VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Robert J. Dole VA Medical Center in Wichita, Kansas

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Figure 1. Robert J. Dole VA Medical Center in Wichita, Kansas
(Source: *https://vaww.va.gov/directory/guide/, accessed on
January 28, 2020)*

Abbreviations

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

Report Overview

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

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

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

1. Quality, safety, and value

2. Medical staff privileging

3. Environment of care

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

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

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

7. Women's health (examining comprehensive care)

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

The unannounced visit was conducted during the week of November 18, 2019, at the Robert J. Dole VA Medical Center and Hays VA Clinic. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this medical center's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this medical center and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

Leadership and Organizational Risks

At the time of the OIG's visit, the medical center's leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant Director. Organizational communications and accountability were managed through a committee reporting structure with the Quality, Safety, and Value (QSV) Board overseeing several working groups. The leaders monitor patient safety and care through the QSV Board which has the authority and responsibility to establish quality, safety, reliability, and value through clinical and business systems by enterprise-wide approaches, risk aversion, and continuous improvement.

When the OIG team conducted this inspection, the medical center's leaders had been working together since August 2018. The Director had served in the role since 2016, and the other team members were permanently assigned in 2018.

The OIG team reviewed selected employee satisfaction survey results and concluded that the ADPCS appeared to have opportunities to improve employee satisfaction. Selected patient experience survey scores for male respondents generally reflected similar or higher care ratings than the VHA average; however, scores for female respondents were consistently lower than the VHA average. Overall, patients appeared satisfied with the care provided.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[1] However, the OIG had significant concerns regarding the patient safety program—specifically, identifying sentinel events and/or institutional disclosures.

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[2]

In individual interviews, the executive leaders were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve performance, as well as employee

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

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

and patient survey results. In addition, the executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL models.

The OIG noted opportunities for improvement in all eight clinical areas reviewed and issued 26 recommendations that are attributable to the Director, Chief of Staff, ADPCS, and Associate Director. These are briefly described below.

Quality, Safety, and Value

The medical center complied with requirements for a committee responsible for QSV oversight functions and protected peer review. However, the OIG identified significant weaknesses with the interdisciplinary review of utilization management data, root cause analyses, and submission of an annual patient safety report to medical center leaders.[3]

Medical Staff Privileging

The OIG identified deficiencies with focused and ongoing professional practice evaluation and healthcare provider exit review processes.[4]

Environment of Care

The inspection team did not note any issues with the availability of medical equipment and supplies but noted an opportunity to improve signage and navigation at the medical center. The OIG identified issues with special use spaces, environmental cleanliness, and privacy.

Medication Management

The OIG team observed compliance with many elements of expected performance, including pain screening, justification for concurrent therapy with benzodiazepines, and urine drug testing. The medical center was generally compliant with the use of a multidisciplinary pain management committee to oversee and monitor required quality measures. However, the OIG found deficiencies with aberrant behavior risk assessments, informed consent processes, and follow-up with patients after therapy initiation.

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

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

Mental Health

The inspection team found compliance with the requirements for a designated suicide prevention coordinator, tracking of and follow-up with high-risk veterans, and completion of monthly outreach activities. The OIG noted that although the medical center had a tracking process in place, there were no improvement needs or action plans identified. In addition, areas of concern included completion of mental health visits for at-risk patients, inclusion of required elements in the safety plan, and suicide prevention training.

Care Coordination

The medical center generally complied with requirements such as the supervision of designees. However, the OIG had concerns with the establishment of a multidisciplinary life-sustaining treatment decisions committee.

Women's Health

The medical center complied with requirements for most of the provision of care indicators and each of the selected staffing elements reviewed. However, the OIG identified a weakness with the multidisciplinary composition of the Women Veterans Health Committee.

High-Risk Processes

The medical center did not meet many of the requirements for the proper operations and management of reprocessing reusable medical equipment. The OIG identified deficiencies with the annual risk analysis, airflow checks, eating or drinking in prohibited areas, and endoscope storage.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued 26 recommendations for improvement to the Medical Center Director, Chief of Staff, ADPCS, and Associate Director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this medical center. The intent is for medical center leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if not addressed, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and interim Medical Center Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 96–97, and the responses within the body of the report

for the full text of the directors' comments.) The OIG considers recommendation 25 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
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Contents

Purpose and Scope

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

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[5] Investments in a culture of safety and continuous quality improvement, in concert with robust leadership and communication, significantly contribute to positive patient outcomes.[6] Figure 2 illustrates the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

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

1. Leadership and organizational risks

2. Quality, safety, and value (QSV)

3. Medical staff privileging

4. Environment of care

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

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

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

8. Women's health (examining comprehensive care)

9. High-risk processes (emphasizing reusable medical equipment)[7]

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

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

[7] See Figure 2. CHIP inspections address these processes during FY 2020 (October 1, 2019, through September 30, 2020); they may differ from prior years' focus areas.
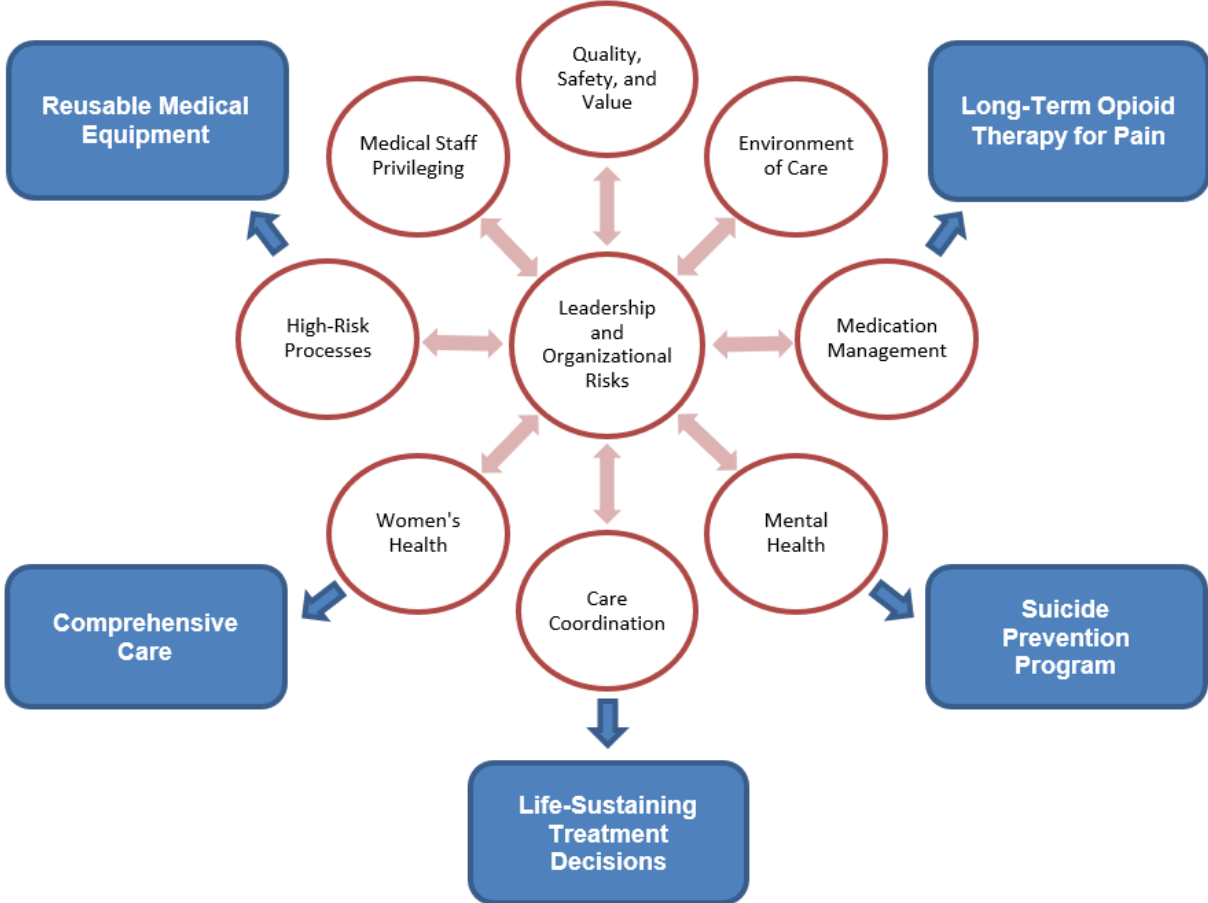
Figure 2. Fiscal Year (FY) 2020 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

Methodology

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

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports.[8]

The OIG team also selected and physically inspected the Hays VA Clinic and the following areas of the Robert J. Dole VA Medical Center:

- Community living center (CLC)[9]

- Emergency Department

- Intensive care unit

- Medical/surgical inpatient unit

- Outpatient clinic

- Post-anesthesia care unit

- Sterile processing services areas

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

The inspection period examined operations from August 5, 2017, through November 21, 2019, the last day of the unannounced multiday site visit.[10] While on site, the OIG referred concerns beyond the scope of the CHIP inspection to the OIG's hotline management team for further review.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and

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

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

[10] The range represents the time period from the prior CHIP inspection to the completion of the unannounced, multiday CHIP site visit in November 2019.

methodology and makes recommendations to VA leadership, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can impact the healthcare system's ability to provide care in the clinical focus areas.[11] To assess the medical center's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement

2. Employee satisfaction

3. Patient experience

4. Accreditation surveys and oversight inspections

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

6. VHA performance data (medical center)

7. VHA performance data (CLCs)

Executive Leadership Position Stability and Engagement

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

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

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                              Director

   Chief of Staff    ADPCS       Associate      Assistant
                                 Director       Director

   Ambulatory Care   Ambulatory  Equal          Hospital        Busines
   Anesthesia Service Service    Employment     Housekeeping     Development
   Care in the       Inpatient   Opportunity    Government       Marketing &
   Community         Services    Facility       Information      Communication
   Dental            Patient Care Management    Nutrition & Food Compliance
   Emergency         & Education  Facility Planning Service       Public Affairs
   Department        Perioperative Finance &    Mobility          Quality Improvement
   Hospital Services & Sterile    Business       Transportation   Research
   Medical Service   Processing   Operations     Police           Compliance
   Mental Health     Service      Human Resources Safety &
   Service           Telehealth   Logistics      Occupational Health
   Pathology &                    Management     Veteran Experience
   Laboratory Service             Medical
   Pharmacy &                     Administration
   Therapeutic Service            Service
   Radiology                      Social Work Service
   Research &
   Education
   Surgery Service
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Figure 3. *Medical Center's Organizational Chart*
Source: Robert J. Dole VA Medical Center (received November 18, 2019)

At the time of the OIG site visit, the executive team had been working together as a group since August 2018. The Director had served in the role since 2016, and the other team members were permanently assigned in 2018 (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	December 11, 2016
Chief of Staff	April 29, 2018
Associate Director for Patient Care Services	August 5, 2018
Associate Director	March 4, 2018
Assistant Director	May 27, 2018

Source: Robert J. Dole VA Medical Center Human Resources Officer (received November 19, 2019)

