



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Edward Hines, Jr. VA Hospital in Hines, Illinois

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Figure 1. Edward Hines, Jr. VA Hospital in Hines, Illinois.

Source: <https://www.va.gov/hines-health-care/> (accessed August 3, 2023).

Abbreviations

ADPCS	Associate Director, 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 Edward Hines, Jr. VA Hospital, which includes 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 Edward Hines, Jr. VA Hospital during the week of July 24, 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 hospital'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 one recommendation to the Veterans Integrated Service Network Director and four to the Hospital Director in the following areas of review: Medical Staff Privileging, Environment of Care, and Mental Health. The number of recommendations should not be used as a gauge for the overall quality of care provided at this hospital. 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 Hospital 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 considers recommendations 3 and 4 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.



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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 Edward Hines, Jr. VA Hospital 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 hospital 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 Edward Hines, Jr. VA Hospital includes multiple outpatient clinics in Illinois. General information about the hospital can be found in appendix B.

The inspection team conducted an on-site review during the week of July 24, 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 hospital leaders complete corrective actions. The directors' 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 Edward Hines, Jr. VA Hospital occurred in January 2020. The Joint Commission performed unannounced hospital, behavioral health care, and home care accreditation reviews in March 2021.

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 hospital’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 hospital 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 hospital had a leadership team consisting of the Hospital Director (Director); Chief of Staff; Associate Director, Patient Care Services (ADPCS); Associate Director, Resources; and Associate Director, Operations. 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 executive team had worked together for 10 months. The Director had been in the position since March 2020. The Associate Director, Operations and Associate Director, Resources joined the team in April and June 2021, respectively. The Chief of Staff and ADPCS joined in September 2022.

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.

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

Budget and Operations

The OIG noted that the hospital's fiscal year (FY) 2022 annual medical care budget of \$964,864,644 had increased by over 7 percent compared to the previous year's budget of \$897,717,983.¹⁰ Executive leaders reported using the increased funding to create a renal transplant program and expand specialty services such as bariatrics, cardiology, neurology, urology, and surgery. The Director stated renal transplant program staff had completed their first living donor transplant on June 13, 2022, and were on pace to perform 100 transplants in calendar year 2023. The Chief of Staff and Associate Director, Operations shared that leaders spent approximately \$12 million of the increased budget on equipment, primarily to replace aging items.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."¹¹ 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.¹² Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the hospital over time.

Although scores were only slightly lower than VHA averages, leaders acknowledged employees lacked comfort addressing concerns with prior leaders. The ADPCS added that staff did not hesitate to contact current executive leaders with their concerns and attributed the change to transparency in communication.

¹⁰ Veterans Health Administration (VHA) Support Service Center.

¹¹ "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

¹² The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

**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
Edward Hines, Jr. VA Hospital	3.7	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.¹³ The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the hospital from FYs 2020 through 2022. Table 2 provides survey results for VHA and the hospital over time.

Patients’ satisfaction with their inpatient experiences decreased over all three years; whereas satisfaction with primary and specialty care varied. The Chief of Staff discussed expanding specialty care access at community-based outpatient clinics and increasing the focus on patient-centered care in both the primary and home-based healthcare teams.

¹³ “Patient Experiences Survey Results,” VHA Support Service Center.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Hospital	VHA	Hospital	VHA	Hospital
Inpatient: <i>Would you recommend this hospital to your friends and family?*</i>	69.5	67.8	69.7	64.3	68.9	61.5
Patient-Centered Medical Home: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†</i>	82.5	89.2	81.9	89.8	81.7	86.5
Specialty Care: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†</i>	84.8	88.7	83.3	87.4	83.1	87.9

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.

Identified Factors Related to Possible Lapses in Care and Hospital 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.¹⁴ According to The Joint Commission’s standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.¹⁵ A VA medical facility’s culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

¹⁴ Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; “Quality and Patient Safety (QPS),” Department of Veterans Affairs, accessed October 13, 2021, <https://www.va.gov/QUALITYANDPATIENTSAFETY/>.

¹⁵ The Joint Commission, *Standards Manual*, E-dition, July 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>.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.¹⁶

“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).”¹⁷

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.”¹⁸ 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.”¹⁹ To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.²⁰

The OIG requested a list of sentinel events, institutional disclosures, and large-scale disclosures that occurred during FY 2022. Hospital staff reported there were no deaths related to sentinel events that required an institutional disclosure.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

¹⁶ Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

¹⁷ 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.

