DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Dayton VA Medical Center in Ohio

CHIP REPORT | REPORT #20-01271-64 | FEBRUARY 3, 2021

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Figure 1. *Dayton VA Medical Center in Ohio*
Source: https://vaww.va.gov/directory/guide/ (accessed July 23, 2020)

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
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
SPC	suicide prevention coordinator
SPS	Sterile Processing Services
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

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

Comprehensive healthcare 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 areas:

1. COVID-19 pandemic readiness and response[1]
2. Quality, safety, and value
3. Medical staff privileging
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)

This unannounced virtual review was conducted during the week of July 20, 2020, at the Dayton VA Medical Center. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG examined 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 review. 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

[1] "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It." World Health Organization, accessed August 25, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 (coronavirus disease) is an infectious disease caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)."

vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement in five clinical areas reviewed and issued 10 recommendations that are directed to the Director and Chief of Staff. These are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's visit, the medical center's leadership team consisted of the Medical Center Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), acting Associate Director, and Assistant Director. Organizational communications and accountability were managed through the Executive Leadership Team, which oversaw several working groups. The leaders monitored patient safety and care through the Quality, Patient Safety Board, which was responsible for tracking and trending quality of care and patient outcomes.

When the OIG conducted this inspection, the medical center's executive leadership team, including the acting Associate Director, had worked together for five weeks. The Chief of Staff had served in the role since 2012, and the ADPCS had been in the position for more than a year. The Medical Center Director had been in the position since February 2020, and the Assistant Director was assigned on September 15, 2019. The executive leadership team faced multiple challenges, including the COVID-19 pandemic response, beginning of electronic health record modernization, relocation of the VA History Museum on campus, and selection of a new Associate Director.

The OIG found that the medical center average for the survey leadership questions was similar to the VHA average. Opportunities appear to exist for the ADPCS to foster a culture where employees feel safe coming forward with concerns. Patients generally appeared satisfied with the care provided.

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] However, the OIG's inspection noted a repeat finding from the previous comprehensive healthcare inspection related to completion of all required focused professional practice evaluation elements.[3]

[2] 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] VA OIG, *Comprehensive Healthcare Inspection Program Review of the Dayton VA Medical Center, Ohio*, Report No. 18-00619-242, August 14, 2018.

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.[4]

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. 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, and patient experiences and should continue to take actions to sustain and improve performance.

COVID-19 Pandemic Readiness and Response

The results of the OIG's evaluation of the medical center's COVID-19 pandemic readiness and response will be compiled and reported with other facilities in a separate publication to provide stakeholders with a comprehensive picture of VHA challenges and ongoing efforts.

Medical Staff Privileging

The OIG identified deficiencies with focused and ongoing professional practice evaluations and provider exit review processes.[5]

Medication Management

The OIG found the medical center addressed many of the indicators of expected performance, including pain screening, aberrant behavior risk assessment, documented justification for concurrent therapy with benzodiazepines, urine drug testing, informed consent, and timely follow-up. However, the OIG found a deficiency with the pain committee's oversight and monitoring of quality measures.

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[4] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center (VSSC), accessed March 6, 2020, https://vaww.vssc.med.va.gov/vsscenhancedproductmanagement/displaydocument.aspx?documentid=9428. (This is an internal VA website not publicly accessible.)

[5] 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 requirements for a designated suicide prevention coordinator, tracking of high-risk veterans, and suicide prevention training. However, the OIG noted concerns with completion of four appointments within the required time frame, provider and suicide prevention coordinator collaboration after unsuccessful patient follow-up, and timely safety plan completion.

Care Coordination

Generally, the medical center met expectations for a multidisciplinary life-sustaining treatment decisions committee and supervision of designees. However, during the electronic health record review, the OIG discovered inpatient records where the committee responsible for reviewing life-sustaining treatment decisions was not consulted as required.

Women's Health

The OIG found the medical center complied with many of the requirements for women's health, including care provision and most selected staffing elements reviewed. The OIG noted that the Women Veterans Program Manager was assigned a collateral duty.

Conclusion

The OIG conducted a detailed inspection across nine key areas and subsequently issued 10 recommendations for improvement to the Medical Center Director and Chief of Staff. The number of recommendations should not be used, however, as a gauge for the overall quality of care 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 Veterans Integrated Service Network Director and Medical Center Director agreed with the Comprehensive Healthcare Inspection Program findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 63–64, 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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Assistant Inspector General
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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 Dayton 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.

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual review and paused physical inspection steps, especially those involved in the environment of care-focused review topic, and initiated a COVID-19 pandemic readiness and response evaluation.

As such, to examine risks to patients and the organization, the OIG focused on core processes in the following nine areas of administrative and clinical operations (see figure 2):[3]

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[4]
3. Quality, safety, and value (QSV)
4. Medical staff privileging
5. Medication management (targeting long-term opioid therapy for pain)

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[1] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055.

[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*, March 24, 2015, https://npsf.site-ym.com/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen.

[3] Virtual CHIP site visits addressed these processes during fiscal year 2020 quarter 4 (July 1, 2020, through September 30, 2020); they may differ from prior years' focus areas.

[4] "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," World Health Organization, accessed August 25, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 (coronavirus disease) is an infectious disease caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)."

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)

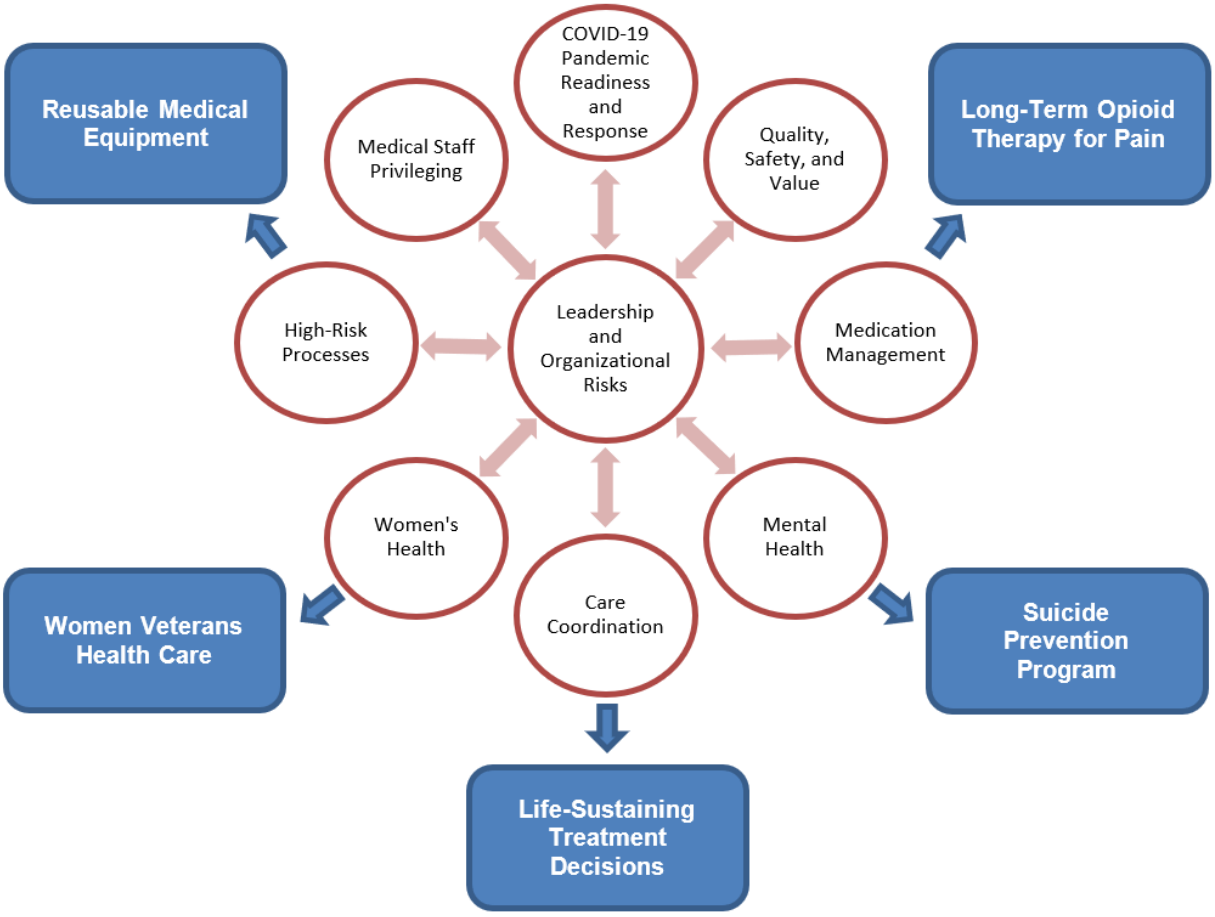

Figure 2. *Fiscal year (FY) 2020 comprehensive healthcare inspection of operations and services*
Source: VA OIG

Methodology

The Dayton VA Medical Center includes multiple outpatient clinics in Ohio and Indiana. 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.[5]

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

The inspection examined operations from March 24, 2018, through July 24, 2020, the last day of the unannounced multiday evaluation.[6] During the virtual review, the OIG did not receive any complaints beyond the scope of the CHIP visit.

The results of the OIG's evaluation of the medical center's COVID-19 pandemic readiness and response will be compiled and reported with other facilities in a separate publication to provide stakeholders with a comprehensive picture of VHA challenges and ongoing efforts.

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 the medical center leaders developed based on the reasons for noncompliance.

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

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can affect the healthcare system's ability to provide care in the clinical focus areas.[7] To assess the medical center's risks, the OIG considered several 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 (community living centers (CLCs))[8]

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), acting Associate Director, and Assistant Director. The Chief of Staff and ADPCS oversee patient care, which requires managing service directors and chiefs of programs and practices.

[7] Laura Botwinick, Maureen Bisognano, and Carol Haraden. 2006. *Leadership Guide to Patient Safety*, Innovation Series White Paper. Institute for Healthcare Improvement.