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

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

The Director serves as the chairperson of the Quality, Safety, and Value (QSV) Board, which has the authority and responsibility to establish quality, safety, reliability, and value through clinical and business systems by enterprise-wide approaches, risk aversion, and continuous improvement. The QSV Board oversees various groups such as the Medical Executive Committee, Quality and Performance Council, and Nursing Practice Council. In addition, recommendations from the QSV Board are tasked to medical center teams for improved outcomes. See Figure 4.
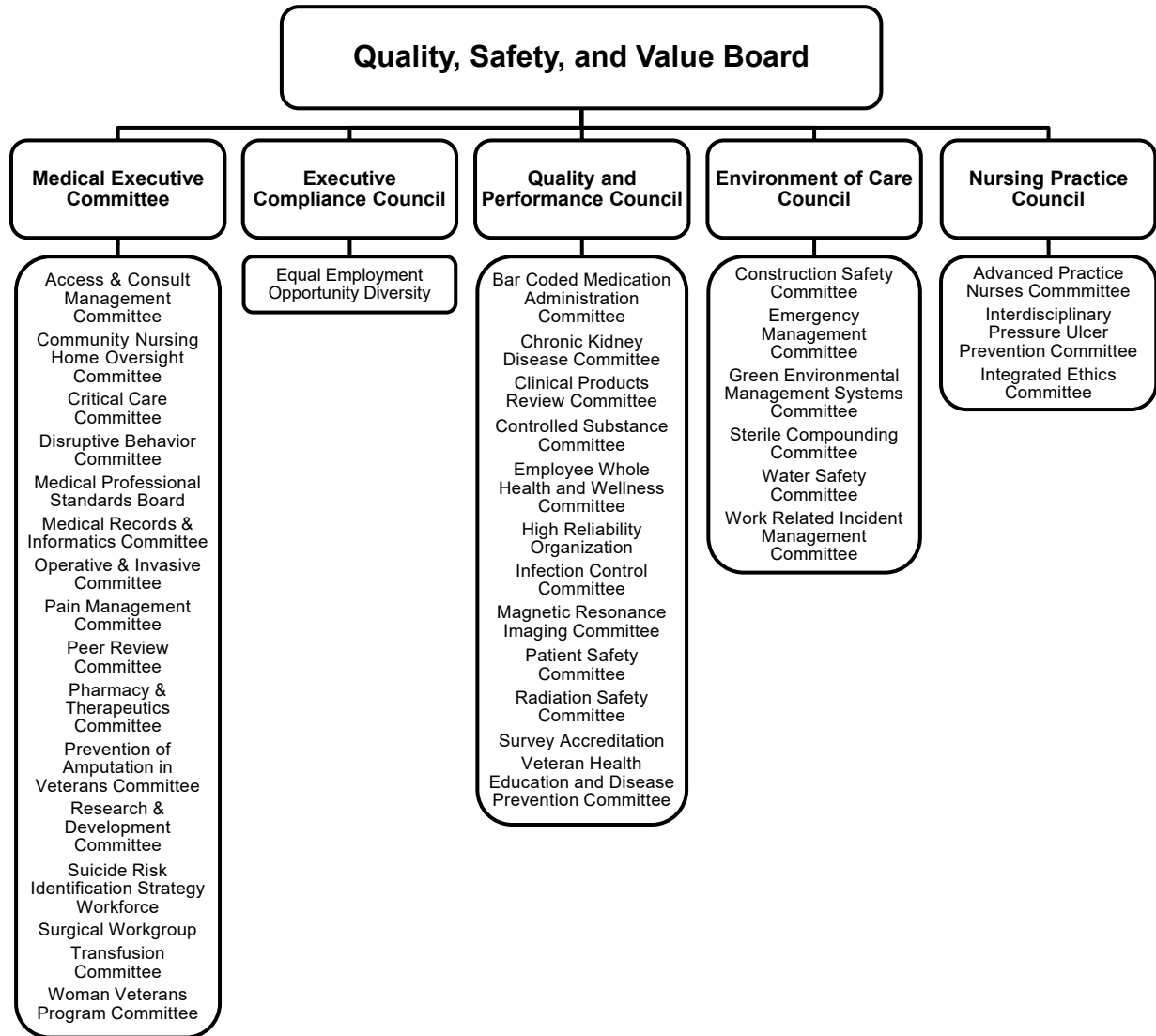
Quality, Safety, and Value Board

Medical Executive Committee

- Access & Consult Management Committee
- Community Nursing Home Oversight Committee
- Critical Care Committee
- Disruptive Behavior Committee
- Medical Professional Standards Board
- Medical Records & Informatics Committee
- Operative & Invasive Committee
- Pain Management Committee
- Peer Review Committee
- Pharmacy & Therapeutics Committee
- Prevention of Amputation in Veterans Committee
- Research & Development Committee
- Suicide Risk Identification Strategy Workforce
- Surgical Workgroup
- Transfusion Committee
- Woman Veterans Program Committee

Executive Compliance Council

- Equal Employment Opportunity Diversity

Quality and Performance Council

- Bar Coded Medication Administration Committee
- Chronic Kidney Disease Committee
- Clinical Products Review Committee
- Controlled Substance Committee
- Employee Whole Health and Wellness Committee
- High Reliability Organization
- Infection Control Committee
- Magnetic Resonance Imaging Committee
- Patient Safety Committee
- Radiation Safety Committee
- Survey Accreditation
- Veteran Health Education and Disease Prevention Committee

Environment of Care Council

- Construction Safety Committee
- Emergency Management Committee
- Green Environmental Management Systems Committee
- Sterile Compounding Committee
- Water Safety Committee
- Work Related Incident Management Committee

Nursing Practice Council

- Advanced Practice Nurses Commmittee
- Interdisciplinary Pressure Ulcer Prevention Committee
- Integrated Ethics Committee

Figure 4. Medical Center Committee Reporting Structure
Source: Robert J. Dole VA Medical Center (received November 18, 2019, revised February 5, 2020, and June 8, 2020)

Employee Satisfaction

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

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

October 1, 2018, through September 30, 2019.[12] Table 2 provides relevant survey results for VHA, the medical center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center average for the selected survey leadership questions was similar to or lower than the VHA average.[13] Although the Servant Leader Index Composite was higher for the ADPCS, the average for the remaining selected survey questions were similar to or lower than the VHA and medical center averages. Other executive leaders' scores were similar to or higher than both the medical center and VHA. Some opportunities appear to exist for the ADPCS to improve employee satisfaction.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite.*[14]	0–100 where higher scores are more favorable	72.6	70.3	75.7	86.0	88.0	87.1	77.8
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.4	3.3	3.9	3.6	3.4	3.9	3.8

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

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

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.4	4.0	3.7	3.4	4.0	3.8
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.5	4.0	3.8	3.2	4.1	3.6

Source: VA All Employee Survey (accessed October 8, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[15] Note that the medical center average for the selected survey questions was similar to the VHA average. In contrast, the leaders' average scores were generally better than both VHA and the medical center.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.7	4.1	4.3	4.0	4.3	3.8

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.8	3.9	4.1	3.8	4.1	4.3
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.4	1.5	1.2	1.5	1.2	1.0	1.1

Source: VA All Employee Survey (accessed October 8, 2019)

Patient Experience

To assess patient experiences with the medical center, which directly reflect on its leaders, the OIG team reviewed patient experience survey results that relate to the period of October 1, 2018, through June 30, 2019. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for VHA and the medical center.[16]

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

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

reflect patients' attitudes toward their healthcare experiences (see Table 4). For this medical center, the patient survey results generally reflected higher ratings than the VHA average. Patients appeared satisfied with the care provided.

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

Questions	Scoring	VHA Average	Robert J. Dole Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.1	70.8
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	85.9
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	77.3	84.6
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	78.0	79.9

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 2019)

In 2015, women represented 9.4 percent of the total veteran population in the United States, and it is projected that women will represent 16.3 percent of living veterans by 2043. Further, from 2005 to 2015, the number of women veterans using VA health care increased by 46.4 percent, from almost 240,000 to 455,875.[17] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients' experiences by gender (see Tables 5–7), including those for Inpatient, Patient-Centered Medical Home, and Specialty Care Survey questions. The OIG team noted that the results for

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

male respondents were generally similar to or more favorable than the corresponding VHA averages, while those for female respondents were consistently less positive when compared with female VHA patients nationally. Medical center leaders appeared to be actively engaged; however, the Director stated that male and female scores were not reviewed separately, but customer service for female veterans would be emphasized in the future. The Director also acknowledged that, although primary care focused on female veterans' care needs, comparable adjustments had not been implemented throughout the medical center.

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

Questions	Scoring	VHA[18]		Medical Center[19]	
		Male Average	**Female Average**	**Male Average**	**Female Average**
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.3	83.6	88.0	50.2
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.7	83.0	88.0	82.8
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	68.5	62.0	71.8	56.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 2019)

[18] The VHA averages are based on 34,077–34,469 male and 1,647–1,665 female respondents, depending on the question.

[19] The medical center averages are based on 261–268 male and 17 female respondents, depending on the question.

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

Questions	Scoring	VHA[20]		Medical Center[21]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.8	43.2	61.2	38.3
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.8	49.5	69.1	47.7
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.0	64.8	66.5	45.3

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 2019)

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[20] The VHA averages are based on 60,437–183,790 male and 4,400–9,816 female respondents, depending on the question.

[21] The medical center averages are based on 382–1,041 male and 24–51 female respondents, depending on the question.

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

Questions	Scoring	VHA[22]		Medical Center[23]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.3	44.4	43.5	22.8
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	53.9	58.3	27.9
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	69.9	69.4	71.2	53.5

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 2019)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[24] Table 8 summarizes the relevant medical center inspections most recently performed by the OIG and The Joint Commission (TJC).[25] Of note, at the time of the OIG visit, the medical center had received

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[22] The VHA averages are based on 50,373–158,294 male and 2,617–8,357 female respondents, depending on the question.

[23] The medical center averages are based on 198–624 male and 13–36 female respondents, depending on the question.

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

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

action plan approval from TJC for the 43 requirements for improvement issued after the August 2019 site visit.

At the time of the inspection, the OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[26] Additional results included the Long Term Care Institute's inspection of the medical center's CLCs.[27]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the Robert J. Dole VA Medical Center Wichita, Kansas,* Report No. 17-01748-82, February 6, 2018)	July 2017	14	0
OIG (*Healthcare Inspection Quality of Care and Other Concerns, Robert J. Dole VA Medical Center Wichita, Kansas,* Report No. 15-04641-304, July 19, 2017)	July 2015	6	0
TJC Hospital Accreditation TJC Behavioral Health Care Accreditation TJC Home Care Accreditation	August 2019	29 12 2	29 12 2

Source: OIG and TJC (inspection/survey results verified with the Chief of Quality Management on November 19, 2019)

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

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

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

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

The OIG requested lists of sentinel events and institutional disclosures from patient safety and risk management programs for the period of July 18, 2019, through November 18, 2019. Although the facility did not identify any sentinel events, the OIG noted medication errors that led to patients receiving additional care and treatment and a single event related to timeliness and appropriateness of care that may have contributed to a patient's death. These appeared to meet the definition of sentinel events. In addition, institutional disclosures were not conducted for these events.

It appears the medical center leaders have an opportunity to review the current processes used to identify sentinel events—specifically events related to permanent or temporary harm during treatment—and the criteria used to determine if disclosure is warranted. These reviews may highlight opportunities to improve and mitigate future risk and harm to patients as the medical center embarks on the journey to becoming a high reliability organization, as indicated by executive leaders' interviews.[28] Table 9 lists the reported patient safety events from July 31, 2017 (the prior OIG comprehensive healthcare inspection), through November 18, 2019.[29]

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[28] The high reliability organization (HRO) concept was pioneered in industries like aviation and nuclear power, that were able to reduce accidents in their complex environments. Research shows HROs experience fewer accidents despite being high-risk environments where small errors can produce catastrophic results. HROs put procedures and protocols in place that maximize safety and minimize harm.