¹⁸ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

¹⁹ VHA Directive 1004.08.

²⁰ 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.)

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.²¹ 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.²² Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.²³

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.²⁴ 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.²⁵

The OIG assessed the hospital's processes for conducting peer reviews of clinical care.²⁶ 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."²⁷ 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.²⁸

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed seven deaths that occurred within 24 hours of inpatient admission during FY 2022.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

²² VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

²³ VHA Directive 1100.16.

²⁴ VHA Handbook 1050.01; VHA Directive 1050.01(1).

²⁵ The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

²⁶ 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.

²⁷ VHA Directive 1190.

²⁸ 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.”²⁹ 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.”³⁰

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.³¹ LIPs are granted clinical privileges for a limited time and must be repriviledged prior to their expiration.³²

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.³³

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.³⁴ 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 facilities to have credentialing and

²⁹ 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.)

³⁰ VHA Handbook 1100.19.

³¹ VHA Handbook 1100.19.

³² VHA Handbook 1100.19.

³³ VHA Handbook 1100.19.

³⁴ VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.³⁵

The OIG interviewed key managers and selected and reviewed the privileging folders of 29 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires service chiefs to complete LIPs' Ongoing Professional Practice Evaluations on a regular basis. VHA also requires VISN chief medical officers to oversee privileging processes for each medical facility in the network.³⁶ The OIG found the LIPs' privileging folders lacked evidence of all required Ongoing Professional Practice Evaluation elements, such as service chiefs' recommendations for reprivileging and service-specific evaluation criteria. Incomplete evaluations can result in LIPs having approved privileges without evidence of clinical competency, potentially jeopardizing patient safety. The Chief of Staff reported the evaluations were incomplete due to lack of awareness of service-specific forms and multiple service chief vacancies. The OIG found similar deficiencies during the January 2020 comprehensive healthcare inspection.³⁷ Based on the prior and current inspection findings, the OIG was concerned about the VISN oversight of privileging processes.

Recommendation 1

1. The Veterans Integrated Service Network Director ensures the Veterans Integrated Service Network Chief Medical Officer oversees the hospital's privileging process.

³⁵ 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.

³⁶ VHA Handbook 1100.19; VHA Directive 1100.21(1).

³⁷ VA OIG, [Comprehensive Healthcare Inspection of the Edward Hines, Jr. VA Hospital in Hines, Illinois](#), Report No. 20-00069-222, August 25, 2020.

Veterans Integrated Service Network Director concurred.

Target date for completion: November 1, 2024

Veterans Integrated Service Network response: The VISN Chief Medical Officer (CMO) and VISN Credentialing and Privileging Officer (CPO) perform annual credentialing and privileging site audits of all VISN 12 VA Medical Centers. The VISN Network Director, VISN Chief Medical Officer, and VISN Credentialing and Privileging Officer evaluated and identified several factors contributing to the observed non-compliance at Edward Hines, Jr. VA Hospital, including a critical vacancy in the Edward Hines, Jr. VA Hospital credentialing and privileging department and lack of resolution of FY 2022 audit findings.

The VISN CMO and VISN CPO noted, during the FY 2022 Edward Hines, Jr. VA Hospital credentialing and privileging audit on August 17, 2022, that some FY 2022 reappointments were completed utilizing information from outdated Ongoing Professional Practice Evaluation (OPPE) templates. At that time, the VISN CMO and VISN CPO recommended Edward Hines, Jr. VA Hospital “initiate use of the newly developed OPPE templates as mandated by VHA with the next OPPE cycle.” The recommendation was communicated to Edward Hines, Jr. VA Hospital Medical Center Director, Chief of Staff, and Chief of Quality Management in a Memo entitled VISN 12 Credentialing and Privileging Review dated August 19, 2022. The VISN CMO and VISN CPO requested the site take action to resolve this recommendation. The Edward Hines, Jr. VA Hospital Credentialing and Privileging Lead responded with remediating actions in a memo entitled Credentialing and Privileging Review dated September 28, 2022. The Edward Hines, Jr. VA Hospital memo dated September 28, 2022, did not include remediating actions on updating Edward Hines, Jr. VA Hospital OPPE utilizing the newly developed and VHA approved specialty specific OPPE indicators as requested and there was no additional follow-up.