[8] 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.

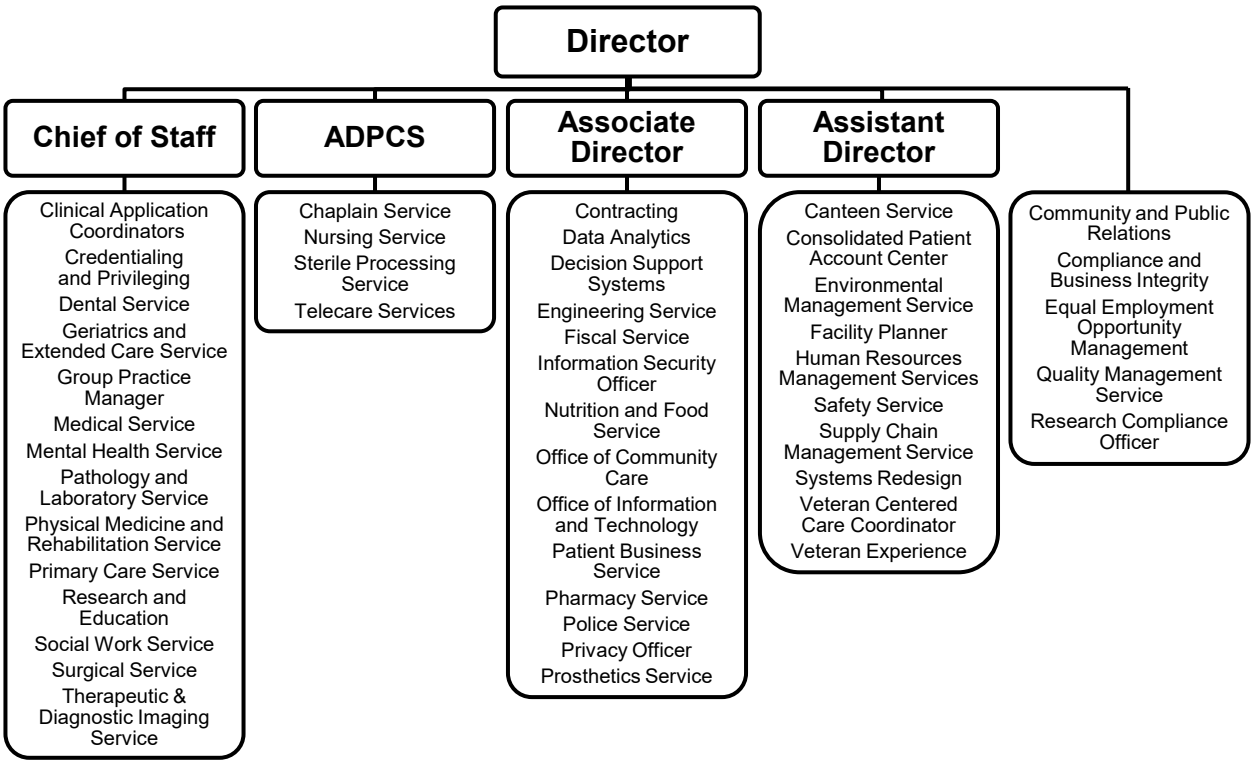

Figure 3. *Medical center organizational chart*
Source: Dayton VA Medical Center (received July 20, 2020)

At the time of OIG's virtual review, the medical center's executive leadership team, including the acting Associate Director, had worked together for five weeks. The Chief of Staff had served in the role since 2012, and the ADPCS had been in the position for more than a year (in an acting capacity since September 24, 2018, until permanently assigned on October 27, 2019). The Medical Center Director was assigned on February 16, 2020, and the Assistant Director was assigned on September 15, 2019 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	February 16, 2020
Chief of Staff	October 9, 2012
Associate Director for Patient Care Services	October 27, 2019
Associate Director	June 15, 2020 (acting)
Assistant Director	September 15, 2019

Source: Deputy Senior Strategic Business Partner VISN 10 Human Resources (received July 21 and 22, 2020)

To help assess the medical center executive leaders' engagement, the OIG interviewed the 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 and CLC SAIL measures. In individual interviews, the executive leadership team members were able to speak about actions taken during their tenure to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

The executive leadership team faced multiple challenges, including responding to the COVID-19 pandemic, beginning electronic health record modernization, relocating the VA History Museum on their campus, and selecting a new Associate Director.

The medical center governance policy provided to OIG reflected an Executive Leadership Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board oversaw various working groups until a transitioning of governance structure began on May 28, 2020, which replaced the Executive Leadership Board with the Executive Leadership Team.

The Executive Leadership Team has the authority to determine policy, strategy, operations, and oversight of the medical center. It oversees the Administrative Executive; Clinical Executive; Nurse Executive; Safety and Environment of Care; Organizational Health; and Quality, Patient Safety Boards. Each working group is chaired by a member of the Executive Leadership Team.

These leaders monitor patient safety and care through the Quality, Patient Safety Board. The Quality, Patient Safety Board was responsible for tracking and trending quality of care, patient outcomes, and all the Executive Leadership Team are members of this committee (see figure 4).

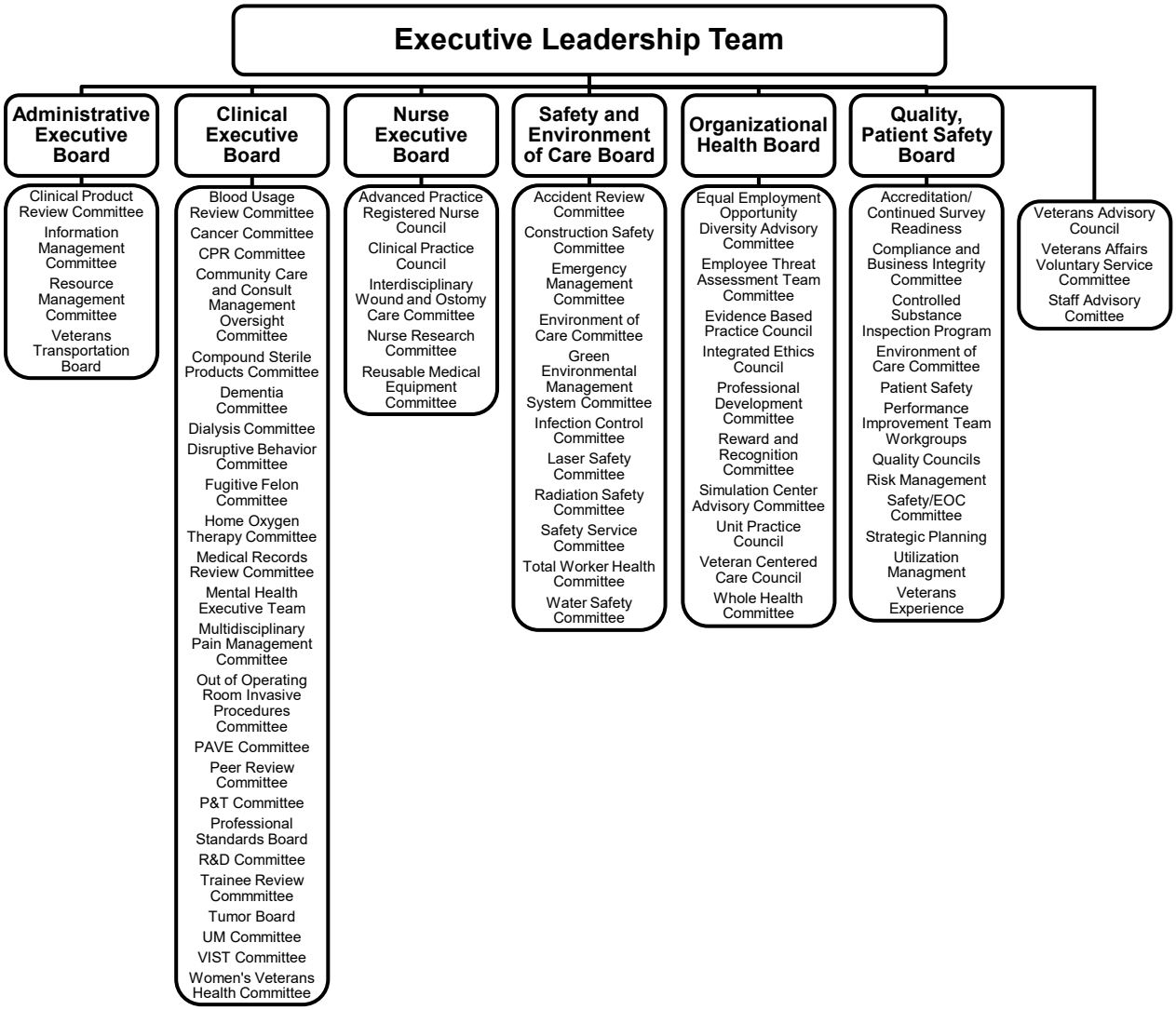

Figure 4. *Medical center committee reporting structure*
Source: Dayton VA Medical Center (received July 23, 2020)

CPR = Cardiopulmonary Resuscitation
EOC = Environment of Care
PAVE = Prevention of Amputation in Veterans Everywhere
P&T = Pharmacy & Therapeutics
R&D = Research & Development
UM = Utilization Management
VIST = Visual Impairment Services Team

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 from October 1, 2018, through September 30, 2019.[9] 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 the VHA average.[10] Survey scores for the leadership roles were generally higher than the VHA and medical center averages.[11]

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	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite.*[12]	0–100 where higher scores are more favorable	72.6	72.0	98.6	–[13]	78.3	88.0	96.0

[9] Ratings are based on responses by employees who report to or are aligned under the Director, ADPCS, Associate Director, and Assistant Director.

[10] 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.

[11] It is important to note that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current Director, ADPCS, acting Associate Director, or Assistant Director, who assumed their roles after the survey period.

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

[13] Data were not available for the Chief of Staff.