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

Table 9. Summary of Selected Organizational Risk Factors (July 31, 2017, through November 18, 2019)

Factor	Number of Occurrences
Sentinel Events[30]	0
Institutional Disclosures[31]	3
Large-Scale Disclosures[32]	0

Source: Robert J. Dole VA Medical Center Chief of Quality Management (received November 19, 2019)

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[33]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2019. Of note, Figure 5 uses blue and green data points to indicate high performance for the medical center (for example, in the areas of ambulatory care sensitive conditions (ACSC) hospitalization, registered nurse (RN) turnover, care transition, and mental health (MH) continuity (of) care). Metrics that need improvement are denoted in orange and red (for example, patient-centered medical home

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

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

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

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

(PCMH) care coordination, best place to work, MH population (popu) coverage, and specialty care (SC) coordination.[34]
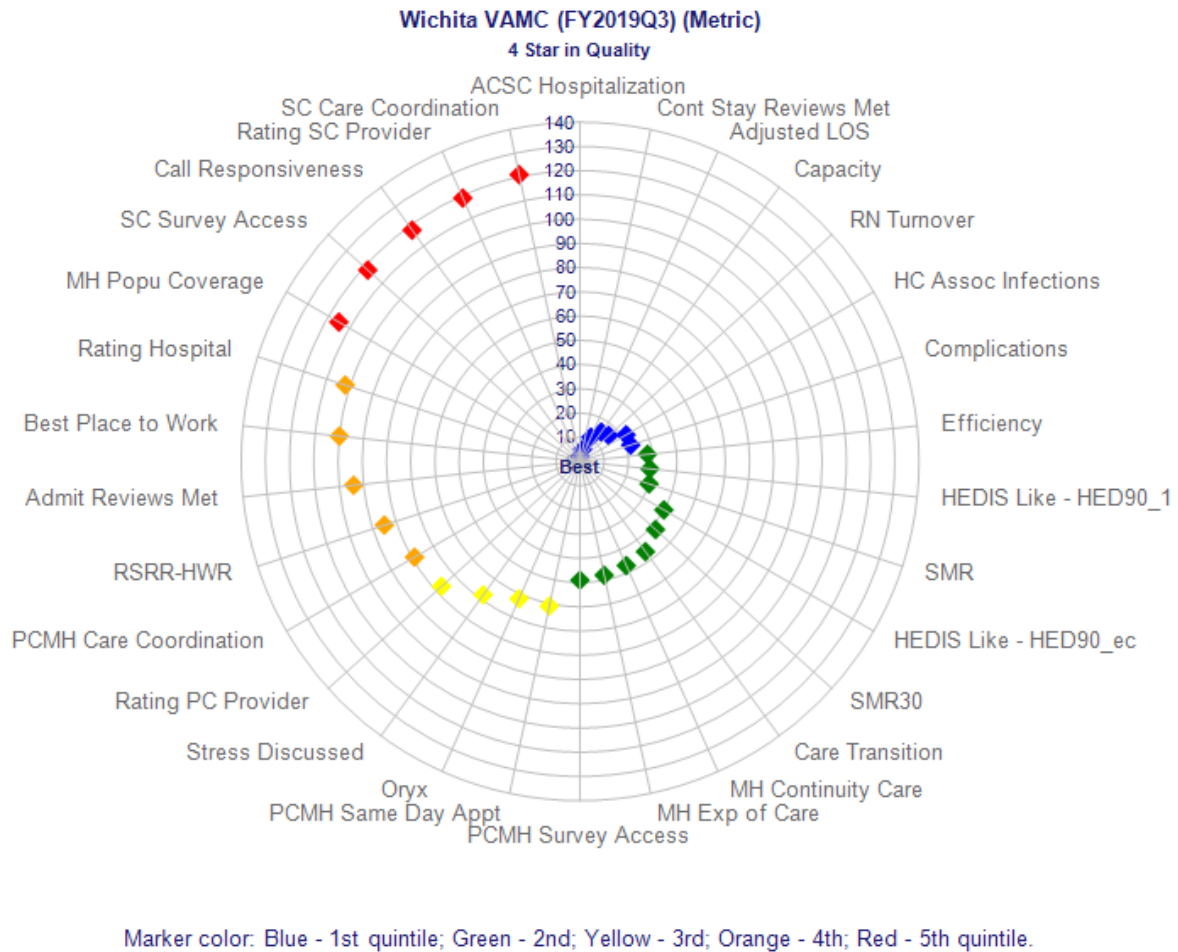

Figure 5. System Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

Veterans Health Administration Performance Data for Community Living Centers

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

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

Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource to review quality measures and health inspection results.[35]

Figure 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2019. Figure 6 uses blue and green data points to indicate high performance for the medical center's CLC (for example, in the areas of physical restraints–long-stay (LS), ability to move independently worsened (LS), and improvement in function–short-stay (SS)). Metrics that need improvement are denoted in orange and red (for example, moderate-severe pain (LS), catheter in bladder (LS), and urinary tract infection (UTI) (LS)).[36]
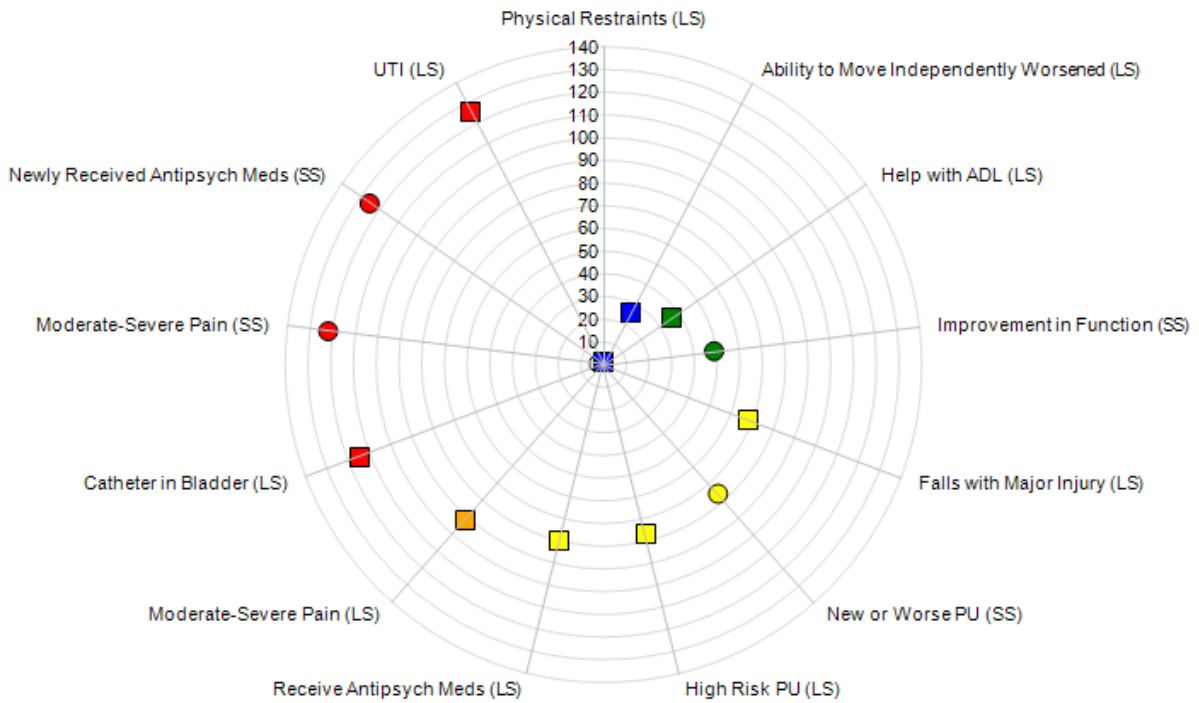

Figure 6. *Robert J. Dole VA Medical Center CLC Quality Measure Rankings (as of June 30, 2019)*
LS = Long-Stay Measure   SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

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

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

Leadership and Organizational Risks Conclusion

The medical center's executive leadership team appeared stable, with four of the five positions filled in 2018 and the Director serving in the role since December 2016. Selected employee satisfaction survey scores revealed opportunities for the ADPCS to improve employee attitudes toward senior leaders. Patient experience survey data noted that patients appeared satisfied with the care provided, and facility leaders appeared to be actively engaged with patients. However, the OIG found that selected survey results for female respondents were consistently lower than those for female VHA patients nationally. The OIG's review of the medical center's accreditation findings did not identify any substantial organizational risk factors. However, the OIG identified concerns regarding processes to review patient incidents, identify sentinel events, and/or conduct institutional disclosures. In individual interviews, the executive leaders were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve performance employee satisfaction and patient experiences. The executive leaders were also generally knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL models and should continue to take actions to sustain and improve performance.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.[37] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and to maintain Joint Commission accreditation.[38] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[39]

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

- Review of aggregated QSV data

- Recommendation and implementation of improvement actions

- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the medical center's processes for conducting protected peer reviews of clinical care.[40] Protected peer reviews, when conducted systematically and credibly, reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[41] The OIG team examined the completion of the following elements:

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

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

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

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

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

[41] VHA Directive 1190.

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

- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[42]

- Completion of final reviews within 120 calendar days

- Implementation of improvement actions recommended by the Peer Review Committee

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

Next, the inspection team assessed the medical center's utilization management (UM) program, a key component of VHA's framework for quality, safety, and value, which provides vital tools for managing the quality and the efficient use of resources.[43] It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[44] Inspectors reviewed several aspects of the UM program:

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

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

- Interdisciplinary review of UM data

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

Finally, the OIG reviewers assessed the medical center's reports of patient safety incidents with related root cause analyses.[45] Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the medical center.[46] The medical center was assessed for its performance on several dimensions:

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[42] VHA Directive 1190.

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

[44] VHA Directive 1117(2).

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

[46] VHA Handbook 1050.01.

- Annual completion of a minimum of eight root cause analyses[47]

- Inclusion of required content in root cause analyses

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

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

- Submission of annual patient safety report to medical center leaders

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents.[48]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for QSV oversight functions and protected peer review. The OIG identified weaknesses in various key QSV functions:

- Interdisciplinary review of UM data

- Inclusion of required content in root cause analyses

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

VHA requires that an interdisciplinary group review UM data. This group must include, but not be limited to, "representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR [chief business office revenue-utilization review]."[49] The OIG found that from November 2018, through October 2019, the UM committee lacked representation from mental health. As a result, the UM committee performed reviews and analyses of UM data without the perspectives of key mental health colleagues. The Utilization Manager stated the facility does not have inpatient mental health care, but after reviewing the UM committee charter and the VHA directive, the manager stated the lack of mental health representation was an oversight. The Chief of Quality Management subsequently reported that the representative for mental health joined the committee two weeks prior to the OIG site visit.

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

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

[49] VHA Directive 1117(2).

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reason(s) for noncompliance and ensures all required representatives consistently participate in interdisciplinary reviews of utilization management data.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: A Behavioral Health representative was added to the Utilization Management Committee in October 2019, by the Utilization Management Committee Lead and Chair. The Charter was revised to reflect this in October 2019. The Utilization Management Committee re-evaluated the Utilization Management Committee charter during the May 28, 2020, meeting and revised it to reflect meeting attendance requirement and reporting of attendance non-compliance to the Medical Executive Committee quarterly. This quarterly reporting of non-compliance will be done by the Utilization Management Committee Lead and/or Utilization Management nurse starting with the August 2020 Utilization Management Committee report to Medical Executive Committee. The Utilization Management Committee Lead (Chief Hospitalist) approved the revised Utilization Management Committee Charter on May 28, 2020. Utilization Management Committee meeting attendance will be tracked in monthly Utilization Management Committee meeting minutes indefinitely. Monitoring of Medical Executive Committee reporting of identified non-compliance with Utilization Management Committee meeting attendance will be done by the Utilization Management nurse for two consecutive quarters (August 2020 and November 2020 Medical Executive Committee meetings), with a target of 90 percent of Utilization Management Committee members being compliant with attendance requirement. The Medical Executive Committee reports to Quality, Safety, and Value Board co-chaired by the Medical Center Director.

The Medical Center Committee Reporting Structure was revised and approved by the Medical Center Director on June 8, 2020, to ensure it accurately reflects Utilization Management Committee reporting to Medical Executive Committee.

DATA DEFINITIONS:

Numerator: The number of Utilization Management Committee members compliant with Utilization Management Committee attendance requirement.

Denominator: The total number of Utilization Management committee required members.

VHA requires that (1) root cause analyses include specific content that ensures reviews are thorough and credible and (2) any corrective action(s) identified are implemented and evaluated for effectiveness. These evaluations are to also include consideration of relevant literature and the "determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such

improvement opportunities exist."[50] Additionally, WebSPOT (a software application within the VHA Patient Safety Information System) must be used to document root cause analyses.[51] All five root cause analyses reviewed by the OIG inspectors did not have consideration of relevant literature, three did not include determination of potential improvement in processes or systems, and three did not have corrective actions implemented. Incomplete reviews may result in future occurrences of similar patient safety incidents.

