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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Illiana Health Care System in Danville, Illinois

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Figure 1. *Danville VA Medical Center of the VA Illiana Health Care System in Illinois.*

Source: https://www.va.gov/illiana-health-care/locations/ (*accessed July 3, 2023*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Illiana Health Care System, which includes the Danville VA Medical Center and multiple outpatient clinics in Illinois. 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 the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

The OIG initiated an unannounced inspection of the VA Illiana Health Care System during the week of June 12, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued two recommendations to the Chief of Staff in the Medical Staff Privileging and Mental Health areas of review. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 20.

VA Comments

The Veterans Integrated Service Network Director and Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 23–24, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Illiana Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[1]

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.[2] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[3]

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:[4]

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

[1] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

[2] 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): 13, https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae F. Sfantou et al., "Importance of Leadership Style towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, https://doi.org/10.3390/healthcare5040073.

[4] CHIP site visits addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The VA Illiana Health Care System includes the Danville VA Medical Center and multiple outpatient clinics in Illinois. General information about the healthcare system can be found in appendix B.

The OIG initiated an unannounced inspection of the VA Illiana Health Care System the week of June 12, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[6] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, 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 healthcare system leaders complete corrective actions. The Executive Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that 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's last comprehensive healthcare inspection of the VA Illiana Health Care System occurred in January 2020. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in May 2021, and a laboratory review in February 2023.

[6] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[7] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their organization's vision and strategy, and "practice systems thinking and collaboration across boundaries."[8] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[9]

To assess this healthcare system's leadership and risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and healthcare system leaders' responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the chief of staff and associate director positions had been vacant since February and April 2023, respectively.[10] The Director was newest member of the leadership team, assigned in December 2021. The most tenured leader, the ADPCS, had served in the role since March 2016.

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[7] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[8] Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs.*

[9] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement White Paper, 2017.

[10] Staff serving in an acting capacity occupied the positions.

To help assess executive leaders' engagement, the OIG interviewed the Director, acting Chief of Staff, ADPCS, and acting Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of $366,623,957 had increased approximately 11 percent compared to the previous year's budget of $329,660,983.[11] The Director reported spending the funds on external specialty care services, explaining there were few specialty services available at the facility and, due to its location, it was more convenient to purchase care near patients' homes.[12] The ADPCS added that leaders spent funds on pay increases for nursing personnel (including advanced practice, registered, and licensed practical nurses, as well as nursing assistants) and retention incentives for nutrition staff and social workers. The ADPCS further stated staff partnered with the local community college's nursing assistant program to help fill positions, adding that five recently hired employees had enrolled in a five-week course at the college, with a one-year obligation to work at the facility after completing the training. The acting Associate Director also reported spending the budget increase on recruitment and retention incentives for providers and engineers.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[13] 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 facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[14] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

The healthcare system's averages were lower than VHA's. To improve the scores, the Director reported increasing leaders' visits to work areas to hear concerns directly from staff, conducting open forums (listening sessions) to further engage with staff, and placing posters throughout the

[11] Veterans Health Administration (VHA) Support Service Center.

[12] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed December 5, 2023, https://www.va.gov/communitycare/.

[13] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

[14] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

facility so employees know who to contact about concerns. The Director also described publicly stating during a townhall that leaders are open to communication from employees.

Table 1. All Employee Survey Question: Ability to Disclose a Suspected Violation (FYs 2020 through 2022)

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
VA Illiana Health Care System	3.6	3.8	3.8

Source: VA All Employee Survey (accessed December 7, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[15] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

The healthcare system's inpatient scores indicate patient satisfaction had increased over time. Although the scores consistently improved, the ADPCS indicated that inadequate care transition planning and inpatient visitation restrictions due to the COVID-19 pandemic negatively affected the scores. To address care transition concerns, the ADPCS reported hiring a nurse to manage patients from admission to discharge, provide education on new medications, and assist with follow-up needs as appropriate.

Scores for primary and specialty care improved in FY 2022, indicating patients' satisfaction with care provided in this healthcare system had increased. The Director attributed the higher scores to improving employee experiences, explaining that if employees are happy, they provide better interactions and care to patients. The Director also mentioned implementing Tour of Duty training, which teaches employees about military life and public service and allows them an opportunity to reaffirm their commitment to the organization and patients.[16] The ADPCS said

[15] "Patient Experiences Survey Results," VHA Support Service Center.