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.4	3.4	4.8	–	3.8	4.4	4.8
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.6	4.9	–	3.6	4.7	4.6
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.7	5.0	–	4.0	4.7	5.0

Source: VA All Employee Survey (accessed June 15 and 16, 2020)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[14] The OIG noted that the medical center average for the selected survey questions was similar to the VHA average. Opportunities appear to exist for the ADPCS to foster a culture where employees feel safe coming forward with concerns.[15]

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

[15] It is important to note that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current Medical Center Director, ADPCS, acting Associate Director, or Assistant Director, who assumed their roles after the survey period.

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	Asst. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.7	4.9	–	4.1	4.6	–[16]
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	4.6	–	3.3	4.3	–
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.4	1.3	0.3	–	1.8	1.1	0.2

Source: VA All Employee Survey (accessed June 15 and 16, 2020)

Patient Experience

To assess patient experiences with the medical center, which directly reflect on its leaders, the OIG team reviewed 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

[16] Data were not available for the Assistant Director.

of Healthcare Experiences of Patients 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.[17]

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

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

Questions	Scoring	VHA Average	Dayton 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	71.2
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	82.3
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	80.0
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	78.0	82.5

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

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

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.[18] 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. Although the medical center leaders had opportunities to improve veterans' experiences, the OIG found it noteworthy that most Inpatient Survey results and Specialty Care Survey results for women veterans were better than those for female patients nationally. Medical center leaders appeared to be actively engaged with male and female patients (for example, conducting veteran town hall meetings, creating separate spaces for women to feel welcome in, and providing mammograms on campus through the use of a mobile mammography unit).

Table 5. Inpatient Survey Results on 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
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	82.0	80.5
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	86.6	90.5
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	70.0	94.4

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 6, 2020)

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

[19] The VHA averages are based on 48,259–48,798 male and 2,342–2359 female respondents, depending on the question.

[20] The medical center averages are based on 370–374 male and 14 female respondents, depending on the question.

Table 6. Patient-Centered Medical Home 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).	51.2	43.3	57.3	63.1
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.9	49.7	62.9	44.2
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	71.0	44.9

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 6, 2020)

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

[22] The medical center averages are based on 481–1,362 male and 42–79 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[23]		Medical Center[24]	
		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	44.7	76.1
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	55.0	54.9	77.3
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	71.3	75.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 6, 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.[25] Table 8 summarizes the relevant medical center inspections most recently performed by the OIG and The Joint Commission (TJC).[26] Of note, at the time of the OIG visit, the medical center had closed all recommendations for improvement issued from the previous CHIP site visit conducted in March

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

[24] The medical center averages are based on 540–1,616 male and 27–74 female respondents, depending on the question.

[25] 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.

[26] 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."

2018. However, there was a repeat finding related to completion of all required focused professional practice evaluation elements for the determination of providers' privileges. The Chief of Quality Management Service reported working with medical center managers to address the 13 open recommendations resulting from the focused OIG report on quality of care in the CLC and Emergency Department that was published on February 20, 2020.[27]

At the time of the virtual review, 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.[28] Additional results included the Long Term Care Institute's inspection of the medical center's CLCs.[29]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the Dayton VA Medical Center, Ohio,* Report No. 18-00619-242, August 14, 2018)	March 2018	10	0
OIG (*Alleged Inadequate Mental Health Treatment at the Dayton VA Medical Center, Ohio,* Report No. 17-03382-294, September 20, 2018)	February 2018	3	0

[27] VA OIG, *Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center, Ohio*, Report No. 18-01275-89, February 20, 2020.

[28] 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 collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs. "About the College of American Pathologists," College of American Pathologists, accessed February 20, 2019, https://www.cap.org/about-the-cap. For 70 years the College of American Pathologists has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016. VHA laboratories must meet the requirements of the College of American Pathologists.

[29] Long Term Care Institute, accessed on March 6, 2019, http://www.ltciorg.org/about-us/. 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."

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center Ohio*, Report No. 18-01275-89, February 20, 2020)	October 2018	13	13[30]
TJC Hospital Accreditation	December 2019	31	0
TJC Behavioral Health Care Accreditation		4	0
TJC Home Care Accreditation		6	0

Source: OIG and TJC (inspection/survey results verified with the Chief of Quality Management Service on July 22, 2020)

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

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

Table 9 lists the reported patient safety events from March 24, 2018 (the prior OIG CHIP site visit), through July 24, 2020.[31] The OIG did not find identify any significant organizational risk related to lapses in care and medical center response.

[30] As of January 2021, three recommendations remained open (7, 8, and 13).

[31] 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 Dayton VA Medical Center is a mid-high complexity (1c) affiliated system as described in appendix B.)

Table 9. Summary of Selected Organizational Risk Factors (March 24, 2018, through July 20, 2020)

Factor	Number of Occurrences
Sentinel Events[32]	14
Institutional Disclosures[33]	9
Large-Scale Disclosures[34]	0

Source: Dayton VA Medical Center Risk Management Manager (received July 20, 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.[35]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2019. Of note, figure 5 shows the Dayton VA Medical Center's performance in the second to fourth quintiles. Those in the second quintile (green data points) are better-performing measures (for example, in the areas of adjusted length of stay (LOS), rating (of) specialty care (SC) provider, and care transition). Metrics in the fourth quintile are those that need improvement and are denoted in orange (for

[32] 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."

[33] 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."

[34] 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."

[35] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center, accessed March 6, 2020. https://vaww.vssc.med.va.gov/vsscenhancedproductmanagement/displaydocument.aspx?documentid=9428. (This is an internal VA website not publicly accessible.)

example, patient-centered medical home (PCMH) care coordination, acute care 30-day standardized mortality ratio (SMR30), and stress discussed).[36]

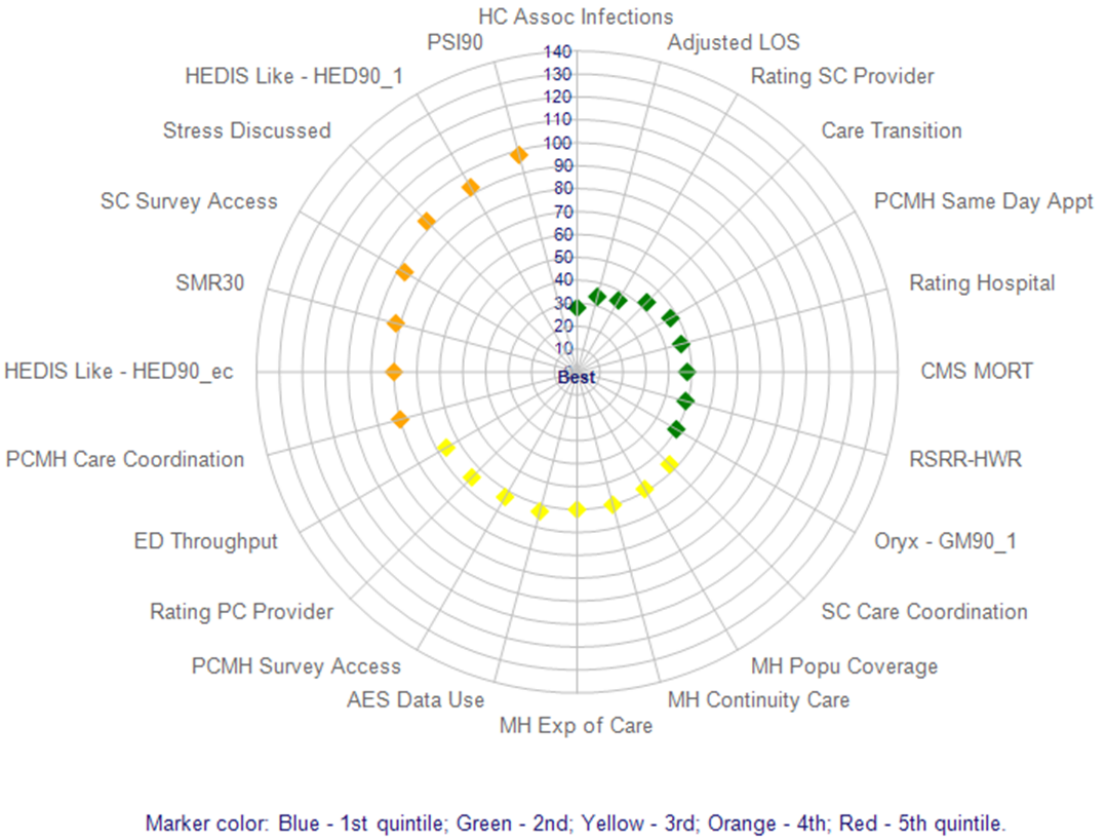

Figure 5. *Medical center quality of care and efficiency metric rankings, FY 2020 quarter 1 (as of December 31, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

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 &

[36] 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.[37]

Figure 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2019. Figure 6 displays the Dayton VA Medical Center's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of physical restraints–long-stay (LS), urinary tract infections (UTI) (LS), and high risk pressure ulcer (PU) (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, rehospitalized after nursing home (NH) admission–short-stay (SS), ability to move independently worsened (LS), and new or worse pressure ulcer (PU) (SS)).[38]