As of February 11, 2024, the Edward Hines, Jr. VA Hospital hired and onboarded a new Health Systems Specialist - Credentialing and Privileging Analyst to serve as the subject matter expert. This position is responsible for implementation, maintenance, and updating of OPPEs.

Every six months, the VISN CPO will audit OPPEs for completion by auditing a random sample of at least 30 providers’ OPPEs. The VISN CPO will continue audits until 90 percent compliance is achieved then maintained for six consecutive months. The numerator will be the number of accurately completed OPPEs in the sample each six months. The denominator will be the number of OPPEs within the sample that were due for completion each six months. The VISN Credentialing and Privileging Officer will report the monthly compliance results to the VISN Healthcare Delivery Council, which is chaired by the VISN Chief Medical Officer, until 90 percent compliance is achieved then maintained 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.”³⁸ The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.³⁹

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.⁴⁰

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

- Community living center (Friendly Cove)
- Emergency Department
- Intensive care unit (Cardiac/Medical Intensive Care)
- Medical/surgical inpatient unit (7 East)
- Mental health inpatient unit (2 South)
- Primary care clinic (PACT [Patient Aligned Care Team] C)

Environment of Care Findings and Recommendations

VHA requires staff to conduct environment of care inspections “a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year in all areas where patient care is

³⁸ 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.)

³⁹ 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.

⁴⁰ 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.)

delivered.”⁴¹ The OIG found staff did not inspect the chapel, Office of Information Technology, and warehouse/central supply (Logistics) once in FY 2022. As a result, staff may not have identified potential deficiencies that can lead to an unsafe environment for patients, visitors, and staff. A safety and occupational health specialist reported that staff followed VA guidance during the COVID-19 pandemic by limiting environment of care inspections early in the FY. This specialist also said that, due to the size of the hospital, staff were unable to inspect all required areas once the restrictions were lifted.

Recommendation 2

2. The Hospital Director ensures staff conduct environment of care inspections in non-patient care areas at least once per fiscal year.

Hospital Director concurred.

Target date for completion: October 31, 2024

Hospital response: The Hospital Director will ensure that facility staff completed and documented the number of environment of care inspections required for non-patient care areas. The Acting Safety and Occupational Health Manager is responsible for tracking and monitoring the number of environment of care inspections completed each month using an electronic data base. The numerator equals the number of environment of care inspections completed each fiscal year in non-patient care areas. The denominator is the total number of environment of care inspections expected to be completed each fiscal year in non-patient care areas. The Acting Safety and Occupational Health Manager will monitor and report compliance to the Safety Committee monthly, which is chaired by the Acting Associate Director of Operations, until 90 percent compliance is achieved and sustained for six consecutive months.

VHA requires staff to check inventory in storerooms and remove expired or outdated items.⁴² The OIG found expired culture swabs and wound care supplies in the medical/surgical inpatient and Cardiac/Medical Intensive Care units. Expired supplies can be less effective and pose safety risks to patients. A chief nurse and a nurse manager reported believing staff overlooked the supplies because they did not use them regularly. Because staff corrected the deficiency during the inspection, the OIG made no recommendation.

VHA requires that “video or audio monitoring equipment installed for patient safety purposes is only accessed and viewed by VA health care providers, who are responsible for ensuring the safe delivery of care and authorized to take action based on the monitoring.”⁴³ During inspections, the

⁴¹ VHA Directive 1608.

⁴² VHA Directive 1761.

⁴³ VHA Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*, November 29, 2021.

OIG observed that video camera monitors in the medical/surgical inpatient and the Cardiac/Medical Intensive Care units were viewable by individuals who were not involved in the delivery of patient care, which may violate patients' rights to privacy. A chief nurse for both units reported staff had installed cameras to monitor and communicate with patients during the pandemic and inadvertently failed to remove them afterward. Staff removed the cameras during the site visit; therefore, the OIG made no recommendation.

VHA also requires mental health inpatient unit nursing stations to be secure from unauthorized access.⁴⁴ The OIG found the mental health inpatient unit nursing station was not secure from unauthorized access. Unauthorized access to the nursing station could lead to patients harming themselves, staff, and others. The General Engineer reported leaders had approved a redesign contract and staff had mitigated the conditions with a half door and increased monitoring of the immediate area. Because staff took actions to minimize safety risks, the OIG made no recommendation.