The Patient Safety Manager stated a lack of awareness of the requirement to document consideration of relevant literature and believed conducting relevant literature reviews was for personal knowledge. The Patient Safety Manager reported that ensuring documentation of all elements of root cause analyses is an area of weakness and provided no further reasons for missing determinations of potential improvements. The Patient Safety Manager also explained that implementing corrective actions as part of the root cause analysis process did not occur because the Nurse Manager, who was assigned the task, was on leave. The covering Assistant Nurse Manager did not have access to information regarding implementation actions at the time of the visit.

Recommendation 2

2. The Medical Center Director evaluates and determines any additional reason(s) for noncompliance and ensures that root cause analyses include all required review elements and are properly documented in the VHA Patient Safety Information System.

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[50] VHA Handbook 1050.01.
[51] VHA Handbook 1050.01.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The medical center's patient safety nurse sought mentorship from the VISN 15 Patient Safety Officer beginning in November 2019. On February 15, 2020, the Patient Manager position was vacated. The patient safety nurse was reassigned to the Patient Safety Manager on March 25, 2020. The established mentoring of the Patient Safety Manager with the VISN 15 Patient Safety Officer continued after reassignment. The Patient Safety Manager received additional training and coaching regarding conducting and facilitating Root Cause Analyses that include all four components required to ensure thoroughness in the Root Cause Analyses process. This training and coaching included the need and how to identify and analyze potential improvements in processes or systems to reduce the likelihood of recurrence, and document the potential improvements identified and analyzed or that no such improvement opportunities were identified in Web-SPOT (the National Center for Patient Safety's Root Cause Analysis documentation system). The Patient Safety Manager continues to submit Root Cause Analyses documentation to the VISN 15 Patient Safety Officer for review and guidance prior to finalization and Root Cause Analysis debriefing of members of the Medical Center Executive Leadership Team.

The Patient Safety Manager developed a Root Cause Analyses Process Checklist that includes all steps needed for a thorough Root Cause Analysis. This checklist will include identification and analysis of potential process or systems improvements to reduce the likelihood of recurrence, documentation of literature relevant to the Root Cause Analysis in Web-SPOT, documentation of the outcome of this analysis in Web-SPOT, and when corrective actions were implemented. A new Patient Safety Manager started June 9, 2020. Orientation of the checklist was completed during orientation. Moving forward, new patient safety staff will be trained on how to utilize and complete the Root Cause Analyses Process Checklist during their orientation.

The Patient Safety Manager will monitor the use of the Root Cause Analyses Process Checklist at the completion of each Root Cause Analyses and report compliance with consideration and documentation of relevant literature review and determination of potential process or system improvement opportunities to the Quality and Performance Council quarterly beginning in August 2020, until 90 percent compliance is sustained for two consecutive quarters. The Quality and Performance Council reports to the Quality, Safety, and Value Board. The Medical Center Director is a Co-Chair of this board.

DATA DEFINITIONS:

Sample size: 100 percent of Root Cause Analyses conducted.

Numerator: Number of Root Cause Analyses compliant with consideration and documentation of relevant literature review and determination of potential process or system improvement opportunities, and all required Root Cause Analysis elements.

Denominator: Number of Root Cause Analyses completed.

Recommendation 3

3. The Medical Center Director evaluates and determines any additional reason(s) for noncompliance and ensures that root cause analysis actions are implemented and properly documented in the VHA Patient Safety Information System.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The medical center's patient safety nurse sought mentorship from the VISN 15 Patient Safety Officer beginning in November 2019. On February 15, 2020, the Patient Safety Manager position was vacated. The patient safety nurse was reassigned to the Patient Safety Manager on March 25, 2020. The established mentoring of the Patient Safety Manager with the VISN 15 Patient Safety Officer continued after reassignment. The Patient Safety Manager received additional training and coaching regarding conducting and facilitating Root Cause Analyses that include all four components required to ensure thoroughness in the Root Cause Analyses process. This training and coaching included the need and how to conduct relevant literature review during the Root Cause Analysis and how to document the literature review in Web-SPOT (the National Center for Patient Safety's Root Cause Analysis documentation system). The Patient Safety Manager continues to submit Root Cause Analysis documentation to the VISN 15 Patient Safety Officer for review and guidance prior to finalizing the Root Cause Analysis and debriefing of members of the Medical Center Executive Leadership Team. In February 2020, the Patient Safety Manager began reporting medical center compliance with timely Root Cause Analysis action item completion, outcome measure reporting, and investigation of events reported in the Joint Patient Safety Reporting system within fourteen days to Executive Leaders using the Mission Control Board in the Director's Suite and to Quality and Performance Council monthly. The Quality and Performance Council reports to the Quality, Safety, and Value Board which is co-chaired by the Medical Center Director. The Patient Safety Manager developed a Root Cause Analyses Process Checklist that includes all steps needed for a thorough Root Cause Analyses. This checklist includes identification and analysis of potential process or systems improvements to reduce the likelihood of recurrence, documentation of literature relevant to the Root Cause Analysis in Web-SPOT, documentation of the outcome of this analysis in Web-SPOT, and when corrective actions were implemented. A new Patient Safety Manager started June 8, 2020 and completed orientation of the checklist during orientation. Moving forward, new patient safety staff will be trained on how to utilize and complete Root Cause Analysis Process Checklist during their orientation.

The Patient Safety Manager will monitor the use of the Root Cause Analyses Process Checklist at the completion of each Root Cause Analyses and report compliance to the Quality and Performance Council quarterly beginning in August 2020, until 90 percent compliance is sustained for two consecutive quarters. The Quality and Performance Council reports to the Quality, Safety, and Value Board. The Medical Center Director is a Co-Chair of this board.

DATA DEFINITIONS: Sample size: 100 percent of Root Cause Analyses conducted.

Numerator: Number of Root Cause Analyses compliant with timely action item implementation and documentation as required.

Denominator: Number of Root Cause Analyses completed.

Specifically, VHA requires annual submission of a patient safety report to facility leaders which provides an overview of the status of the patient safety program.[52] The OIG found the annual patient safety report was completed for FY 2018; however, there was no evidence it was submitted to leadership. This resulted in the medical center leaders not having an overview of patient safety issues, successes, or opportunities for improvement. The Patient Safety Manager stated the annual patient safety report was completed and routed to the leaders' administrative staff and the VISN Patient Safety Officer but could not provide evidence that this was done.

Recommendation 4

4. The Medical Center Director evaluates and determines any additional reason(s) for noncompliance and ensures that the Patient Safety Manager or designee provides an annual patient safety report to medical center leaders.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Patient Safety Manager will submit the annual Patient Safety Report to medical center leaders through the Quality and Performance Council and Quality, Safety, Value Board, no later than December 31, 2020. Patient Safety Report routing and final approval by the Medical Center Director will be tracked through the medical center suspense process.

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[52] VHA Handbook 1050.01.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[53]

Clinical privileges need to be specific and based on the individual practitioner's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[54]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance." The FPPE process occurs when a provider is hired at the facility and granted initial privileges and before any new clinical privileges are granted. Additionally, VA facilities must continuously monitor the performance of their providers. VHA requirements state that "the on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered."[55] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[56]
  - Clear documentation of the results and time frames
  - Evaluation by another provider with similar training and privileges
- OPPEs
  - Application of criteria specific to the service or section
  - Use of minimum criteria for selected specialty LIPs[57]
  - Evaluation by another provider with similar training and privileges

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

[54] VHA Handbook 1100.19.

[55] VHA Handbook 1100.19.

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

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

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

Further, VA must put processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former licensed practitioner's clinical practice, VA has an obligation to notify state licensing boards (SLBs) and to subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[58] Further, "VA medical facility Directors must designate an individual, and backup, to be responsible for the SLB reporting process. This individual will be the subject matter expert (SME) for the facility…and ensure oversight of the exit review process, including receipt, review, and maintenance of the Provider Exit Review Forms."[59] The OIG reviewers assessed whether the medical center's staff

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

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

- Reported results to SLBs when indicated.

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

- Thirteen solo/few practitioners who underwent initial or reprivileging during the previous 12 months[60]

- Three LIPs hired within 18 months before the site visit

- Nineteen LIPs privileged within 12 months before the visit

- Nine LIPs who left the healthcare system in 12 months before the visit

Medical Staff Privileging Findings and Recommendations

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

VHA requires the criteria for the FPPE process "to be defined in advance, using objective criteria accepted by the practitioner."[61] The OIG found all three practitioners' profiles reviewed lacked

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

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

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

[61] VHA Handbook 1100.19.

evidence that providers were aware of the criteria for evaluation before initiation of the FPPE process. This could result in providers misunderstanding FPPE expectations. The Chief of Staff attributed the noncompliance to a lack of guidance provided to service chiefs.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures clinical managers define in advance, communicate, and document expectations for focused professional practice evaluations in provider profiles.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff, Service Chiefs, and their Administrative Officers worked in collaboration to revise the focused professional practice evaluation form to include a signature line that attests the Service Line Chief reviewed the focused professional practice evaluation process and required criteria with the provider, and a signature line that attests the provider was instructed and understood the focused professional practice evaluation process and criteria they will be evaluated on. The revised form was approved by the Chief of Staff on June 3, 2020. Education of new providers on the focused professional practice evaluation criteria and process is conducted monthly during New Provider Academy by the Credentialing Health Systems Specialist. Service Line Administrative Officers will track compliance attesting review of the focused professional practice evaluation process and criteria required with the provider, and signature of the provider attesting they have received instruction and understand the focused professional practice evaluation process and criteria and report to the Credentialing Health Systems Specialist. The Credentialing Health Systems Specialist will aggregate the data from all Service Lines monthly, and report compliance to the Medical Professionals Standards Board quarterly, with a sustained compliance goal of 90 percent or greater for two consecutive quarters. The Medical Professionals Standards Board is chaired by the Chief of Staff.

DATA DEFINITION:

Sample size: 100 percent of newly initiated focused professional practice evaluation forms

Numerator: Total number of focused professional practice evaluation forms with signature of the Service Line Chief attesting review of the focused professional practice evaluation process and criteria required with the provider, and signature of the provider attesting they have received instruction and understand the focused professional practice evaluation process and criteria, prior to beginning the focused professional practice evaluation process.

Denominator: Total Number of newly initiated focused professional practice evaluation forms from all Service Lines.

VHA requires that reprivileging decisions are based on OPPE information specific to the service and practitioner.[62] For 15 of 32 practitioners, 7 of whom were solo/few providers, the OIG found that the OPPE criteria was not specific to the service/section. This resulted in inadequate data to support decisions to continue clinical privileges for these LIPs. Again, the Chief of Staff attributed the noncompliance to a lack of guidance provided to service chiefs on OPPE processes.

Recommendation 6

6. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures that reprivileging decisions are based on service-specific ongoing professional practice evaluation data.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff, Service Chiefs and their Administrative Officers worked in collaboration to revise all ongoing professional practice evaluation forms to include service specific criteria, a provider signature, and date line to acknowledge initial receipt of the ongoing professional practice evaluation, and when the final evaluation was received. The new form was reviewed to ensure it met VHA standards, and to ensure adequate data is provided to support decisions to continue clinical privileges for Licensed Independent Practitioners. The revised form was approved by the Chief of Staff and use of the forms began in December 2019. Service Line Administrative Officers will track compliance monthly and report to the Credentialing Health Systems Specialist. The Credentialing Health Systems Specialist will aggregate the data from all Service Lines and report compliance to the Medical Professionals Standards Board bi-annually, with a sustained compliance goal of 90 percent or greater for two consecutive ongoing professional practice evaluation process terms (March 2020 and September 2020). The Medical Professionals Standards Board is chaired by the Chief of Staff.

DATA DEFINITION:

Sample size: 100 percent of ongoing professional practice evaluation forms.

Numerator: Total number of ongoing professional practice evaluation completed monthly that includes service specific ongoing professional practice evaluation data.

Denominator: Total number of ongoing professional practice evaluation forms completed during the ongoing professional practice evaluation process term (every six months – March and September).

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[62] VHA Handbook 1100.19.