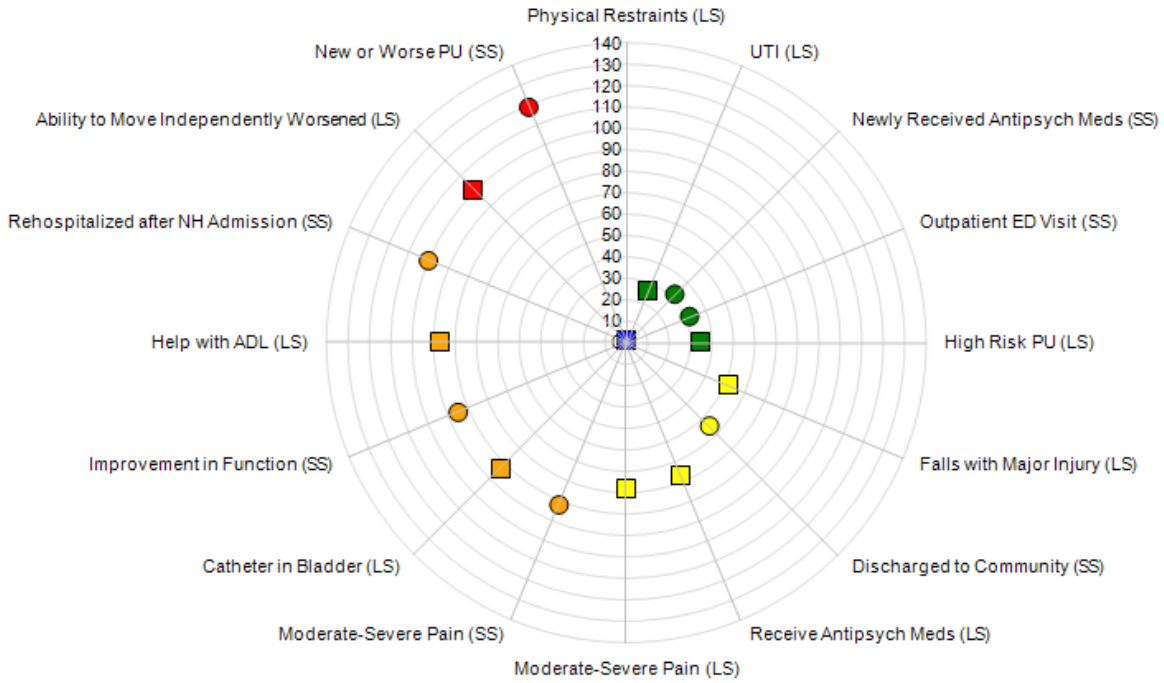

Figure 6. *Dayton CLC quality measure rankings, FY 2020 quarter 1 (as of December 31, 2019)*
LS = Long-Stay Measure *SS = Short-Stay Measure*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

[37] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, July 23, 2020. "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

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

Leadership and Organizational Risks Conclusion

At the time of OIG's inspection, the medical center's executive leadership team, including the acting Associate Director, had worked together for five weeks. The executive leadership team faced multiple challenges, including responding to the COVID-19 pandemic, beginning the electronic health record modernization, relocating the VA History Museum on their campus, and selecting a new Associate Director. Survey scores related to employees' satisfaction with leadership were generally similar to or better than VHA average scores; however, opportunities appear to exist for the ADPCS to foster a culture where employees feel safe coming forward with concerns. It is important to note that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current Medical Center Director, acting Associate Director, or Assistant Director, who assumed the role after the survey was administered.

The medical center leaders seemed actively engaged with employees and patients and were working to sustain and further improve satisfaction. Although the medical center leaders have opportunities to improve veterans' experiences, the OIG found it noteworthy that most Inpatient Survey results and Specialty Care Survey results for women veterans were generally better than those for female patients nationally. The OIG's review of the medical center's accreditation findings, sentinel events, disclosures, and did not identify any substantial organizational risk factors. However, the OIG's inspection noted a repeat finding from the previous CHIP site visit related to completion of all required focused professional practice elements. Leaders were knowledgeable within their scope of responsibilities about performance opportunities highlighted by facility and CLC SAIL and should continue to take actions to sustain and improve performance of quality measure ratings.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic—an outbreak of a disease that occurs over a wide geographic area and affects an exceptionally high proportion of the population.[39]

The *U.S. Government COVID-19 Response Plan* was published on March 13, 2020, to outline the government's coordinated federal response activities for COVID-19 in the United States.[40] VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.[41]

During this time, VA continued providing for veterans' healthcare needs and engaged its fourth mission, "the provision of hospital care and medical services during certain disasters and emergencies" to persons "who would otherwise not have eligibility to receive such care and services."[42] "In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans."[43]

Due to VHA's mission-critical work in supporting both veteran and civilian populations during the pandemic, the OIG conducted an evaluation of the pandemic's impact on the medical center and its leaders' subsequent response. The OIG analyzed performance in the following domains:

- Emergency preparedness
- Supplies, equipment, and infrastructure
- Staffing
- Access to care
- CLC patient care and operations

[39] "WHO Director General's opening remarks at the media briefing on COVID-19 – 11 March 2020, World Health Organization, accessed March 23, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. "Definition of pandemic," Merriam Webster, accessed March 24, 2020, https://www.merriam-webster.com/dictionary/pandemic. A pandemic is an outbreak of a disease that occurs over a wide geographic area and affects an exceptionally high proportion of the population.

[40] Department of Health and Human Services, *U.S. Government COVID-19 Response Plan*, March 13, 2020.

[41] VHA, Office of Emergency Management, *COVID-19 Response Plan*, March 23, 2020.

[42] VA's missions include serving veterans through care, research, and training. A fourth mission for the provision of hospital care and medical services during certain disasters and emergencies was outlined by 38 CFR § 17.86 – [d]uring and immediately following a disaster or emergency…VA under 38 U.S.C §1785 may furnish hospital care and medical services (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency.

[43] VA OIG, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness, March 19–24, 2020*, Report #20-02221-120, March 26, 2020.

The OIG also surveyed medical center staff to solicit their feedback and potentially identify any problematic trends and/or issues that may require follow-up.

The results of the OIG's evaluation of the medical center's COVID-19 pandemic readiness and response will be compiled and reported with other facilities in a separate publication to provide stakeholders with a comprehensive picture of VHA challenges and ongoing efforts.

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.[44] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[45] 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.[46]

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 committee responsible for quality, safety, and value (QSV) oversight functions; its ability to review data, information, and risk intelligence; and its ability to ensure that key QSV functions are discussed and integrated on a regular basis. Specifically, OIG inspectors examined the following requirements:

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

The OIG reviewers also assessed the medical center's processes for conducting protected peer reviews of clinical care.[47] 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.[48] The OIG team examined the completion of the following elements:

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

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

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

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

[47] 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."

[48] VHA Directive 1190.

- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[49]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee
- 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.[50] 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.[51] Inspectors reviewed several aspects of the UM program:

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

Finally, the OIG reviewers assessed the medical center's reports of patient safety incidents with related root cause analyses.[52] Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the medical center.[53] The medical center was assessed for its performance on several dimensions:

[49] VHA Directive 1190.

[50] VHA Directive 1117, *Utilization Management Program*, October 8, 2020. UM reviews include evaluation of the "appropriateness, medical necessity and the efficiency of health care services, according to evidence-based criteria."

[51] VHA Directive 1117.

[52] 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."

[53] VHA Handbook 1050.01.

- Annual completion of a minimum of eight root cause analyses[54]
- Inclusion of required content in root cause analyses
- Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
- Provision of feedback about root cause analysis actions to reporting employees
- Submission of an 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.[55]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with most of the elements reviewed. However, the OIG noted a deficiency with the interdisciplinary review of UM data.

VHA requires that an interdisciplinary group review UM data. This group must include, but is not limited to, "representatives from UM, medicine, nursing, social work, case management, mental health, and chief business office revenue-utilization review (CBOR-UR)."[56] The OIG found social work and CBOR-UR representatives attended two of four UM Committee meetings between January 1, 2019 and December 31, 2019. As a result, the UM Committee performed reviews and analyses without the perspectives of key staff.

However, on October 8, 2020, VHA updated the requirement for the review of UM data to be performed by "a multidisciplinary committee, which may include representatives from" various services.[57] Therefore, the OIG made no recommendation.

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

[55] The OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

[56] VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019.

[57] VHA Directive 1117, *Utilization Management Program*, October 8, 2020.

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).[58]

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.[59]

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

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[61]
  - 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[62]
  - Evaluation by another provider with similar training and privileges

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

[59] VHA Handbook 1100.19.

[60] VHA Handbook 1100.19.

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

[62] VHA Acting DUSHOM Memorandum, *Requirements for Peer Review of Solo Practitioners*.

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 subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[63] 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."[64] 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:

- Twelve solo/few practitioners who underwent initial or reprivileging during calendar year 2019[65]
- Ten LIPs who completed an FPPE in calendar year 2019
- Ten LIPs privileged during calendar year 2019
- Twelve LIPs who left the medical center in calendar year 2019

Medical Staff Privileging Findings and Recommendations

The OIG identified deficiencies with FPPE, OPPE, and provider exit review processes.

VHA requires FPPE criteria "to be defined in advance, using objective criteria accepted by the practitioner."[66] The OIG found 4 of 12 providers' profiles contained evidence that the LIPs were

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

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

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

[66] VHA Handbook 1100.19.

aware of the criteria for evaluation before service chiefs initiated the FPPE process. This could have resulted in the remaining LIPs not being aware of FPPE expectations. Service chiefs provided individual explanations for the FPPE processes at the service level. Surgery service leaders were unable to provide documentation of one provider accepting the criteria in advance. The Health System Specialist to the Chief of Staff reported that the former Assistant Chief of Primary Care, who was responsible for onboarding new primary care providers, was no longer in the role and was on leave during the OIG inspection. Primary care leaders were unable to provide evidence that four providers had accepted the criteria in advance. The Chief of Medicine described discussing FPPE criteria with new providers during the hiring process; however, there was no documentation that two providers reviewed had accepted the criteria in advance. The Chief of Therapeutic and Diagnostic Imaging Service reported that, due to an oversight, one provider did not receive the criteria in advance.

Recommendation 1

1. The Chief of Staff evaluates and determines additional reasons for noncompliance and ensures service chiefs define in advance, communicate, and document expectations for focused professional practice evaluations in provider profiles.

Medical center concurred.