⁴⁴ VHA Handbook 1160.06; VHA Directive 1160.06; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," September 30, 2020.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.⁴⁵ Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.⁴⁶ The suicide rate for veterans was higher than for nonveteran adults during 2020.⁴⁷ “Congress, VA, and stakeholders continue to express concern over seemingly limited progress made...to reduce veteran suicide.”⁴⁸

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.⁴⁹ 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.⁵⁰

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.⁵¹

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.

⁴⁵ VA Secretary memo, “Agency-Wide Required Suicide Prevention Training,” October 15, 2020.

⁴⁶ “Suicide Prevention: Facts about Suicide,” Centers for Disease Control and Prevention, accessed March 14, 2022.

⁴⁷ VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

⁴⁸ Congressional Research Service, “Veteran Suicide Prevention,” IF11886 version 2, July 29, 2021.

⁴⁹ 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.)

⁵⁰ 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.)

⁵¹ 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 requires the suicide prevention team to conduct a “minimum [of] five outreach activities per month.”⁵² The OIG found the team conducted only three outreach activities in both April and July 2022 and four in August 2022. Failure to conduct outreach could lead to missed opportunities to connect with at-risk veterans who have not received mental health services at the VA. The Social Work Clinical Manager for Specialty Mental Health attributed noncompliance to difficulty scheduling community outreach events due to the pandemic and suicide prevention coordinator staffing changes.

Recommendation 3

3. The Hospital Director ensures the suicide prevention team conducts a minimum of five outreach activities per month.⁵³

Hospital Director concurred.

Target date for completion: Completed

Hospital response: The Hospital Director ensured the Suicide Prevention team conducted the required number of outreach activities each month. The lead Suicide Prevention Coordinator or a team member tracked and monitored outreach activities each month until 90 percent compliance had been achieved and sustained for six consecutive months. The numerator equals the total number of outreach activities conducted each month. The denominator equals the total number of required outreach activities to be completed each month.

VHA requires the suicide prevention coordinator to report suicide-related events monthly to “local mental health leadership and quality management.”⁵⁴ The OIG found a suicide prevention coordinator did not consistently report suicide-related events monthly to mental health leaders or quality management staff in FY 2022. The lack of frequent reporting could hinder leaders’ oversight and result in missed opportunities for them to enhance suicide prevention initiatives. The acting Chief, Mental Health and the Chief, Quality and Patient Safety could not explain the noncompliance because they were not in their roles during FY 2022. A suicide prevention coordinator and the Chief, Social Work acknowledged being unaware of the requirement, but reported the suicide prevention team had verbal communication weekly with mental health leaders.

⁵² VHA Directive 1160.07.

⁵³ The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

⁵⁴ VHA Directive 1160.07.

Recommendation 4

4. The Hospital Director ensures the suicide prevention coordinators report suicide-related events monthly to mental health leaders and quality management staff.⁵⁵

Hospital Director concurred.

Target date for completion: Completed

Hospital response: The Hospital Director ensured the lead Suicide Prevention Coordinator or team member reported suicide related events to mental health leadership and quality management monthly. The lead Suicide Prevention Coordinator or team member tracked and monitored the reporting of monthly suicide related events to mental health leadership and quality management until 90 percent compliance is achieved and sustained for six consecutive months. The numerator equals the total number of months with suicide related events reported to both mental health leadership and quality management each month. The denominator equals the total number of months.

VHA expects providers to complete the Comprehensive Suicide Risk Evaluation on the same day as a positive suicide risk screen in all ambulatory care settings.⁵⁶ The OIG estimated that providers did not complete the evaluation for 49 (95% CI: 35 to 63) percent of patients following a positive screen, which is statistically significantly above the OIG's 10 percent deficiency benchmark.⁵⁷ Failure to complete the evaluation could result in missed opportunities for providers to identify patients at imminent risk of suicide and intervene. The Associate Chief, Medicine, Primary Care-Community Based Outpatient Clinics and the Program Manager, Primary Care Mental Health Integration reported believing the providers assessed the patients and determined they were not at risk but prioritized clinical care over completing the evaluations.

Recommendation 5

5. The Hospital Director ensures providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.

⁵⁵ The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

⁵⁶ 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)."

⁵⁷ 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.

Hospital Director concurred.