VHA requires that, at the time of reprivileging, service chiefs consider relevant, service- and practitioner-specific data using defined criteria when recommending the continuation of LIPs' privileges to the Executive Committee of the Medical Staff (known as the Medical Professional Standards Board at this medical center).[63] Additionally, VHA requires that LIPs are evaluated on an ongoing basis by providers with similar training and privileges.[64]

For 28 of 32 LIPs who were re-privileged, 11 of whom were solo providers, profiles lacked evidence that the service chiefs' determinations to continue privileges were based in part on results of OPPE activities. Additionally, three provider profiles did not have evidence that OPPE results were based on an evaluation by another provider with similar training and privileges. This may result in providers continuing to deliver care without a thorough evaluation of their practice. Again, the Chief of Staff attributed the noncompliance to a lack of guidance provided to service chiefs on OPPE processes. Additionally, the Medical Service Administrative Officer stated that the VISN sole provider peer review process is not effective due to limited access to the data), and when peer reviews are submitted, they are either not returned or not returned in a timely manner.

Recommendation 7

7. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures clinical managers consistently collect and review ongoing professional practice evaluation data.

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[63] VHA Handbook 1100.19.

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

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: To ensure Service Chief determinations to continue privileges are based on results of ongoing professional practice evaluation activities, a new process that requires all chart review results and the ongoing professional practice evaluation summary sheet be kept as one file to demonstrate that recommendation for continued privileges was thorough and complete was implemented in January 2020. This ongoing professional practice evaluation review file, including the summary sheet, is then uploaded to the confidential Credentialing and Privileging SharePoint for tracking purposes. This new ongoing professional practice evaluation process includes documentation that recredentialing recommendations are based on the data included in the ongoing professional practice evaluation. Documentation of how the recommendation was determined is noted in the subsequent minutes of the Medical Professional Standards Board. Education on the new process was completed on January 13, 2020 during the Medical Professional Standards Board meeting.

Service Line Administrative Officers will track compliance of ongoing professional practice evaluation review files, including summary sheet, being uploaded to the confidential Credentialing and privileging SharePoint, monthly and report to the Credentialing Health Systems Specialist. The Credentialing Health Systems Specialist will aggregate the data from all Service Lines and report compliance to the Medical Professionals Standards Board every six months, with a sustained compliance goal of 90 percent or greater for two consecutive ongoing professional practice evaluation process terms (March 2020 and September 2020). The Medical Professionals Standards Board reports to the Medical Executive Committee which is chaired by the Chief of Staff.

DATA DEFINITION:

Sample size: 100 percent of ongoing professional practice evaluation reviews.

Numerator: Total number of ongoing professional practice evaluation review files, including the summary sheet, uploaded to the confidential Credentialing and Privileging SharePoint.

Denominator: Total number of ongoing professional practice evaluations completed during the ongoing professional practice evaluation process term (every six months – March and September).

Recommendation 8

8. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures that providers with similar training and privileges complete ongoing professional practice evaluations of licensed independent practitioners.

Medical center concurred.

Target date for completion: March 31, 2021

Medical center response: The Chief of Staff, Service Chiefs, and their Administrative Officers worked collaboratively to evaluate reasons for OIG identified noncompliance and determined the ongoing professional practice evaluation form needed to be revised to include a typed name line to identify the reviewer name and specialty, in addition to the existing line for the reviewer's signature. The revised form was approved by the Chief of Staff and use of the form began in April 2020.

Service Line Administrative Officers will track compliance of completed ongoing professional practice evaluation forms having the typed name line identifying the reviewer name and specialty, and the signature line completed, monthly and report to the Credentialing Health Systems Specialist. The Credentialing Health Systems Specialist will aggregate the data every six months from all Service Lines and report compliance to the Medical Professionals Standards Board every six months with a sustained compliance goal of 90 percent or greater for two consecutive ongoing professional practice evaluation process terms (every six months, September 2020 and March 2021). The Medical Professionals Standards Board reports to the Medical Executive Committee which is chaired by the Chief of Staff.

DATA DEFINITION:

Sample size: 100 percent of ongoing professional practice evaluation reviews.

Numerator: Total number of ongoing professional practice evaluation results with evidence the evaluation was performed by another provider with similar training and privileges.

Denominator: Total number of ongoing professional practice evaluations completed during the ongoing professional practice evaluation process term (every six months – March and September).

VHA requires that the Executive Committee of the Medical Staff (known as the Medical Professional Standards Board at this medical center) to "consider all information available" prior to making the "recommendation for the granting of privileges to the Director," and that the "deliberation must be clearly documented in the minutes."[65] For all three FPPEs and 28 of 32 OPPE profiles reviewed (including 11 solo providers), the Medical Professional Standards Board

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[65] VHA Handbook 1100.19.

recommended continuation of privileges without documented FPPE results or without the required OPPE data needed for the review. This resulted in the Director approving providers' privileges without the Medical Professional Standards Board's consideration of all relevant information. The Chief of Staff stated that OPPE evidence was not consistently provided to the Medical Professional Standards Board due to a lack of instruction for service chiefs to include that information.

Recommendation 9

9. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and makes certain that Medical Professional Standards Board meeting minutes consistently reflect the review of professional practice evaluation results when recommending continuation of privileges.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: At this medical center there are two separate committees involved in the focused professional practice and ongoing professional practice evaluation processes, the Medical Professional Standards Board, and the Medical Executive Committee. The focused and ongoing professional practice evaluation processes are as follows: satisfactorily completed focused and ongoing professional practice evaluations submitted by Service Chiefs are reviewed and signed by the Chief of Staff; completed focused and ongoing professional practice evaluations are then submitted to the Medical Professional Standards Board; Service Chiefs consider the completed focused and ongoing professional practice evaluations in the process of submitting a provider for recredentialing and re-privileging; the Medical Professional Standards Board minutes reflect consideration of the focused and ongoing professional practice evaluations in the credentialing and privileging processes; Medical Professional Standards Board recommendations are then sent to the Medical Executive Committee; Medical Executive Committee considers the Medical Professional Standards Board recommendations; decisions of the Medical Executive Committee are reflected in the ACTION column of the minutes as approved, tabled, or follow-up needed; those that are approved have the final recommendation sent to the Medical Center Director for final determination.

Currently Medical Professionals Standards Board reports monthly focused professional practice evaluations that have been approved to roll-up to the ongoing professional standards board without an ongoing list of providers that are still in the 90-day focused professional practice evaluation process. Moving forward, all providers in the focused professional practice evaluation process will be noted in the Medical Professionals Standards Board minutes, with a notation of when the initiation of the focused professional practice evaluation process began, the date the focused professional practice evaluation process was completed satisfactorily, and the date the provider received recommendation to be converted to the ongoing professional practice evaluation process.

The Credentialing Health Systems Specialist will audit monthly and report quarterly compliance of the focused professional practice evaluation 90-day evaluation period being completed with appropriate focused professional practice evaluation data and information review by the Medical Professional Standards Board before recommendation to transition provider to the ongoing professional practice evaluation is made. Compliance will be reported to the Medical Executive Committee quarterly with a sustained compliance goal of 90 percent or greater for two consecutive quarters. The Medical Executive committee is chaired by the Chief of Staff.

DATA DEFINITIONS:

Sample Size: 100 percent of focused professional practice evaluations with the 90-day evaluation period completed each month.

Numerator: Number of focused professional practice evaluation 90-day evaluation periods completed with appropriate focused professional practice evaluation data and information review by the Medical Professional Standards Board before recommendation to transition provider to the ongoing professional practice evaluation is made each month.

Denominator: Total number of focused professional practice evaluation 90-day evaluations completed each month.

VHA requires that "Provider Exit Review forms must be completed within 7-calendar days of the departure of a licensed health care professional from a VA facility."[66] The provider's first- or second-line supervisors must sign the exit review form. Additionally, practitioners failing to meet professional practice standards for delivering patient care are reported to SLBs.[67] Among the nine providers who left the medical center in the previous 12 months, the OIG found that service chiefs did not complete the forms for four providers within seven calendar days after their departure. One form was completed within 10 days of the provider's exit, and three forms were completed between 24 and 26 days before the providers departed the medical center. During that time, those three providers continued to deliver patient care. In addition, four of the nine forms were not completed correctly—either the service chief signature was in two locations, or the signature was placed in the area of the form indicating the provider failed to meet acceptable standards. The OIG was unable to determine, based on the review, if these providers should have been referred to the SLB or if the forms were simply completed incorrectly. A lack of oversight of the exit review process may lead to the inability to identify providers who are not meeting professional practice standards or delay time-appropriate reporting of providers not meeting standards for care delivery to state licensing boards. The OIG noted the potential lack of local oversight for the exit review process.

Recommendation 10

10. The Chief of Staff determines reason(s) for noncompliance and makes certain that provider exit review forms are completed within seven calendar days of licensed healthcare professionals departing the medical center.

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[66] VHA Notice 2018-05.

[67] VHA Notice 2018-05.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: To better track providers planning to exit or who have exited the medical center and will require a Provider Review Exit Form within 7-calendar days following their departure date, the Credentialing and Privileging Service were added to the weekly distribution of the staff Gains and Loss Report. This report is sent on the first workday of the week by Human Resources to the Credentialing Program Specialist. In addition, all completed Provider Review Exit Forms are reviewed by Credentialing and Privileging staff to ensure timely, accurate completion within the required 7-calendar days. The Credentialing Health Systems Specialist will monitor timely completion of Provider Review Exit Forms monthly, and report quarterly to the Medical Executive Committee until a sustained compliance of 90 percent or greater for two consecutive quarters is achieved. The Medical Executive Committee is chaired by the Chief of Staff.

DATA DEFINITIONS:

Sample size: 100% of Provider Review Exit Forms completed each month.

Numerator: Number of Provider Review Exit Forms completed within 7-calendar days following the providers departure date for each month.

Denominator: Total number of Providers who departed the medical center each month.

Recommendation 11

11. The Chief of Staff determines reason(s) for noncompliance and ensures the departing licensed healthcare professional's first- or second-line supervisor appropriately signs the exit review form.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: Prior to the OIG inspection, Provider Review Exit Forms did not clearly delineate the "provider met" or "failed to meet" acceptable standards sections and did not have clearly identified lines for both typed name and signature of the Service Chief. In December 2019, the Credentialing Program Specialist revised the Provider Review Exit Form to clearly identify a signature line for the first or second-line supervisors' signature. The Credentialing Program Specialist will provide training to all Service Chiefs on how and when to complete the revised form during the July 13, 2020 monthly Medical Professional Standards Board. The Credentialing Health Systems Specialist will monitor correct completion of Provider Review Exit Forms monthly, and report quarterly to the Medical Executive Committee until a sustained compliance of 90 percent or greater for two consecutive quarters is achieved. The Medical Executive Committee is chaired by the Chief of Staff.

DATA DEFINITIONS:

Sample size: 100% of Provider Review Exit Forms completed each month.

Numerator: Number of Provider Review Exit Forms completed correctly within seven calendar days for each month.

Denominator: Total number of Providers who departed the medical center each month.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct Comprehensive Environment of Care Inspection Rounds and to resolve issues in a timely manner. The goal of the Comprehensive Environment of Care Program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[68]

The purpose of this facet of the OIG inspection was to determine whether the medical center maintained a clean and safe healthcare environment in accordance with applicable requirements.[69] The inspection team reviewed relevant documents, interviewed key employees and managers, and examined several aspects of the medical center's environment:

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

During its review of the environment of care, the OIG team inspected the Hays VA Clinic and the following six patient care areas at Robert J. Dole VA Medical Center:

- CLC
- Emergency Department

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

[69] The medical center does not have an inpatient mental health unit.

- Intensive care unit

- Medical/surgical inpatient unit

- Primary care clinic

- Post-anesthesia care unit

Environment of Care Findings and Recommendations

The inspection team did not note any issues with the availability of medical equipment and supplies, but noted that facility leaders have an opportunity to improve signage and navigation at the medical center. The medical center had signage in some areas where oxygen is stored for patient use; however, OIG noted that three inspected patient care areas lacked signage indicating oxygen storage location.[70] Additionally, in the primary care area of Building 29, the OIG observed an interim life safety egress plan routing patients and staff away from a closer exit. The routing path was corrected while the OIG was on site.

The OIG identified additional vulnerabilities within the medical center's special use spaces, specifically supply storage, environmental cleanliness, and privacy.