Target date for completion: March 31, 2021

Medical center response: The Chief of Staff office updated the process for tracking Focused Professional Practice Evaluation (FPPE) Memorandums in September 2020. Prior to or on the first day of New Employee Orientation, the COS [Chief of Staff] or designee sends out tasking to the appropriate service chief requiring a copy of the signed and dated FPPE Plan memo be provided to the COS office and Medical Staff Office. The COS office maintains the copy for three years as a backup to the established process where the service maintains the original signed memo. The Medical Staff Office will suspense the Service Chief to ensure fee basis and contract staff providers sign the FPPE memorandum immediately after privileges are approved (electronic signature acceptable). The Service Chief will report the start dates of fee basis and contract providers for the previous month at the first Professional Standards Board (PSB) meeting of the month. Monitoring was implemented in October 2020 with data being reported monthly to the PSB and Clinical Executive Board (CEB). Sustained compliance of 90% or greater for a minimum of six (6) months will be achieved for monitor closure.

VHA requires that service chiefs include the minimum specialty-specific criteria for FPPEs and OPPEs of gastroenterology, nuclear medicine, pathology, and radiation oncology practitioners.[67] The OIG found that two of the four provider profiles reviewed (a gastroenterology provider and

[67] VHA Acting DUSHOM Memorandum, *Requirements for Peer Review of Solo Practitioners*.

a pathology provider) contained the minimum specialty-specific criteria. The remaining two providers reviewed (nuclear medicine) lacked the minimum specialty criteria in their profiles. This resulted in the nuclear medicine providers practicing without a thorough evaluation of competency. The Chief of Therapeutic and Diagnostic Imaging Service acknowledged that the providers' professional practice evaluations had general radiology criteria but should have also contained the standard elements required by VHA for nuclear medicine.

Recommendation 2

2. The Chief of Staff determines the reasons for noncompliance and makes certain that service chiefs include the minimum specialty-specific criteria for professional practice evaluations of licensed independent practitioners.

Medical center concurred.

Target date for completion: April 30, 2021

Medical center response: The COS [Chief of Staff] tasked the applicable services to include the standard elements required by Veterans Health Administration (VHA) in specialties that VHA requires minimum criteria be included in the professional practice evaluation. For example, ensure Nuclear Medicine chart reviews for all radiologists that perform nuclear medicine work are part of their Ongoing Professional Practice Evaluation (OPPE). Audit by applicable Service Chiefs of one chart review per specialty per month, reported at the PSB [Professional Standards Board] (Nuclear Medicine, Radiation Oncology, Pathology, Gastroenterology). Data tracking started in November 2020. Monitoring data will be reported monthly to the PSB and the CEB [Clinical Executive Board]. Sustained compliance of 90% or greater for a minimum of six (6) consecutive months will be achieved for monitor closure.

VHA requires that all LIPs new to the medical center have FPPEs completed and documented in the practitioner's provider profile and the evaluation results reported to the Executive Committee of the Medical Staff, which is referred to as the Clinical Executive Board at this facility. The FPPE process involves the evaluation of "privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges" at the medical center.[68] For 11 of 12 newly hired LIPs, the OIG found evidence that FPPE results were documented in the provider's profile and reported to the Clinical Executive Board. This resulted in a solo provider practicing without a thorough evaluation of competency, which may have affected quality care and patient safety.

The solo provider mentioned above was hired at the medical center in November 2018; medical center staff provided the OIG with an unsigned memo dated November 28, 2018, which introduced the FPPE to the provider. The Chief of Surgery reported that the provider's FPPE was

[68] VHA Handbook 1100.19.

completed; however, the medical center did not produce evidence of the completed FPPE, and Clinical Executive Board minutes from February 2019 through September 2019 lacked documentation of the completed FPPE results. The Chief of Surgery reported that the provider underwent a review of practice in October 2019 due to performance issues. The OIG identified similar concerns with the FPPE process during the prior CHIP site visit in 2018.[69]

Recommendation 3

3. The Chief of Staff determines the reasons for noncompliance and makes certain that service chiefs complete and document focused professional practice evaluations on all newly hired licensed independent practitioners and evaluation results are reviewed and documented by the Clinical Executive Board.

Medical center concurred.

Target date for completion: May 31, 2021

Medical center response: The COS [Chief of Staff] directed the Medical Staff Office designee to update and simplify the FPPE tracking database. Each month the applicable service(s) are tasked to provide a signed copy of the FPPE completion memo for all providers approved to transition to OPPE to the Medical Staff Office within seven (7) days of the PSB [Professional Standards Board] meeting. A 100% audit report at the following PSB will be reported by the Medical Staff Office. Monitoring began in December 2020 with data reported monthly to the PSB and CEB [Clinical Executive Board]. Sustained compliance of 90% or greater for a minimum of six (6) consecutive months will be achieved for monitor closure.

VHA requires that service chiefs consider relevant service- and practitioner-specific data when recommending the continuation of privileges to the Executive Committee of the Medical Staff.[70] For 14 of 20 providers reprivileged in calendar year 2019, the OIG found that service chiefs recommended the continuation of privileges based, in part, on service-specific OPPE data. For the remaining six LIPs, the Clinical Executive Board had inadequate data to support decisions to continue clinical privileges. Despite being in the role since 2015, the Chief of Medicine reported not being aware of the requirement for OPPEs to have service-specific elements until 2019, after which new forms were implemented.

[69] VA OIG, *Comprehensive Healthcare Inspection Program Review of the Dayton VA Medical Center, Ohio*, Report No. 18-00619-242, August 14, 2018.

[70] VHA Handbook 1100.19.

Recommendation 4

4. The Chief of Staff evaluates and determines additional reasons for noncompliance and ensures that reprivileging decisions are based on service-specific ongoing professional practice evaluation data.

Medical center concurred.

Target date for completion: July 30, 2021

Medical center response: The COS [Chief of Staff] tasked the services to update one of the following: chart review forms to include specialty specific criteria or update OPPE data for semi-annual reviews that includes specialty specific data. Copies of chart review forms with specialty specific criteria or semi-annual review summaries with specialty specific data were submitted at the November 2020 PSB [Professional Standards Board] meeting. Providers continue to be individually evaluated at the PSB and CEB [Clinical Executive Board] prior to renewal of privileges based on approved OPPE criteria as presented by the service chief. Effective with the November 2020 PSB meeting, all specialties have OPPE programs which include specialty specific data tied to privileges. An audit of privilege renewal reviews to show compliance will start in January 2021 PSB. Service chief action was completed in November with tracking of criteria being specific to the service or section to start in February 2021. Monitoring data will be reported monthly to the PSB and CEB. Sustained compliance of 90% or greater for a minimum of six (6) consecutive months will be achieved for monitor closure.

VHA requires that "Provider Exit Review forms are completed within 7 calendar days of departure of any licensed health care professional and that SLB reporting is initiated when a licensed health care professional has been identified as performing substandard care."[71] The OIG found that 7 of 12 providers who departed the medical center in calendar year 2019 had exit forms completed within seven calendar days. When providers' exit forms are not completed in a timely manner, reporting of potential substandard care to SLBs could be delayed. The Credentialing Coordinator reported that providers were supposed to notify the credentialing department as part of the exit process, but this did not happen consistently. The Credentialing Coordinator did not provide any reasons for noncompliance.

Recommendation 5

5. The Medical Center Director determines 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.

[71] VHA Notice 2018-05.

Medical center concurred.

Target date for completion: March 31, 2021

Medical center response: The Medical Center Director instructed the Medical Staff Office to collaborate with Human Resources to ensure receipt of departure information timely. Dayton VAMC is participating in the VISN-wide initiative to implement a clearance process with an electronic form that includes the Medical Staff Office (MSO) so that the MSO receives notice the day the provider terminates employment. The COS [Chief of Staff] and the services established December 31st each year (the end of contract for Fee Basis Providers) as the standard departure date for any fee basis providers not being renewed. For Fee Basis providers not being renewed for performance or clinical care issues, the service chief will bring the issues to the PSB [Professional Standards Board] when it is identified. In that case, the exit review suspense will be sent upon approval of the PSB and CEB [Clinical Executive Board] minutes with documentation of the decision not to renew the provider. A suspense will go out to services by December 15th each year requesting information and evaluations be sent on the last duty day of the year. For contracts, Contracting Officer Representatives will be responsible for identifying departing contract providers departure dates. The COR [Contracting Office Representative] will notify the applicable service chief and the MSO by e-mail when a contract provider is identified as no longer providing services. Monitoring began in October 2020 with data reported monthly to the PSB and the CEB. Sustained compliance of 90% or greater for a minimum of six (6) consecutive months will be achieved for monitor closure.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[72] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[73] 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.[74] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[75]

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.[76] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[77] 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.[78] 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.[79]

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

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

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[72] "Information Sheet on Opioid Overdose," World Health Organization, accessed November 6, 2019, https://www.who.int/substance_abuse/information-sheet/en/.

[73] "Opioid Overdose, Understanding the Epidemic," Centers for Disease Control and Prevention, accessed November 6, 2019, https://www.cdc.gov/drugoverdose/epidemic.

[74] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*, Version 3.0. February 2017.

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

[76] "Benzodiazepines, Street Names: Benzos, Downers, Nerve Pills, Tranks," U.S. Drug Enforcement Administration, accessed December 1, 2019, https://www.deadiversion.usdoj.gov/drug_chem_info/benzo.pdf. Benzodiazepines "are a class of drugs that produce central nervous system (CNS) depression and that are most commonly used to treat insomnia and anxiety."

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

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

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

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

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures include, but are not limited to, "adherence to published clinical practice guidelines, timeliness of pain treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment…patient satisfaction, physical and psychosocial functioning, and quality of life."[80] The OIG examined 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 45 randomly 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 inspection 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 OIG found the medical center addressed many of the indicators of expected performance, including pain screening, aberrant behavior risk assessment, documented justification for concurrent therapy with benzodiazepines, urine drug testing, informed consent, and timely follow-up. However, the OIG found a deficiency with the Multidisciplinary Pain Management Committee's oversight and monitoring of quality measures.