[16] "The Tour of Duty course is designed to orient federal civilian employees without military background to the life of the military member. They also learn to relate it to their own federal service." Department of Veterans Affairs, "Tour of Duty Course: Understanding, Appreciating Veterans' Service," July 20, 2022, https://news.va.gov/105415/tour-of-duty-course-understanding-appreciating-veterans-service.

many primary care nurses work from home, which allows more time for them to respond to telephone calls. The acting Chief of Staff stated leaders had filled key positions—a nurse practitioner in the pulmonary clinic, a cardiologist, a general surgeon, and a technologist for cardiac testing—to increase access to specialty care.[17]

Table 2. Survey of Healthcare Experiences of Patients (FYs 2020 through 2022)

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	66.4	69.7	69.3	68.9	69.7
Patient-Centered Medical Home: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	82.5	81.8	81.9	82.5	81.7	84.9
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	84.8	84.2	83.3	82.3	83.1	87.3

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8 and 14, 2022).

***** *The response average is the percent of "Definitely yes" responses.*

† *The response average is the percent of "Very satisfied" and "Satisfied" responses.*

[17] The pulmonary medical field specializes in the respiratory system (windpipe to the lungs). "Know Your Providers: What Does a Pulmonologist Do?," American Lung Association, accessed July 18, 2023, https://www.lung.org/blog/know-your-providers-pulmonologist. A cardiologist is a physician who specializes in "diagnosing and treating diseases or conditions of the heart and blood vessels." "What is a Cardiologist?," The Texas Heart Institute, accessed July 18, 2023, https://www.texasheart.org/heart-health/heart-information-center/topics/what-is-a-cardiologist. "A general surgeon has specialized knowledge and experience related to the diagnosis, preoperative, operative, and postoperative management, including the management of complications, in nine primary components of surgery." "General Surgery," American College of Surgeons, accessed July 18, 2023, https://www.facs.org/for-medical-professionals/education/programs/so-you-want-to-be-a-surgeon/section-iii-surgical-specialties/general-surgery.

Identified Factors Related to Possible Lapses in Care and Healthcare System Leaders' Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[18] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[19] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[20]

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[21] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's 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."[22] Lastly, a large-scale disclosure is "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."[23] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[24]

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[18] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 20, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[19] The Joint Commission, *Standards Manual*, E-dition, January 1, 2022. A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

[20] Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.),* Institute for Healthcare Improvement White Paper, 2011.

[21] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission's definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

[22] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[23] VHA Directive 1004.08.

[24] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. The new directive contains similar language regarding patient safety as the rescinded handbook.)

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022. The Risk Manager reported four sentinel events and five institutional disclosures. The Chief of Quality Management confirmed no large-scale disclosures occurred during this time frame.

When asked about the patient safety reporting process, the Director described taking steps toward becoming a high-reliability organization, which resulted in increased reporting of patient safety events.[25] The Director stated the Patient Safety Manager reviews each event and provides a daily report to leaders on results. The Director further said the Quality Executive Board tracks and analyzes data from patient safety events. The acting Chief of Staff and ADPCS added that providers, the Chief of Staff, or both complete the disclosure of events.

The Patient Safety Manager discussed recognizing employees with Good Catch Awards during safety forums and providing education on how to use the reporting system to increase their comfort with entering events.[26]

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

[25] "A high-reliability organization (HRO) is an organization with a goal of achieving 'zero harm' in an environment where accidents are expected due to complexity or risk factors." VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

[26] "The 'Good Catch Award' recognizes employees who report close calls or other patient safety concerns." VHA National Center for Patient Safety, "VA Boston Displays Transparency in Patient Safety," September 22, 2014, accessed March 27, 2023, https://www.patientsafety.va.gov/features/VA_Boston_Displays_Transparency_in_Patient_Safety.asp.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[27] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[28] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[29]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[30] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[31]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[32] 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."[33] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[34]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The OIG did not identify any deaths that occurred within 24 hours of inpatient admission or suicides that occurred within seven days of discharge from an inpatient mental health unit during FY 2022.

Quality, Safety, and Value Findings and Recommendations

VHA requires staff to complete final peer reviews within 120 calendar days from the determination of the need for the review, unless the director approves a written extension request

[27] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[28] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

[29] VHA Directive 1100.16.

[30] VHA Handbook 1050.01; VHA Directive 1050.01(1).