VHA requires that areas used for supply storage must have a stable environment without extreme changes in temperature and/or humidity; relative humidity must be less than 75 percent, and the temperature range from 64–78 degrees Fahrenheit.[71] In the Emergency Department, the OIG found an unmarked and unlabeled room used as a supply storage area. The room's temperature felt markedly higher than the ambient temperature of the Emergency Department, and facility engineering staff was unable to get an accurate temperature reading. The room contained a large blanket warmer, oxygen tanks, and lab supplies. Storing equipment and supplies at a higher-than-recommended temperature may affect product integrity and subsequent use. The Emergency Department staff stated they were using the room for the additional storage needed in the area but were not able to provide a reason for the lack of monitoring temperature and humidity.

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[70] CLC, ED, and Primary Care.

[71] VHA Directive 1761(2), *Supply Chain Inventory Management,* October 24, 2016.

Recommendation 12

12. The Associate Director determines reason(s) for noncompliance and ensures that patient care supply areas are properly designated, and adequate temperature and humidity controls are continuously monitored and maintained.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Medical Center opened a newly constructed Emergency Department February 2, 2020, therefore the Emergency Department storage room which was inspected during the OIG visit is no longer in use. Within the new Emergency Department space, items are stored in separate rooms in accordance with temperature and humidity requirements. The Logistics Supply Room (031-62), and the Medication Room (032-62) are both monitored continuously for temperature and humidity via Temptrak. If the Logistics Supply room or the Medication room alarms out of set point range, Facilities Management Services is responsible for investigating and resolving issues with the heating, ventilation, and air conditioning system. In addition, the blanket warmer and oxygen tanks are not stored in the Logistics Supply room or the Medication room. The Facilities Management Chief will submit a monthly Temptrak humidity and temperature report to the Environment of Care Council until 90 percent compliance with required temperature and humidity is maintained for 2 consecutive quarters. At the time of medical center response, four consecutive months (February 2020 through May 2020) have demonstrated compliance with temperature and humidity requirements based on Temptrak reports.

DATA DEFINITIONS:

Sample Size: 100% of days in each month.

Numerator: Number of days temperature and humidity remained within set parameters in the Logistics Supply Room (031-62) and the Medication Room (032-62) each month.

Denominator: Number of days in each month.

To meet environmental cleanliness standards, TJC requires that facilities establish and maintain a safe and suitable environment and that areas used by patients are clean.[72] While conducting rounds throughout the medical center, the OIG inspector noted dust high on the walls in hallways between patient care units, dusty air conditioning vents, and dust in the elevators. In the CLC, many patient room defects were noted: door jambs with chipped paint; damaged doors; and in particular, a gap in a ceiling tile around a fire sprinkler that staff reported to the OIG and had been noted during the most recent Long Term Care Institute inspection. As a result, the medical center was unable to ensure a safe, clean, and functional clinical environment to promote patient

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[72] TJC. Environment of Care standard EC.02.06.01.

and staff safety. Per the Chief of Engineering, there had recently been several remodeling projects in the CLC, and the staff tried to maintain the area as best as possible.

Recommendation 13

13. The Medical Center Director evaluates and determines any additional reason(s) for noncompliance and ensures that a safe and clean environment is maintained throughout the medical center.

Medical center concurred.

Target date for completion: November 1, 2020

Medical center response: In November 2019, Facilities Management, Safety, and Infection Prevention completed an assessment of all doors in the Community Living Center to identify the level of damage. In addition, all door jams in the Community Living Center were painted, with final completion of this on March 16, 2020. Based on the assessment, the short-term plan is to repair the doors identified in the door assessment by November 1, 2020, and the long-term plan is to replace all doors in the Community Living Center during an upcoming project to expand and renovate so all patient rooms are private. Designs for this project are scheduled to be awarded in FY20. The Facilities Management Chief will submit a report to Environment of Care Council on a monthly basis until 100 percent of doors identified in the risk assessment as needing repaired are completed. Environment of Care Council reports to the Quality, Safety, and Value Board, co-chaired by the Medical Center Director.

Facilities Management repaired the ceiling tile in Community Living Center on April 1, 2020. Moving forward, ceiling tiles in Community Living Center and throughout the Medical Center will be assessed and addressed during Environment of Care rounds. Any discrepancies will be entered and tracked in the Environment of Care Performance Logic database and reported to the Environment of Care Council.

The Environment Management Service Chief directed Environment Management staff to clean hallways between patient care units, air-conditioning vents, and elevators to remove all dust throughout the medical center while OIG CHIP reviewers were on-site. An inspection by the Environment Management Service Chief verified this was satisfactorily completed while OIG CHIP reviewers were on-site.

To ensure a safe, clean, functional clinical environment that promotes patient and staff safety, in February 2020, the new Environment Management Service Chief developed area specific cleaning checklists that include dusting hallways, walls, vents and elevators. On February 26, 2020, and again on March 2, 2020, Environment Management staff were trained on the use of these checklists and staff competency is evaluated bi-annually. Compliance with dusting these areas will be assessed during Environment of Care rounds and weekly Environment Management Service leadership rounds. Any deficiencies related to cleanliness or dust noted during these rounds will be discussed with assigned Environment Management staff member immediately by the Environment Management Service Chief or supervisor and action taken to clean the deficient area. In addition, deficiencies noted during environment of care rounds are documented and tracked in the Environment of Care Performance Logic database and reported to the Environment of Care Council. The Environment Management Chief will audit and report staff compliance with dusting these areas to the Environment of Care Council quarterly until 90 percent or greater compliance is attained and sustained for 2 quarters. The Associate Director is

the Chair of the Environment of Care Council. The Environment of Care Council reports to the Quality, Safety, and Value Board which the Medical Center Director is a co-chair.

DATA DEFINITIONS:

Door Audit

Sample Size: 100% of doors needing repairs.

Numerator: Number of doors that have had repairs completed.

Denominator: Number of doors that were identified in assessment that require repairs be completed.

Dust Audit

Numerator: Number of Environment Management Service leadership rounds with no dust noted.

Denominator: Number of Environment Management Service leadership rounds.

TJC also requires the protection of patient health information against unauthorized access, use, and disclosure.[73] The OIG found that protected patient information was not secured on laboratory specimens transported to the parent facility from offsite locations. The specimens were placed in a cooler and secured with commonly available, unlabeled plastic cable ties which could be removed and replaced easily. This may result in unauthorized access to personally identifiable information. The Lab Manager reported that properly securing specimens had been a suggestion from a previous review and provided no reason for not implementing a change to the specimen transport practice.

Recommendation 14

14. The Chief of Staff determines the reason(s) for noncompliance and ensures that personally identifiable information is protected when transporting information or specimens from the clinics to the medical center.

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[73] VHA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: The Lab Manager is responsible for ensuring the protection of Patient Health Information against unauthorized access, use, and disclosure during transportation of laboratory specimens from offsite locations to the parent facility. Effective May 22, 2020, numbered safety seals are being utilized in lieu of the common zip tie previously in use. The number of the seal to be used to secure a bag each day will be written on the specimen manifest that is faxed to the lab and inserted into each specimen bag prior to courier transport pickup. After courier drop off in the main laboratory and prior to opening a bag, the numbered tag will be compared to the individual Community Based Outpatient Care manifest for matching accuracy. Compliance of proper use of secured transport bag tags will be documented daily upon receipt and reported on a monthly basis to the Lab Manager. Non-compliance will be reported immediately to the Lab Manager for follow-up action with the Community Based Outpatient Care manager. Furthermore, compliance will be monitored monthly and reported to Medical Executive Committee quarterly until 2 consecutive quarters of 90 percent or greater compliance has been achieved. The Medical Executive Committee is chaired by the Chief of Staff.

DATA DEFINITIONS:

Sample Size: 100% of transport days for the month.

Numerator: The number of transport days compliant with secured transport bags utilizing numbered zip ties.

Denominator: The total number of transport days each month.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[74] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[75] Long-term opioid use is of particular concern in the veteran population where there is a high incidence of posttraumatic stress disorder, major depressive disorder, alcohol use, substance abuse, and suicide attempts.[76] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[77]

VHA requires routine assessments of pain and the completion of an opioid risk assessment before initiating patients on long-term opioid therapy and recommends against the therapy for patients with untreated substance use disorders. VHA also recommends avoiding drugs capable of inducing fatal interactions, such as opioids with benzodiazepines.[78] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[79] To achieve VHA's vision of providing patient-driven healthcare, providers are also required to obtain informed consent from patients and to provide education about the risks, benefits, and alternatives prior to initiating long-term opioid therapy.[80] VHA recommends evaluating patients receiving continued opioid therapy for improvement of pain and opioid-related adverse events at least every three months and more frequently as doses increase.[81]

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

- Completion of initial screening for pain

- Assessment of aberrant behavior risk

- Avoidance of concurrent therapy with benzodiazepines

- Completion of urine drug testing with intervention, when indicated

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

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

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

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

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

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

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

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

- Documentation of informed consent

- Timely follow-up with patients included required elements

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures include, but are not limited to, adherence to published clinical practice guidelines, timeliness of treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment, patient satisfaction, and quality of life.[82] The OIG examined the following indicators for program oversight and evaluation:

- Performance of pain management committee activities

- Monitoring of quality measures

- Following the quality improvement process

The OIG interviewed key employees and managers and reviewed relevant documents and the electronic health records of 17 outpatients who had newly dispensed (no VA dispensing in previous six months) long-term opioids for pain, daily or intermittently for 90 or more calendar days through VA from July 1, 2018, through June 30, 2019. The team considered whether providers acted in accordance with guidelines for the provision of pain management and the medical center's oversight process for evaluating pain management outcomes and quality.

Medication Management Findings and Recommendations

The OIG found the medical center addressed many of the indicators of expected performance, including pain screening, documented justification for concurrent therapy with benzodiazepines, and urine drug testing. The medical center was generally compliant with the use of a multidisciplinary pain management committee to oversee and monitor required quality measures. However, the OIG found deficiencies with aberrant behavior risk assessment, informed consent, and patient follow-up after therapy initiation.

VA/DoD recommends completion of a behavioral risk assessment, including history of substance abuse, psychological disease, and aberrant drug-related behaviors,[83] prior to initiating long-term opioid therapy.[84] The OIG found that clinicians assessed patients for a history of substance abuse, psychological disease, and aberrant drug-related behaviors prior to initial dispensing in 53 percent of the patient electronic health records reviewed.[85] This may have resulted in providers prescribing opioids for patients at high risk for misuse. The Chief of Primary Care, Associate

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

[83] *Pain Management, Opioid Safety, VA Educational Guide (2014)*, July 2014; Examples of aberrant drug related behaviors include "lost prescriptions, multiple requests for early refills, unauthorized dose escalation, apparent intoxication, and frequent accidents."

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

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

Chief of Pharmacy, and the certified Pain Clinic provider stated that time constraints led to a lack of attention to detail with documentation and that providers are challenged with numerous VHA requirements.

Recommendation 15

15. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures that clinicians complete a behavioral risk assessment that includes a history of substance abuse, psychological disease, and aberrant drug-related behaviors on patients prior to initiating long-term opioid therapy.

Medical center concurred.

Target date for completion: May 1, 2021

Medical center response: The VISN Academic Detailer, local Clinical Application Coordinator, Chief of Primary Care, Chief of Pharmacy, and Pain Management Provider will work collaboratively to develop and implement a medical center "Controlled Substance Prescribing and Risk Review" note by July 2020. This note will include a behavioral risk assessment prior to initiating long-term opioid therapy. Beginning September 2020, monthly chart audit reviews of all new long-term opioid therapy prescriptions will be conducted by the pain Clinical Pharmacy Specialist. Data will be reviewed monthly and reported quarterly to the Medical Executive Committee by the pain Clinical Pharmacy Specialist with an expected sustained compliance of 90 percent or greater for two consecutive quarters. Compliance will be reported quarterly to the Medical Executive Committee which is chaired by the Chief of Staff.

DATA DEFINITION:

Sample Size: 20 charts or 100% if the number of charts if less than 20.

Numerator: The number of charts with completed behavioral risk assessments prior to initiating Long Term Opioid Therapy (LTOT).