VHA requires the facility to have a multidisciplinary pain management committee to "provide oversight, coordination, and monitoring of pain management activities and processes…[which includes] the quality of pain assessment and effectiveness of pain management interventions."[81] Although the Multidisciplinary Pain Management Committee met twice between July 1, 2019, and December 31, 2019, there were no measures in place to evaluate the quality or effectiveness of pain management care, such as adherence to published clinical practice guidelines, timeliness of pain treatment, adequacy of pain control, or patient satisfaction. This resulted in the committee's inability to oversee, coordinate, and monitor the medical center's provision of pain

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

management care and quality. The Chief of Rehabilitation Service reported that pain assessments were completed, but not reported to the committee.

Recommendation 6

6. The Medical Center Director determines the reasons for noncompliance and makes certain that the Multidisciplinary Pain Management Committee monitors the quality of pain assessment and the effectiveness of pain management interventions.

Medical center concurred.

Target date for completion: May 31, 2021

Medical center response: The Medical Center Director concurred with the appointment of the Medical Director of Integrated Medicine as the chair for the multi-disciplinary Pain Management Committee. The committee meets monthly and will address the quality of pain assessments, and the effectiveness of pain management interventions. This data will be reviewed by the committee and included in the minutes. The committee minutes will be monitored until 90% or greater compliance is maintained for 6 consecutive months. The monitor will be reported quarterly into the Quality Patient Safety Board (QPSB).

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.[82] 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.[83] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[84]

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.[85]

VHA requires that each medical center and very large community-based outpatient clinic 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.[86] The OIG examined various requirements related to SPCs:

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

[82] "Preventing Suicide," Centers for Disease Control and Prevention, accessed on March 4, 2020, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.

[83] 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*.

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

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

[86] 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.

VHA also requires that any patient determined to be at high risk for suicide be added to the facility high-risk list and have a High Risk for Suicide (HRS) Patient Record Flag (PRF) placed in his or her electronic health record "as soon as possible but no later than 1 business day after such determination by the SPC."[87] 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."[88] 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.[89] 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.[90]

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."[91] 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."[92] 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."[93]

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

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

[89] *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.

[90] A safety plan is a "written list of coping strategies and sources of support that patients can 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*.

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

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

[93] VHA, response to questions by VA OIG Office of Healthcare Inspections from February 12, 2020, received February 19, 2020.

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 is warranted, patients identified as at-risk for suicide could have flags placed in their charts 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."[94]

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.[95] VHA also requires that all staff receive annual refresher training.[96] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[97]

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

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

[95] 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.

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

[97] VHA DUSHOM Memorandum, *Suicide Awareness Training*, April 11, 2017. 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.

- Relevant documents;
- The electronic health records of 38 outpatients whose electronic health records were flagged as high risk for suicide from July 1, 2018, to June 30, 2019; and
- Staff training records.

Mental Health Findings and Recommendations

The OIG found the medical center complied with requirements for a designated SPC, tracking of high-risk veterans, and suicide prevention training.

However, the OIG found deficiencies. With VHA's original requirement that was in place when these patients received care—that "Any patient determined to be High Risk for Suicide must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"[98]—the OIG estimated that 50 percent of HRS PRFs were placed within 24 hours of referral to the SPC.[99] Based on the current updated requirement that the SPC be responsible for determining placement of the HRS PRF (without a defined timeframe for doing so), the OIG further calculated that the average time from referral to HRS PRF placement for the patients reviewed was five days (observed range was 0–32 days).

The OIG also noted concerns with the completion of four appointments within the required time frame, provider and SPC collaboration after unsuccessful patient follow-up, and timely safety plan completion.

VHA requires a veteran to have four follow-up visits with a qualified provider within 30 days of the HRS PRF placement. The follow-up visits should be face-to-face unless the veteran requests a telephonic visit, and there must be documentation identifying the veteran's preference for a telephone call.[100] The OIG estimated that providers conducted four mental health visits within 30 days of HRS PRF placements for 74 percent of electronic health records reviewed.[101] Insufficient follow-up with the remaining high-risk veterans may potentially lead to a lack of appropriate and timely care. The Chief of Mental Health reported that veterans who have an HRS PRF placed while in the inpatient setting receive education on the importance of follow-up. Compliance with the appointments was tracked and monitored by mental health leaders on a weekly basis.

The Chief of Mental Health reports veterans who had an HRS PRF placed in the outpatient setting were not included in the weekly monitoring process, nor did they have four appointments

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

[99] The OIG estimated that 95 percent of the time, the true compliance rate is between 34.2 and 65.8 percent, which is statistically significantly below the 90 percent benchmark.

[100] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care Suicide Prevention Coordinator Guide*, January 5, 2018.

[101] The OIG estimated that 95 percent of the time, the true compliance rate is between 59.0 and 87.2 percent, which is statistically significantly below the 90 percent benchmark.

scheduled at the time of HRS PRF placement. Follow-up was the responsibility of the Suicide Prevention Program and according to the SPC, a national database was used as a tracking tool to monitor attendance. The SPC stated staffing issues affected the ability to meet requirements and reported that from June 2018 to January 2019, the Suicide Prevention Program had vacancies in two of four positions.

Recommendation 7

7. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that qualified providers conduct four follow-up visits within 30 days of a High Risk for Suicide Patient Record Flag placement.

Medical center concurred.

Target date for completion: May 31, 2021

Medical center response: The Mental Health Service Line will ensure patients that have a High Risk for Suicide Patient Record Flag are scheduled for the required four (4) visits in the first 30 days of being identified as high risk or at discharge from the Dayton Veterans Administration Medical Center (VAMC) or a community hospital. When a Suicide Prevention Case Manager (SPCM) is contacted by a community hospital, care coordination is initiated. This includes the scheduling of four (4) visits within 30 days post discharge. Sustained compliance of 90% or greater for a minimum of six consecutive months will be achieved for monitor closure. The data will be reported monthly to the Mental Health Quality Council (MHQC) and the QPSB [Quality Patient Safety Board] quarterly.

For patients with an HRS PRF who miss mental health appointments, VHA requires that a mental health provider attempt to contact the patient. Further, when attempted contact is unsuccessful, "the suicide prevention coordinator will collaborate with the treatment provider(s) to determine the next appropriate step utilizing clinical judgment and the pre-developed Safety Plan."[102] The OIG found that collaboration efforts were documented in three of the five electronic health records reviewed. Failure to follow up with a patient who is at high risk for suicide could result in missed opportunities to identify potential interventions and offer additional treatment. The Program Director for Ambulatory Mental Health indicated that there was "not a prompt" for the provider to collaborate with the SPC when attempts to contact the patient were unsuccessful. Additionally, the SPC stated that from June 2018 to January 2019, the Suicide Prevention Program had vacancies in two of four positions; this affected the medical center's ability to meet requirements. However, the OIG made no recommendations due to the small sample of patients identified for this review element.

[102] VHA DUSHOM Memorandum, *Guidance on Patients Failure to Attend Appointments (No Shows)*, August 6, 2013.

According to guidance from a VHA subject matter expert to OIG, "for patients with a new or reactivated HRS-PRF, the safety plan should be completed within 7 days before or after the current HRS-PRF date."[103] The OIG estimated that 68 percent of patients had a safety plan completed within seven days before or after the high-risk designation, based on electronic health records reviewed.[104] When safety plans are not completed in a timely manner, patients may not be able find critical resources when needed.

The SPC stated that from June 2018 to January 2019, the Suicide Prevention Program had vacancies in two of four positions; this affected the medical center's ability to meet requirements. Additionally, the lead psychologist indicated that documentation requirements were very lengthy and time-consuming, especially for new patient appointments. If the veteran appeared late for an appointment, less time was available to complete the documentation.

Recommendation 8

8. The Chief of Staff evaluates and determines additional reasons for noncompliance and ensures that clinicians complete patient safety plans within seven days before or after the current High Risk for Suicide Patient Record Flag date.

Medical center concurred.

Target date for completion: May 31, 2021

Medical center response: The Mental Health Service Line will ensure Veterans with a new or reactivated High Risk for Suicide Flag has a completed or updated safety plan in the Electronic Health Record (EHR) within 7 days of the flag placement and the contract is documented in the EHR. If the Veteran declines a safety plan this is documented in the EHR. Sustained compliance of 90% or greater for a minimum of six consecutive months will be achieved for monitor closure. The data will be reported monthly to the MHQC [Mental Health Quality Council] and QPSB [Quality Patient Safety Board] quarterly.

[103] VHA suicide subject matter expert response to timing of safety plan completion, July 8, 2019.

[104] The OIG estimated that 95 percent of the time, the true compliance rate is between 50.0 and 83.9 percent, which is statistically significantly below the 90 percent benchmark.

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."[105]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD handbook by July 12, 2018.[106] 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.[107] 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.[108]

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.

[105] 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.

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

[107] 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.

[108] VHA Directive 1139, *Palliative Care Consult Teams (PCCT) And VISN Leads*, June 14, 2017. Hospice patients are defined 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 address 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.[109] Inspectors examined if the medical center established an LSTD committee that was comprised of a multidisciplinary membership, which included representation from the 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 39 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

[109] VHA Handbook 1004.03(1).

Care Coordination Findings and Recommendations

The OIG found the medical center generally complied with requirements for a multidisciplinary LSTD committee and supervision of designees. Additionally, with VHA's original requirements that were in place when these patients received care, the OIG estimated that

- 49 percent of patients' LST progress notes addressed identification of a surrogate if the patient loses decision-making capacity,[110]
- 26 percent of patients' LST progress notes addressed previous advance directive(s), state-authorized portable orders, and/or LST notes, and[111]
- 49 percent of patients' LST progress notes addressed the patient's or surrogate's understanding of the patient's condition.[112]

However, VHA amended requirements for the documentation of these elements in the LST progress note. The OIG did not issue recommendations on these original requirements but remains concerned that this change could result in practitioners not addressing these important goals of care conversation elements.

Further, during the electronic health record review, the OIG discovered inpatient records in which the committee responsible for reviewing LSTD was not consulted as required.