[31] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

[32] 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, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

[33] VHA Directive 1190.

[34] VHA Directive 1190.

from the peer review committee.[35] The OIG found that from October 1, 2021, through September 30, 2022, staff finalized two peer reviews after 120 calendar days, and the Peer Review Committee requested extensions, but only after the peer reviews had been finalized. Neither the acting Chief of Staff nor the Risk Manager could provide a reason for the delay in requesting the extensions. The OIG noted that leaders have revised their process for tracking completion of peer reviews to ensure timeliness. Because the peer reviews were ultimately completed, the OIG did not make a recommendation.

[35] VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[36] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[37]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[38] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[39]

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[40]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[41] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires each facility to have credentialing and

[36] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[42]

The OIG interviewed key managers and selected and reviewed the privileging folders of 27 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires service chiefs to incorporate service-specific criteria in professional practice evaluations.[43] The OIG found Ongoing Professional Practice Evaluations for LIPs did not consistently have service-specific criteria. When service chiefs do not evaluate LIPs based on service-specific criteria, they may overlook specific practice deficiencies that could compromise patient safety. The acting Chief of Staff and the Credentialing and Privileging Manager reported that prior to March 2022, the facility did not have a consistent process for service chiefs to review evaluation forms and ensure service-specific elements were included. This is a repeat finding from the previous comprehensive healthcare inspection.[44]

Recommendation 1

1. The Chief of Staff ensures service chiefs incorporate service-specific criteria in professional practice evaluations.

[42] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

[43] VHA Handbook 1100.19; VHA Directive 1100.21(1). For example, an LIP who works in neurology should also be evaluated based on criteria relevant to the care provided in that specialty.

[44] VA OIG, *Comprehensive Healthcare Inspection of VA Illiana Health Care System in Danville, Illinois*, Report No. 20-00062-205, July 29, 2020.

Healthcare system concurred.

Target date for completion: December 30, 2024

Healthcare system response: The Medical Center Director and Chief of Staff reviewed and did not determine any additional reasons for noncompliance. The Chief of Staff, in collaboration with the Health Systems Specialist for Credentialing and Privileging, will ensure that all service chiefs use service-specific criteria in the professional practice evaluations of licensed independent practitioners. Each Service Chief (Surgical Services, Medical Services, Ambulatory Medicine Services, Diagnostics and Therapeutics, Mental Health, Social Work, and Pharmacy) has submitted an updated chart review and summary sheet template for each specialty to the Credentials Committee and Clinical Executive Board for approval. All submitted forms contain service-specific criteria that aligns with the National Program Offices for each specialty's recommendations. Each form was reviewed and approved by the Committee and Clinical Executive Board.

The Credentialing & Privileging staff has reviewed each completed professional practice evaluation for use of appropriate board approved documents in the professional practice evaluations of licensed independent practitioners. Additionally Credentialing & Privileging staff, along with the Medical Staff Survey Readiness Team will conduct an audit review on all approved chart review and professional practice evaluation summary forms for all service lines at VA Illiana Health Care System. The team will verify that the facility has implemented the profession practice evaluation forms with the VHA specialty specific indicators for 100% of the specialties with privileged providers at Illiana.

A report will be submitted to the Quality and Patient Safety Committee, which is chaired by the Director, starting April 2024 until 90% compliance has been achieved and sustained for six consecutive months.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[45] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[46]

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[47]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected nine patient care areas:

- Community living centers (Unity, Victory, and Honor House neighborhoods)
- Medical/surgical inpatient unit
- Mental health inpatient unit
- Primary care clinic
- Specialty clinic
- Urgent care clinic
- Women's clinic

[45] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

[46] VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[47] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

Environment of Care Findings and Recommendations

The OIG made no recommendations.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[48] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[49] The suicide rate for veterans was higher than for nonveteran adults during 2020.[50] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[51]

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[52] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[53]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[54]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 49 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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[48] VA Secretary memo, "Agency-Wide Required Suicide Prevention Training," October 15, 2020.

[49] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed November 30, 2022.

[50] VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

[51] Congressional Research Service, "Veteran Suicide Prevention," IF11886 version 2, July 29, 2021.

[52] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," November 23, 2022.)