Target date for completion: December 24, 2024

Hospital response: The Hospital Director reviewed the recommendation and found no additional reasons for noncompliance. The Suicide Prevention team, consisting of several Suicide Prevention Coordinators and a Lead, will monitor a daily report to identify all positive Columbia Suicide Severity Rating Scale screens and then confirm a Comprehensive Suicide Risk Evaluation (CSRE) was completed on the same day. In the event of a missed CSRE, a member of the Suicide Prevention team will reach out to the appropriate staff to inform them that a CSRE is required. A Suicide Prevention Coordinator will complete monthly audits and will report compliance at the Mental Health Leadership monthly meeting. The numerator will be the number of CSREs completed on the same day as a patient's positive suicide risk screen in all ambulatory care settings each month. The denominator will be the number of CSREs due for completion in all ambulatory care settings each month. The Acting Chief of Mental Health or designee will report compliance monthly to the Medical Executive Board which is chaired by the Chief of Staff. Compliance will be tracked 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 hospital, the OIG conducted a detailed inspection of five clinical and administrative areas and provided five 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 hospital. 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 five OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. One recommendation is attributable to the VISN Director and four to the Hospital Director. 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	<ul style="list-style-type: none"> • None
Quality, Safety, and Value	<ul style="list-style-type: none"> • None
Medical Staff Privileging	<ul style="list-style-type: none"> • The Veterans Integrated Service Network Director ensures the Veterans Integrated Service Network Chief Medical Officer oversees the hospital's privileging process.
Environment of Care	<ul style="list-style-type: none"> • Staff conduct environment of care inspections in non-patient care areas at least once per fiscal year.
Mental Health: Suicide Prevention Initiatives	<ul style="list-style-type: none"> • The suicide prevention team conducts a minimum of five outreach activities per month. • The suicide prevention coordinators report suicide-related events monthly to mental health leaders and quality management staff. • Providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.

Appendix B: Hospital Profile

The table below provides general background information for this highest complexity (1a) affiliated hospital reporting to VISN 12.¹

**Table B.1. Profile for Edward Hines, Jr. VA Hospital (578)
(October 1, 2019, through September 30, 2022)**

Profile Element	Hospital Data FY 2020*	Hospital Data FY 2021†	Hospital Data FY 2022‡
Total medical care budget	\$821,787,328	\$897,717,983	\$964,864,644
Number of:			
• Unique patients	56,304	59,167	58,171
• Outpatient visits	819,410	892,654	830,865
• Unique employees§	3,542	3,567	3,518
Type and number of operating beds:			
• Blind rehabilitation	34	34	34
• Community living center	210	210	210
• Domiciliary	25	25	25
• Medicine	66	66	66
• Mental health	29	29	29
• Rehabilitation medicine	10	10	10
• Spinal cord injury	68	58	58
• Surgery	41	41	41
Average daily census:			
• Blind rehabilitation	13	9	10
• Community living center	104	101	92
• Domiciliary	12	10	10
• Medicine	67	69	74
• Mental health	14	12	9
• Rehabilitation medicine	3	4	5

¹ VHA medical facilities are classified according to a complexity model; a designation of “1a” indicates a facility with “high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs.” VHA Office of Productivity, Efficiency & Staffing (OPES), “VHA Facility Complexity Model Fact Sheet,” October 1, 2020. An affiliated hospital is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Hospital Data FY 2020*	Hospital Data FY 2021†	Hospital Data FY 2022‡
Average daily census:			
• Spinal cord injury	31	27	42
• Surgery	15	16	13

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 12, 2024

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

Subj: Comprehensive Healthcare Inspection of the Edward Hines, Jr. VA Hospital in Hines, Illinois

To: Director, Office of Healthcare Inspections (54CH06)
Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

1. I have reviewed the Comprehensive Healthcare Inspection of the Edward Hines, Jr. VA Hospital in Hines, 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 the Edward Hines, Jr. VA Hospital in Hines, Illinois.

(Original signed by:)

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

Appendix D: Hospital Director Comments

Department of Veterans Affairs Memorandum

Date: March 7, 2024

From: Director, Edward Hines, Jr. VA Hospital (578)

Subj: Comprehensive Healthcare Inspection of the Edward Hines, Jr. VA Hospital in Hines, Illinois

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Edward Hines, Jr. VA Hospital. I have reviewed the document and concur with the recommendations.
2. A corrective action plan has been implemented as detailed in the attached report. If additional information is needed, please contact the Edward Hines, Jr. VA Hospital.

(Original signed by:)

James Doelling
Hospital Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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