VHA requires a multidisciplinary committee to review life-sustaining treatment plans for patients who lack decision-making capability and do not have a decision-making surrogate.[113] The OIG discovered inpatient electronic health records in which the provider identified the patients as lacking both decision-making capacity and a surrogate but did not place a referral to the multidisciplinary committee. Additionally, resident physicians had initiated LSTD notes that were incomplete, had conflicting information, and were not signed by a delegating provider; some notes also indicated that they were referred to or had been approved by the multidisciplinary committee. Failure to ensure that life-sustaining treatment plans are reviewed by a multidisciplinary committee may impede effective and ethical decision-making for initiation, limitation, or discontinuation of life-sustaining treatments on behalf of incapacitated patients. The LSTD Initiative Implementation Coordinator did not provide a reason for the lack of committee referrals but stated the resident physicians may have confused the daily inpatient multidisciplinary rounds with the formal LSTD consult process as one reason why some notes indicated approval from the multidisciplinary committee.

[110] The OIG estimated that 95 percent of the time, the true compliance rate is between 33.3 and 65.0 percent, which is statistically significantly below the 90 percent benchmark.

[111] The OIG estimated that 95 percent of the time, the true compliance rate is between 12.5 and 40.0 percent, which is statistically significantly below the 90 percent benchmark.

[112] The OIG estimated that 95 percent of the time, the true compliance rate is between 33.3 and 64.9 percent, which is statistically significantly below the 90 percent benchmark.

[113] VHA Handbook 1004.03(1).

Recommendation 9

9. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that life-sustaining treatment plans for patients who lack both decision-making capacity and a surrogate are referred to and reviewed by the assigned multidisciplinary committee.

Medical Center concurred.

Target date for completion: May 31, 2021

Medical Center response: The Hospitalists, attendings, and residents will be educated on consulting the Facility's Multidisciplinary Committee (Consultative Ethics Service) when patients lack capacity and have no surrogate. The life-sustaining treatment (LST) notes in the electronic health record (EHR) will be monitored for consultation to the Facility's Multidisciplinary Committee (Consultative Ethics Service) when patients lack capacity and have no surrogate. The monitor is reported monthly at the Community Living Center (CLC), Extended Care Quality Council (ECQC) meeting and quarterly at the QPSB [Quality Patient Safety Board]. Sustained compliance of 90% or greater for six (6) consecutive months will be achieved for monitor closure.

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[114] 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.[115] To help the VA better understand the needs of the growing women veterans 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."[116] 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."[117]

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.[118] 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."[119]

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:

- Provision of care requirements
    - Designated Women's Health Patient Aligned Care Team established
    - Primary Care Mental Health Integration services available
    - Gynecologic care coverage available 24/7

[114] "VETPOP2016 LIVING VETERANS BY AGE GROUP, GENDER, 2015-2045," Table 1L, National Center for Veterans Analysis and Statistics, accessed November 14, 2019, https://www.va.gov/vetdata/Veteran_Population.asp.

[115] "Veteran Population," National Center for Veterans Analysis and Statistics, accessed September 16, 2019, https://www.va.gov/vetdata/docs/Demographics/VetPop_Infographic_2019.pdf.

[116] Department of Veterans Affairs, "Study of Barriers for Women Veterans to VA Health Care," Final Report, April 2015.

[117] 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.

[118] VHA Directive 1330.01(4), *Health Care Services for Women Veterans,* February 15, 2017, amended January 8, 2021.

[119] VHA Directive 1330.01(4).

  - Facility women's health primary care providers designated
  - Community-based outpatient clinic women's health primary care providers designated
- Oversight of program and monitoring of performance improvement data
  - Women Veterans Health Committee established
    - Quarterly meetings held
    - Core members attend
    - Quality assurance data collected and tracked
    - Reports made to clinical executive leaders
- Assignment of required staff
  - Women Veterans Program Manager
  - Women's Health Medical Director or clinical champion
  - Maternity Care Coordinator
  - Women's health clinical liaison at each community-based outpatient clinic

Women's Health Findings and Recommendations

The medical center generally complied with requirements for the provision of care indicators and most staffing elements reviewed. However, the OIG identified that the Women Veterans Program Manager had an assigned collateral duty.

VHA requires the facility to have a women veterans program manager who is full-time and free of collateral duties.[120] The OIG found the Women Veterans Program Manager had been also serving as the acting VISN 10 Women Veterans Program Lead for the past three years. This could negatively impact the medical center's ability to deliver the best healthcare services to women veteran patients due to potential multiple competing priorities. The Women Veterans Program Manager reported that the collateral duty began in July 2017 with the resignation of the prior lead. At the time of the virtual CHIP visit, the Women Veterans Program Manager stated the VISN had plans to fill the position and processes were in place to post the vacancy.

Recommendation 10

10. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures the medical center's Women Veterans Program Manager is free of collateral duties.

[120] VHA Directive 1330.01(4).

Medical center concurred.

Target date for completion: March 31, 2021

Medical center response: The Medical Center Director supports the Dayton Women Veterans Program. The Dayton Women Veterans Program Manager (WVPM) assumed the collateral duty of the VISN 10 WVPM due to a position vacancy. The VISN has posted a position for a VISN Special Populations Manager. The posting has closed, and interviews are currently in process. The Dayton WVPM will be relieved of the collateral duty when the new Population Manager is hired and is active in the role.

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have Sterile Processing Services (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment."[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 that are based on current manufacturers' 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, personal protective equipment available for immediate use, and standard operating procedures readily available to guide the reprocessing of RME.[127]

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

[122] Julie Jefferson, Martha Young. *APIC Text of Infection Control and Epidemiology.* Association for Professionals in Infection Control and Epidemiology, 2019. "Chapter 107: Sterile Processing."

[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.

[127] VHA Directive 1116(2).

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

To determine whether the medical center complied with OIG-selected requirements, the inspection team examined relevant documents and training records and interviewed key managers and staff on the following:

- Requirements for administrative processes
  - RME inventory file is current
  - Standard operating procedures 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 monitored
  - Eyewash station checked
  - Daily cleaning schedule maintained
  - Required temperature and humidity maintained
- Monitoring of quality assurance
  - High-level disinfectant solution tested
  - Bioburden tested
- Completion of staff training, competency, and continuing education
  - Required training completed in a timely manner
  - Competency assessments performed
  - Monthly continuing education received

High-Risk Processes Findings and Recommendations

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

[128] VHA Directive 1116(2).

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 (medical center) • VHA performance data for CLCs	Ten 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 and Chief of Staff. See details below.
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback	The results of the OIG's evaluation of the medical center's COVID-19 pandemic readiness and response will be compiled and reported with other facilities in a separate publication to provide stakeholders with a comprehensive picture of VHA challenges and ongoing efforts.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• None	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• Service chiefs define in advance, communicate, and document expectations for FPPEs in provider profiles. • Service chiefs include the minimum specialty-specific criteria for professional practice evaluations of licensed independent practitioners. • Service chiefs complete and document FPPEs on all newly hired licensed independent practitioners and evaluation results are reviewed and documented by the Clinical Executive Board. • Reprivileging decisions are based on service-specific OPPE data.	• Provider exit review forms are completed within seven calendar days of licensed healthcare professionals' departure from the medical center.

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	• The Multidisciplinary Pain Management Committee monitors the quality of pain assessment and the effectiveness of pain management interventions.
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Tracking and follow-up of high-risk veterans • Provision of suicide prevention care • Completion of suicide prevention training requirements	• Qualified providers conduct four follow-up appointments within 30 days of High Risk for Suicide Patient Record Flag placement. • Clinicians complete safety plans within the required time frame for patients with High Risk for Suicide Patient Record Flags.	• None
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• Life-sustaining treatment plans for patients who lack both decision-making capacity and a surrogate are referred to and reviewed by the assigned multidisciplinary committee	• None
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• The Women Veterans Program Manager is free of collateral duties.	• None
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Quality assurance monitoring • Staff training	• None	• None

Appendix B: Medical Center Profile

The table below provides general background information for this mid-high complexity (1c) affiliated[1] medical center reporting to VISN 10.[2]

Table B.1. Profile for Dayton VA Medical Center (552)
(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	$408,580,165	$434,447,748	$438,975,915
Number of:			
• Unique patients	40,254	40,538	41,397
• Outpatient visits	498,573	520,309	521,288
• Unique employees[6]	2,057	1,991	2,018
Type and number of operating beds:			
• Community living center	200	200	200
• Domiciliary	99	99	99
• Medicine	35	35	35
• Mental Health	25	25	25
• Surgery	31	31	31
Average daily census:			
• Community living center	128	121	108
• Domiciliary	87	74	68
• Medicine	36	35	28
• Mental health	10	8	10
• Surgery	7	7	7

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

[1] Associated with a medical residency program.

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

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

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

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

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

Appendix C: VA Outpatient Clinic Profiles[1]

The VA outpatient clinics in communities within the catchment area of the healthcare system 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
Middletown, OH	552GA	9,078	2,759	Anesthesia Cardiology Dermatology Endocrinology Eye Nephrology Podiatry	EKG	Nutrition Weight management

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

[2] VHA Directive 1230(2), *Outpatient Scheduling Processes And Procedures*, July 15, 2016, amended January 22, 2020. An encounter is a "professional contact between a patient and a provider 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.

