacy Social work Weight management

Source: VHA Support Service Center and VA Corporate Data Warehouse

Note: The OIG did not assess VA's data for accuracy or completeness.

n/a = not applicable

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

Quarterly New Primary Care Patient Average Wait Time in Days

	VHA Total	(557) Dublin, GA (Carl Vinson)	(557GA) Macon, GA	(557GB) Albany, GA	(557GC) Milledgeville, GA	(557GE) Brunswick, GA	(557GF) Tifton, GA	(557HA) Perry, GA
JAN-FY19	9.0	12.7	16.0	12.2	3.8	0.8	9.2	19.0
FEB-FY19	8.5	11.0	19.3	6.0	4.4	3.8	14.8	18.8
MAR-FY19	8.1	9.3	9.7	7.7	2.3	1.8	13.1	7.2
APR-FY19	7.8	10.3	13.8	12.6	0.7	3.9	14.5	32.5
MAY-FY19	7.6	6.8	7.7	8.9	1.8	4.8	4.1	9.7
JUN-FY19	7.6	4.3	10.2	3.8	0.9	0.7	3.9	21.0
JUL-FY19	7.3	5.5	8.7	3.3	1.3	0.3	1.0	18.4
AUG-FY19	7.4	3.1	9.7	2.1	1.1	0.4	0.9	11.9
SEP-FY19	7.3	2.9	4.1	1.8	1.4	4.9	4.1	10.8
OCT-FY20	6.9	1.6	3.9	2.6	1.1	3.7	3.4	7.7
NOV-FY20	7.1	1.8	6.4	2.4	0.5	5.2	1.5	8.5
DEC-FY20	7.8	0.3	7.5	5.7	0.1	6.3	1.0	4.9

Source: VHA Support Service Center

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

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

Quarterly Established Primary Care Patient Average Wait Time in Days

Number of Days

	VHA Total	(557) Dublin, GA (Carl Vinson)	(557GA) Macon, GA	(557GB) Albany, GA	(557GC) Milledgeville, GA	(557GE) Brunswick, GA	(557GF) Tifton, GA	(557HA) Perry, GA
JAN-FY19	5.0	5.9	5.4	4.2	2.5	1.5	11.3	18.9
FEB-FY19	4.6	5.4	4.9	3.4	2.9	1.3	9.6	6.3
MAR-FY19	4.6	5.1	2.7	3.4	1.8	1.6	3.7	3.1
APR-FY19	4.5	4.6	3.0	4.7	1.8	1.9	14.0	7.8
MAY-FY19	4.5	5.6	2.1	2.4	0.8	1.6	3.4	5.3
JUN-FY19	4.5	3.5	3.6	2.4	1.6	3.9	9.4	14.3
JUL-FY19	4.6	2.6	3.3	2.3	2.3	3.4	3.2	9.0
AUG-FY19	4.5	2.0	3.6	2.3	1.1	3.7	9.4	5.4
SEP-FY19	4.3	1.6	3.3	2.5	1.8	3.2	2.1	7.9
OCT-FY20	3.9	2.2	2.7	2.2	1.4	3.6	3.0	3.6
NOV-FY20	4.2	2.2	2.9	2.0	2.4	3.2	20.1	6.2
DEC-FY20	4.2	2.1	2.8	3.2	1.5	5.6	3.2	7.0

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness.

Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

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

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

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

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

Source: VHA Support Service Center

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

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

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

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

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 22, 2020

From: Director, VISN 7 (10N7)

Subj: Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, Georgia

To: Director, Office of Healthcare Inspections (54CH02)

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

1. I have had the opportunity to review the Comprehensive Healthcare Inspection at the Carl Vinson VA Medical Center, Dublin, GA

2. Carl Vinson VA Medical Center concurs with recommendations 1–17 and the submitted action plans.

3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

4. If you have any questions or require further information, please contact the Quality Management Officer.

(Original signed by:)

Joe D. Battle

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: September 22, 2020

From: Director, Carl Vinson VA Medical Center (557/00)

Subj: Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, Georgia

To: Director, VISN 7 (10N7)

1. I have had the opportunity to review the Comprehensive Healthcare Inspection at the Carl Vinson VA Medical Center, Dublin, GA

2. Carl Vinson VA Medical Center concurs with recommendations 1–17 and the submitted action plans.

3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

4. If you have any questions or require further information, please contact the Quality Management Officer.

(Original signed by:)

David L. Whitmer, FACHE

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