Denominator: The total number of audited charts of all new long-term opioid therapy prescriptions each month.

TIMELINE:

June 2020: Completion of medical center "Controlled Substance Prescribing and Risk Review" note.

July 2020: Education of staff in Primary Care and trial of the note to two Primary Care PACT teams for feedback and to make any needed modifications.

August 2020: Education of staff of other medical center departments (e.g. Specialty Care, Surgery, Emergency Department) and execution of note for medical center use.

September 2020: Initiate monthly chart audit reviews with data pulled from Acute Pain Dashboard and medical center "Controlled Substance Prescribing and Risk Review" note.

Target date for completion: May 2021 (to capture data of the 3 months follow-up care from February 2021 visits).

VHA requires providers to obtain and document informed consent prior to initiating therapeutic treatments that "have a significant risk of complication or morbidity", including long-term opioid therapy.[86] VHA also recommends that the informed consent conversation cover the risks and

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[86] VHA Directive 1005.

benefits of opioid therapy, as well as alternative therapies.[87] The OIG determined that clinicians documented informed consent prior to initiating long-term opioid therapy in 65 percent of the patients at the medical center, based on electronic health records reviewed.[88] The remaining patients had potentially received treatment without knowledge of the risks associated with long-term opioid therapy, including opioid dependence, tolerance, addiction, and intentional or unintentional fatal overdose.

The Chief of Primary Care, Associate Chief of Pharmacy, and certified Pain Clinic provider stated there had been no formal provider education for approximately 18 months; this was due to a vacancy for a quality improvement staff member responsible for identifying gaps in patient care and/or documentation of opioid therapy and safety concerns. Additionally, the facility leaders shared that VHA requirements for separate progress notes with very specific titles (for example, Prescription Drug Monitoring and Consent for Long-Term Opioid Therapy) were tedious, resulting in providers not consistently completing the notes and possibly causing patient care items to "fall through the cracks."

Recommendation 16

16. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and makes certain that healthcare providers consistently obtain and document informed consent for patients who are initiating long-term opioid therapy.

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[87] VHA Directive 1005.

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

Medical center concurred.

Target date for completion: May 1, 2021

Medical center response: The VISN Academic Detailer, local Clinical Application Coordinator, Chief of Primary Care, Chief of Pharmacy, and Pain Management Provider will work collaboratively to develop and implement a medical center "Controlled Substance Prescribing and Risk Review" note by July 2020. This note will include a discussion of the risks and benefits and obtain informed consent prior to initiating long-term opioid therapy. Beginning September 2020, monthly chart audits of all new long-term opioid therapy prescriptions will be conducted by the pain Clinical Pharmacy Specialist. Data will be reported quarterly to the Medical Executive Committee by the pain Clinical Pharmacy Specialist with an expected sustained compliance of 90 percent or greater for two consecutive quarters. The Medical Executive Committee is chaired by the Chief of Staff.

DATA DEFINITION:

Sample Size: 20 charts or 100% if the number of charts if less than 20.

Numerator: The number of monthly charts with completed informed consent prior to initiating long term opioid therapy.

Denominator: The total number of audited charts of all new long-term opioid therapy prescriptions each month.

VA/DoD clinical practice guidelines recommend that providers evaluate the "benefits of continued opioid therapy and risk for opioid-related adverse events at least every three months" after initiating long-term opioid therapy.[89] Regular follow-up can also help providers assess adherence to plans and the effectiveness of interventions.[90] The OIG evaluated care events through the first three months after initiation of long-term opioid therapy and found that clinicians provided patient follow-up in 75 percent of the patients reviewed.[91] For the remaining patients, failure to follow up can result in missed opportunities to assess adherence to the therapy plan, effectiveness of treatment, and risks of continued opioid therapy. The Chief of Primary Care, Associate Chief of Pharmacy, and certified Pain Clinic provider stated that time limitations caused by numerous VHA-required screenings contributed to a lack of attention to detail with completing documentation.

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

[90] VHA Directive 2009-053.

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

Recommendation 17

17. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures healthcare providers follow up with patients within three months after initiating long-term opioid therapy.

Medical center concurred.

Target date for completion: May 31, 2021

Medical center response: The VISN Academic Detailer, local Clinical Application Coordinator, Chief of Primary Care, Chief of Pharmacy, and Pain Management Provider will work collaboratively to develop and implement a medical center "Controlled Substance Prescribing and Risk Review" note. This note will include a follow-up care evaluation either via face-to-face or telehealth modality (e.g. Video Connect or Telephone Visit) within three months after initiating long-term opioid therapy. The "Controlled Substance Prescribing and Risk Review" note will be implemented by July 2020. Beginning September 2020, a monthly chart review of all new long-term opioid therapy prescriptions will be conducted by the pain Clinical Pharmacy Specialist. The data will be reported quarterly to the Medical Executive Committee by the pain Clinical Pharmacy Specialist with an expected sustained compliance of 90 percent or greater for two consecutive quarters. The Medical Executive Committee is chaired by the Chief of Staff.

DATA DEFINITION:

Sample Size: 20 charts or 100% if the number of charts is less than 20.

Numerator: The number of charts with completed follow-up encounters within three months of initiating long-term opioid therapy.

Denominator: The total number of audited charts of all new long-term opioid therapy prescriptions each month.

Mental Health: Suicide Prevention Program

In 2017, suicide was the 10th leading cause of death, with approximately 47,000 lives lost across the United States.[92] The suicide rate was 1.5 times greater for veterans than for non-veteran adults and estimated to represent approximately 22 percent of all suicide deaths in the United States.[93] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[94]

VHA has identified suicide prevention as a top priority and implemented various evidence-based approaches to reduce the veteran suicide rate. In addition to expanded mental health services and community outreach, VHA has developed comprehensive screening and assessment processes to identify at-risk patients.[95]

VHA requires that each medical center and very large CBOC have a full-time suicide prevention coordinator (SPC) to track and follow up with high-risk veterans, develop a process for responding to referrals from hotlines such as the Veteran Crisis Line, and conduct community outreach activities.[96] The OIG examined various requirements related to SPCs:

- Assignment of a full-time SPC

- Tracking and follow-up of high-risk veterans

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

   o Safety plan completion within the required time frame

   o Mental health teams' contacts with patients for missed appointments

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

- Completion of at least five outreach activities per month

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

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

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

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

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

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

such determination by the SPC."[97] According to VHA, "Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death…The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions."[98] The HRS PRF is reviewed at least every 90 days and depending on changes to the suicide risk status, will remain active or be removed.[99] Additionally, VHA requires designated high-risk patients to have a completed suicide safety plan and four face-to-face visits with an acceptable provider within the first 30 days of designation.[100]

The OIG noted that from July 1, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA required that "Any patient determined to be High Risk for Suicide [by the licensed independent provider] must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination."[101] However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management changed the requirement for the HRS PRF placement to be "as soon as possible but no later than 1 business day after determination by the SPC."[102] VHA further provided additional clarifying information:

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

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

- The SPC's determination process "may be beyond 24 hours after a referral, due to case consultation and review."[103]

The OIG is concerned that the updated requirement may result in delayed placement of HRS PRFs for at-risk patients. Without defined time frames for SPC determination that the HRS PRF is warranted, patients identified as at-risk for suicide could have flags placed in his or her chart several days after referral. For example, the current requirement would allow for a patient to be

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

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

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

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

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

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

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

identified as high risk for suicide and referred to the SPC on Monday, the SPC to assess the patient for risk and determine the need for an HRS PRF on the following Friday, and the SPC to place an HRS PRF on the subsequent Monday (a week after referral).

On March 27, 2020, VHA also updated existing policy requirements to allow the review of HRS PRFs to "occur no earlier than 10 days before and no later than 10 days after the 90-day due date."[104]

Inspectors examined the completion of several requirements:

- Review of HRS PRFs within the required time frame

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

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

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

All VHA employees must complete suicide risk and intervention training within 90 days of entering their position. Clinical staff (including physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and Vet Center counselors) must complete Suicide Risk Management Training for Clinicians, and nonclinical staff must complete Operation S.A.V.E. training.[105] VHA also requires that all staff receive annual refresher training.[106] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[107]

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

- Relevant documents;

- The electronic health records of 42 outpatients whose electronic health records were flagged as high risk for suicide from July 1, 2018, to June 30, 2019; and

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

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

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

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

- Staff training records.

Mental Health Findings and Recommendations

The OIG found the medical center complied with requirements for a designated SPC, follow-up with high-risk veterans, and monthly outreach activities. The OIG noted that although the medical center had patient tracking process in place, there were no improvement needs or action plans identified.

With VHA's original requirement that was in place when these patients received care—that "Any patient determined to be High Risk for Suicide must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"[108] —the OIG determined that 64 percent of HRS PRFs were placed by end of next day following referral to the SPC.[109] Based on the current updated requirement that the SPC be responsible for determining placement of the HRS PRF (without a defined timeframe for doing so)[110], the OIG further calculated that the average time from referral to HRS PRF placement for the patients reviewed was two days (observed range was 0–22 days).

Further, the OIG noted concerns with reviewing HRS PRFs in a timely manner. VHA required that all patients with an HRS PRF be reevaluated at least every 90 days and there is documented justification for continuing or discontinuing the flag.[111] The OIG estimated that 74 percent of patients with an HRS PRF were reevaluated at least every 90 days.[112] However, based upon the updated requirement that HRS PRFs be reviewed up to 10 days prior to or after the due date for reevaluation, the OIG found that 38 of 42 (90 percent) of patients were reviewed within the expected time frame (observed range was 17–111 days).[113]

Additionally, the OIG noted concerns with mental health visits for at-risk patients, required elements in suicide safety plans, and suicide prevention training.

VHA requires an at-risk veteran to have four follow-up visits with a qualified provider within 30 days of HRS PRF placement. The follow-up visits should be face-to-face unless the veteran requests a telephonic visit, and there must be documentation identifying the patient's preference

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

[109] The OIG estimated that 95 percent of the time, the true compliance rate is between 50.0 and 78.6 percent, which is statistically significantly below the 90 percent benchmark. Required elements for EHR reviews are noncompliant only when the entire confidence interval falls below 90 percent.

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

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

[112] The OIG estimated that 95 percent of the time, the true compliance rate is between 60.0 and 86.7 percent, which is statistically significantly below the 90 percent benchmark. Required elements for EHR reviews are noncompliant only when the entire confidence interval falls below 90 percent.

[113] VHA Notice 2020-13.

for a telephone call.[114] The OIG found that 74 percent of electronic health records reviewed had evidence of the required four follow-up appointments.[115] This potentially resulted in inadequate follow-up on high-risk patients. The Associate Chief of Staff of Behavioral Health and the SPC reported that the current template used for phone visits did not have a place for providers to document consent for the calls, the wide geographical area covered by the medical center makes in-person contact with patients difficult, and using telephonic methods increases the opportunity to make successful patient contact. The Associate Chief of Staff of Behavioral Health and the SPC could not provide a reason for noncompliance.

Recommendation 18

18. The Chief of Staff determines reason(s) for noncompliance and makes certain that clinicians conduct four follow-up appointments within the required time frame and document the patient's preference for telephonic follow-up, if warranted.

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

[115] The OIG estimated that 95 percent of the time, the true compliance rate is between 60.0 and 86.4 percent, which is statistically significantly below the 90 percent benchmark. Required elements for EHR reviews are noncompliant only when the entire confidence interval falls below 90 percent.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: Education was provided to Behavioral Health staff regarding the requirement for documenting consent by the patient to utilize phone contact as a means of follow-up. On January 27, 2020, Behavioral Health staff were educated on the necessary changes to local templates to ensure this consent is appropriately documented.

A standard operating procedure for Guidance on Patient Failure to Attend Appointments was developed by Behavioral Health staff and signed by Associate Chief of Staff on December 9, 2019. This standard operating procedure defines responsibilities and procedures for timely and accurately responding to patient failure to attend appointments. The standard operating procedure was distributed to Behavioral Health staff by email and education was provided to the staff at the March 2020 Behavioral Health staff meeting. On March 9, 2020, the Suicide Prevention Coordinator provided additional training to Behavioral Health Discharge Coordinators to ensure that at least four follow-up appointments are scheduled for veterans prior to discharge from an in-patient setting. On May 26, 2020, a missed appointment note template was developed by the Chief of Psychiatry to complement the standard operating procedure. The missed appointment note template is intended to enhance no-show documentation visibility, policy, and increase collaboration among team members.