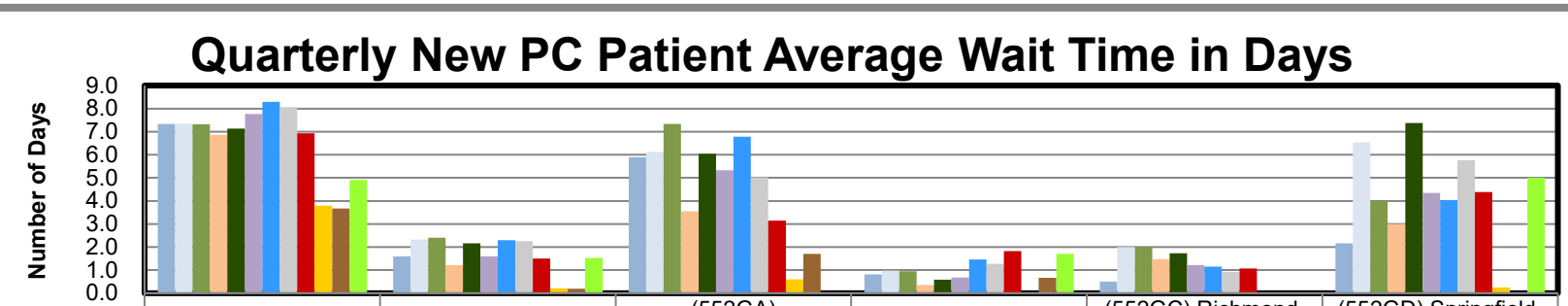
[4] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

[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
Lima, OH	552GB	8,870	2,423	Anesthesia Cardiology Dermatology Endocrinology Eye General surgery Nephrology Podiatry	EKG	Nutrition Pharmacy Prosthetics Social work Weight management
Richmond, IN	552GC	7,724	2,531	Anesthesia Cardiology Dermatology Endocrinology Eye Nephrology Podiatry	EKG	Nutrition Prosthetics Social work Weight management
Springfield, OH	552GD	7,640	2,592	Anesthesia Cardiology Dermatology Endocrinology Eye General surgery Nephrology Podiatry	EKG	Nutrition 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

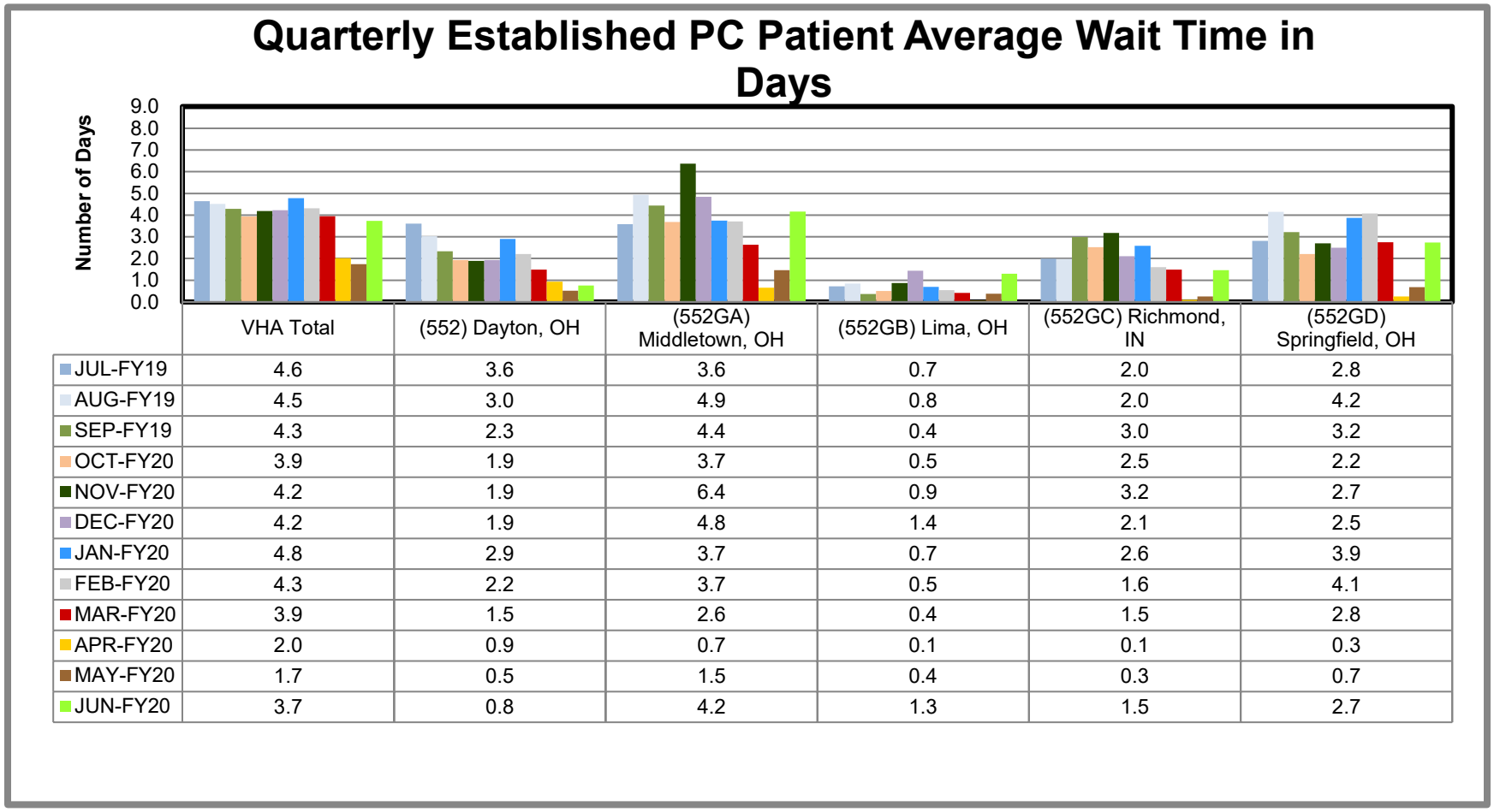


	VHA Total	(552) Dayton, OH	(552GA) Middletown, OH	(552GB) Lima, OH	(552GC) Richmond, IN	(552GD) Springfield, OH
JUL-FY19	7.3	1.6	5.9	0.8	0.5	2.2
AUG-FY19	7.4	2.3	6.1	1.0	2.0	6.5
SEP-FY19	7.3	2.4	7.3	1.0	2.0	4.0
OCT-FY20	6.9	1.2	3.6	0.4	1.5	3.0
NOV-FY20	7.1	2.2	6.0	0.6	1.7	7.4
DEC-FY20	7.8	1.6	5.3	0.7	1.2	4.3
JAN-FY20	8.3	2.3	6.8	1.5	1.2	4.0
FEB-FY20	8.1	2.3	5.0	1.3	0.9	5.8
MAR-FY20	6.9	1.5	3.2	1.8	1.1	4.4
APR-FY20	3.8	0.2	0.6	0.0	n/a	0.3
MAY-FY20	3.7	0.2	1.7	0.7	n/a	n/a
JUN-FY20	4.9	1.5	0.0	1.7	0.0	5.0

[1]

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 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 FY 2015, this metric was calculated using the earliest possible create date. The absence of reported data is indicated by "n/a."

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



	VHA Total	(552) Dayton, OH	(552GA) Middletown, OH	(552GB) Lima, OH	(552GC) Richmond, IN	(552GD) Springfield, OH
JUL-FY19	4.6	3.6	3.6	0.7	2.0	2.8
AUG-FY19	4.5	3.0	4.9	0.8	2.0	4.2
SEP-FY19	4.3	2.3	4.4	0.4	3.0	3.2
OCT-FY20	3.9	1.9	3.7	0.5	2.5	2.2
NOV-FY20	4.2	1.9	6.4	0.9	3.2	2.7
DEC-FY20	4.2	1.9	4.8	1.4	2.1	2.5
JAN-FY20	4.8	2.9	3.7	0.7	2.6	3.9
FEB-FY20	4.3	2.2	3.7	0.5	1.6	4.1
MAR-FY20	3.9	1.5	2.6	0.4	1.5	2.8
APR-FY20	2.0	0.9	0.7	0.1	0.1	0.3
MAY-FY20	1.7	0.5	1.5	0.4	0.3	0.7
JUN-FY20	3.7	0.8	4.2	1.3	1.5	2.7

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
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES Data Use	Composite measure based on three individual AES (All Employee Survey) data use and sharing questions	A higher value is better than a lower value
Care transition	Care transition (inpatient)	A higher value is better than a lower value
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
ED Throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like – HED90_1	Healthcare Effectiveness Data and Information Set (HEDIS) composite score related to outpatient behavioral health screening, prevention, immunization, and tobacco	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS composite score related to outpatient care for diabetes and ischemic heart disease	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value

[1] "Strategic Analytics for Improvement and Learning (SAIL)," VHA Support Service Center, accessed March 6, 2020, https://vaww.vssc.med.va.gov/vsscenhancedproductmanagement/displaydocument.aspx?documentid=9428. (This is an internal VA website not publicly accessible.)

Measure	Definition	Desired Direction
Oryx – GM90_1	ORYX inpatient composite of global measures	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
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher 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
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
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.
Outpatient ED visit (SS)	Short-stay measure: percent of short-stay residents who have had an outpatient emergency department (ED) visit.

[1] Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)," Center for Innovation & Analytics, accessed November 13, 2020, http://vssc.med.va.gov/webrm/vssc_linksv2.aspx?PROD_ID=4466&index=1. (This is an internal VA website not publicly accessible.)

Measure	Definition
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 rehospitalized 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: December 22, 2020

From: Network Director, VA Healthcare System (10N10)

Subj: Comprehensive Healthcare Inspection of the Dayton VA Medical Center in Ohio

To: Director, Office of Healthcare Inspections (54CH03)

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

1. I have reviewed and concur with the response for the draft report of our Comprehensive Healthcare Inspection Program (CHIP) review of the Dayton VAMC.
2. I concur with the responses and action plans submitted by the Dayton VA Medical Center Director.
3. Thank you for the opportunity to respond to this report.

(Original signed by:)

RimaAnn O. Nelson
Network Director

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: December 20, 2020

From: Director, (552/00)

Subj: Comprehensive Healthcare Inspection of the Dayton VA Medical Center in Ohio

To: Director, VA Healthcare System (10N10)

1. I have reviewed the Status Request – Comprehensive Healthcare Inspection Program Review of the Dayton VA Medical Center, Ohio.
2. I concur with the responses submitted by the Dayton VA Medical Center.

(Original signed by:)

Jennifer De Francesco
for
Mark Murdock, MHA, FACHE

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