[53] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

[54] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. "Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

VHA expects providers to complete the Comprehensive Suicide Risk Evaluation on the same day as a positive suicide risk screen in ambulatory care settings.[55] The OIG estimated that providers did not complete the evaluation on the same day following a positive screen for 27 (95% CI: 14 to 40) percent of patients, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[56] When providers do not evaluate patients following a positive screen, they may miss opportunities to identify patients who are at imminent risk for suicide and intervene. The Chief, Mental Health and the Chief of Ambulatory Care identified a lack of local screening and evaluation processes and staffing shortages in primary care and mental health as factors contributing to providers' inconsistently completing the evaluations.

Recommendation 2

2. The Chief of Staff ensures providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in ambulatory care settings.

[55] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)."

[56] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

Healthcare system concurred.

Target date for completion: October 31, 2024

Healthcare system response: The Medical Center Director and Chief of Staff reviewed and did not determine any additional reasons for noncompliance. There is an existing signed Service Agreement between Primary Care Mental Health Integration (PC-MHI) and Patient Aligned Care Teams (PACT) implementing same-day warm hand-off of positive C-SSRS [Columbia-Suicide Severity Rating Scale] from primary care to PC-MHI. The Suicide Prevention Team monitors a report daily that allows the Suicide Prevention Team to identify all positive C-SSRS screens that were not accompanied by a Comprehensive Suicide Risk Evaluation (CSRE). In the event of a missing CSRE, the Suicide Prevention Team reaches out to the PC-MHI staff to complete the required CSRE. The Suicide Prevention Team will complete monthly audits to evaluate compliance. The Suicide Prevention Coordinator will report audit numerator, denominator, and compliance percentage data monthly to the Quality and Patient Safety Committee. Compliance will be tracked through the Quality and Patient Safety Committee, which is chaired by the Director, until a minimum of 90 percent compliance is achieved and sustained for six consecutive months.

Report Conclusion

To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed inspection of five clinical and administrative areas and provided two recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this healthcare system. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines two OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Chief of Staff. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs incorporate service-specific criteria in professional practice evaluations.
Environment of Care	• None
Mental Health: Suicide Prevention Initiatives	• Providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in ambulatory care settings.

Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) affiliated healthcare system reporting to VISN 12.[1]

Table B.1. Profile for VA Illiana Health Care System (550)
(October 1, 2019, through September 30, 2022)

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	$271,976,546	$329,660,983	$366,623,957
Number of:			
• Unique patients	29,647	29,785	29,876
• Outpatient visits	293,537	342,118	337,981
• Unique employees§	1,152	1,248	1,218
Type and number of operating beds:			
• Community living center	217	217	217
• Domiciliary	35	35	35
• Medicine	14	14	14
• Mental health	22	22	22
• Residential rehabilitation	6	6	6
Average daily census:			
• Community living center	85	49	59
• Domiciliary	19	13	17
• Medicine	5	6	5
• Mental health	6	5	6

[1] VHA medical facilities are classified according to a complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Average daily census cont.			
• Residential rehabilitation	2	1	4

Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

**October 1, 2019, through September 30, 2020.*
†*October 1, 2020, through September 30, 2021.*
‡*October 1, 2021, through September 30, 2022.*
§*Unique employees involved in direct medical care (cost center 8200).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 14, 2024

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

Subj: Comprehensive Healthcare Inspection of the VA Illiana Health Care System in Danville, Illinois

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

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

1. I have reviewed the Comprehensive Healthcare Inspection of the VA Illiana Health Care System in Danville, Illinois.
2. I concur with the findings and recommendations proposed.
3. I concur with the submitted action plans from the facility.
4. I would like to thank the OIG Inspection team for a thorough review of VA Illiana Health Care System in Danville, Illinois.

(Original signed by:)

Daniel S. Zomchek, Ph.D., FACHE
Network Director, VISN 12

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: March 7, 2024

From: Executive Director, VA Illiana Health Care System (550)

Subj: Comprehensive Healthcare Inspection of the VA Illiana Health Care System in Danville, Illinois

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection of the VA Illiana Health Care System draft report. I have reviewed the document and concur with the recommendations.
2. A corrective action plan has been implemented as detailed in the attached report to demonstrate actions implemented to address the recommendations. If additional information is needed, please contact the VA Illiana Health Care System.
3. I am proud of the team here at VA Illiana Health Care System, and I appreciate the partnership of the Office of Inspector General in our efforts for continuous process improvement.

(Original signed by:)

Staci M. Williams, Pharm D, RPh

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