A Behavioral Health Interdisciplinary Program Case Documentation standard operating procedure was developed by Behavioral Health staff and signed by Associate Chief of Staff on May 18, 2020. This standard operating procedure establishes procedures for members of the Behavioral Health Interdisciplinary Program team to coordinate care and schedule follow-up or missed appointments if indicated. The Behavioral Health Interdisciplinary Program Case Documentation standard operating procedure was distributed to Behavioral Health staff by email in June 2020. Staff training will be done at the July 2020 Behavioral Health staff meeting.

The Suicide Prevention Coordinator will conduct audits on randomly selected charts monthly until a 90 percent or higher compliance rate is met and sustained for two quarters. Data will be reported quarterly to the Medical Executive Committee which is chaired by the Chief of Staff.

DATA DEFINITION:

Four follow-up appointments data

Sample Size: A minimum of 20 charts (or 100 percent if there are fewer than 20 charts) of high-risk for suicide patients monthly.

Numerator: The number of patients who completed four follow-up appointments within the required timeframe.

Denominator: The number of high-risk for suicide patient charts audited monthly.

Patients preference for telephonic follow-up data

Sample Size: A minimum of 20 charts (or 100 percent if there are fewer than 20 charts) of high-risk for suicide patients monthly.

Numerator: The number of patients with documentation of patient's preference for telephonic follow-up, if warranted.

Denominator: The number of high-risk for suicide patient charts audited monthly.

VHA also requires clinicians to complete suicide safety plans for any patient designated as high-risk. Suicide safety plans should include an assessment of safe medication (opioid) storage, gun safety procedures, and restriction of access to other lethal means and be completed within seven days before or after the placement of the High Risk for Suicide Patient Record Flag.[116] The OIG estimated that for the electronic health records reviewed, suicide safety plans with all required assessment elements were completed within the seven-day timeframe for 62 percent of patients.[117] Failure to complete safety plans within the required timeframe, including assessing for weapon and opioid safety, could pose a significant danger to vulnerable patients. The Associate Chief of Staff of Behavioral Health and SPC reported that multiple changes to VHA directives impacted the facility's implementation of policies and compliance.

Recommendation 19

19. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures that clinicians complete safety plans in a timely manner and that all required elements—including firearm and opioid safety—are assessed for patients with High Risk for Suicide Patient Record Flags.

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[116] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide*; VHA suicide subject matter expert response to timing of safety plan completion, July 8, 2019.

[117] The OIG estimated that 95 percent of the time, the true compliance rate is between 46.6 and 76.1 percent, which is statistically significantly below the 90 percent benchmark.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: On January 14, 2020, the Suicide Prevention Coordinator worked with the medical center Clinical Application Coordinator to ensure the old Suicide Prevention Safety Plan template was removed from the system. Education on utilizing the correct Suicide Prevention Safety Plan template was provided to Behavioral Health staff on June 11, 2020. This template will ensure that all elements of the Suicide Prevention Safety Plan are completed, including access to firearms and opioids. During education, emphasis was made to ensure the need for these plans to be completed within seven days of placement of a High Risk for Suicide Patient Record Flag.

On February 17, 2020, the Medical Center Director signed the updated Suicide Prevention and Management Policy. This update included instruction on both the narrative and flowsheets to ensure everyone is aware of the requirement for a Suicide Prevention Safety Plan for all Veterans who have a High Risk Patient Record Flag designation. Ninety-four percent of assigned VHA staff completed a face-to-face Suicide Prevention Assessment, Management Tool and Policy Review. The remaining six percent of staff will complete the review with the Suicide Prevention Coordinator prior to September 30, 2020.

The Suicide Prevention Coordinator will conduct random chart audits monthly until a 90 percent or higher compliance rate is met and sustained for two quarters. Data will be reported quarterly to the Medical Executive Committee which is chaired by the Chief of Staff.

DATA DEFINITION:

Sample size: A minimum of 20 charts (or 100 percent if there are fewer than 20 charts) of High Risk Patient Record Flag patients monthly.

Numerator: The number of High Risk Patient Record Flag charts which had Suicide Prevention Safety Plans completed with all the required elements within the required timeframe (seven days).

Denominator: The number of High Risk Patient Record Flag patient charts audited monthly.

VHA requires that all employees complete suicide risk and intervention training within 90 days of entering their position. Clinical staff must complete the Suicide Risk Management Training for Clinicians, and nonclinical staff are required to complete Operation S.A.V.E. training. VHA mandates that all staff, clinical and nonclinical, receive annual refresher training thereafter.[118] The OIG found that 3 of 20 clinical and nonclinical staff did not complete annual refresher training as required. Lack of training could prevent employees from providing optimal treatment to veterans who are at risk for suicide. Again, the Associate Chief of Staff of Behavioral Health

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[118] VHA Directive 1071.

and SPC reported that multiple changes to applicable VHA directives affected the facility process and roll-out of actions that impact compliance.

Recommendation 20

20. The Medical Center Director evaluates and determines any additional reason(s) for noncompliance and ensures clinical and nonclinical staff receive annual suicide prevention refresher training.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Suicide Prevention Coordinator met with the Education Department on May 28, 2020, for tracking staff training surrounding suicide prevention. Ninety-nine percent of non-clinical staff assigned are compliant with completing the required annual S.A.V.E. Refresher Training. Ninety-nine percent of assigned clinicians are compliant with completing the required annual Suicide Risk Management Training for Clinicians.

As of May 28, 2020, the Skills Training for Evaluation and Management of Suicide is required for all clinicians to include mental health physicians, non-physician health care staff, nurse practitioners, clinical nurse specialist, psychologists, social workers and counselors and 100 percent of assigned clinicians are compliant with completing the required annual Skills Training for Evaluation and Management of Suicide.

The Suicide Prevention Coordinator will monitor monthly required suicide prevention TMS trainings for all Medical Center employees through TMS reports, until 90 percent or greater compliance is sustained for two quarters. Compliance will be reported quarterly to the Quality Practice Council. The Quality and Performance Council reports to the Quality, Safety, and Value Board which is co-chaired by the Medical Center Director.

DATA DEFINITIONS:

Sample Size: 100 percent of employees required to complete annual suicide prevention trainings.

Numerator: Number of medical center staff, clinical and non-clinical, that have completed required suicide prevention training.

Denominator: Total number of medical center staff, clinical and non-clinical, that require annual suicide prevention trainings.

Care Coordination: Life-Sustaining Treatment Decisions

Life-sustaining treatments (LSTs) are intended to extend the life of a patient expected to die soon without medical intervention. Life-sustaining treatments may include artificial nutrition, hydration, and mechanical ventilation. VHA issued the Life-Sustaining Treatment Decisions (LSTD) handbook to standardize practices related to discussing and documenting goals of care and LSTD. Per VHA, the goal is to encourage personalized, proactive, patient-driven treatment plans for veterans with serious illness by "…eliciting, documenting, and honoring patients' values, goals, and preferences."[119]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.[120] Implementation requirements included initiating conversations about the goals of care. A goals of care conversation is a discussion between a healthcare provider and a patient or surrogate to help define the patient's values, goals, and preferences for care and, based on the discussion, make choices about starting, limiting, or ceasing LSTs.[121] VHA requires practitioners to initiate goals of care conversations with high-risk patients—including hospice patients or their surrogates—within a time frame that meets the medical needs of the patient or at the time of a triggering event.[122]

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

- Decision-making capacity,

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

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

- Goals of care,

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

- Informed consent for the LST plan.

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

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

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

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

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

- Decision-making capacity,

- Goal(s) of care,

- Plan of care for the use of LST, and

- Informed consent for the LST plan.

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

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

- Completion of LSTD notes

- Timely documentation of LSTD

- Inclusion of required elements in LSTD documentation

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

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[123] Inspectors examined if the medical center established an LSTD committee that was comprised of a multidisciplinary membership, which included representation from Ethics Consultation Service, and reviewed proposed LST plans.

To determine whether the medical center complied with the OIG-selected requirements related to LSTD for hospice patients, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 50 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

Care Coordination Findings and Recommendations

The OIG team found the medical center generally complied with requirements, including supervision of designees. Additionally, with VHA's original requirement that was in place when these patients received care, the OIG estimated that 58 percent of patients' LST progress notes

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[123] VHA Handbook 1004.03(1).

addressed previous advance directive(s), state-authorized portable orders, and/or LST notes.[124] However, VHA no longer requires this element be documented in the LST progress note.[125] The OIG remains concerned that this change could result in practitioners not addressing important goals of care conversation elements.

VHA requires the appointment of a multidisciplinary committee to "consider the procedural and ethical validity" of provider-recommended life-sustaining treatment plans for patients who lack decision-making capacity and have no surrogate.[126] The OIG found no evidence of a facility multidisciplinary committee appointed by the Medical Center Director to review such plans. Lack of a multidisciplinary committee may impede ethical decision-making for initiation, limitation, or discontinuation of life-sustaining treatments for incapacitated patients. The Deputy Nurse Executive reported that the charter for the Ethics Consultation Committee, a subcommittee of the facility's Integrated Ethics Committee, was outdated and did not specify responsibility for reviewing LST plans, when needed.

Recommendation 21

21. The Medical Center Director evaluates and determines any additional reason(s) for noncompliance and appoints a multidisciplinary committee responsible for life-sustaining treatment decision reviews that includes representatives from three or more different disciplines.

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[124] The OIG estimated that 95 percent of the time, the true compliance rate is between 42.9 and 72.5 percent, which is statistically significantly below the 90 percent benchmark.

[125] VHA Handbook 1004.03(1).

[126] VHA Handbook 1004.03(1).

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Ethics Consultation Committee Charter was reviewed, revised, and approved by the Medical Center Director on May 28, 2020. The Deputy Nurse Executive is responsible for the Ethics Consultation Committee. The purpose of the Ethics Consultation Committee is to establish an interdisciplinary committee that promotes ethical understanding by serving in an advisory and consultative capacity to persons involved in patient care decision-making, to review and recommend center policy related to health care decision making, and to promote the rights of Veterans, families and their caregivers. Membership of the charter includes: The Deputy Nurse Executive as the chair, Home Telehealth Nurse Manager, Community Living Center Assistant Nurse Manager, Hospice and Palliative Care Social Worker, Staff Psychologist, Home Based Primary Care Medical Director, Safe Patient Handling, Office of Community Care, Program Support Assistant (Deputy Nurse Executive). Ex-Officio Non-Voting Members include: Nutrition and Food Services and the Chaplain. The Ethics Consultation team will develop and implement, by August 30, 2020, an educational plan to educate staff throughout the medical center about the Ethics Consultation process specific to Life Sustaining Treatment. The committee will meet quarterly beginning in July 2020, and when necessary at the call of the Chair. Meeting minutes will include any requests for Life Sustaining Treatment reviews that were completed. The committee reports quarterly to the Integrated Ethics Council which reports to the Quality, Safety, and Value Board co-chaired by the Medical Center Director.

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[127] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans are anticipated to increase.[128] To help the VA better understand the needs of the growing women's veteran population, efforts have been made by VHA to identify and address the urgent needs "by examining health care use, preferences, and the barriers Women Veterans face in access to VA care."[129] Additionally, a VA report in 2016 on suicide among veterans pointed out concerning trends in suicide among women veterans and discussed "the importance of understanding suicide risk among women veterans and developing gender-tailored suicide prevention strategies."[130]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment. Facilities must, therefore, ensure availability of appropriate resources, services, and staffing ratios.[131] VHA also requires delivery of quality care to all women veterans accessing VA emergency services. In addition, VHA requires facilities to establish a multidisciplinary women veteran health committee that "develops and implements a Women's Health Program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans."[132]

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

- Provision of care requirements

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

[128] National Center for Veterans Analysis and Statistics, "Veteran Population," May 3, 2019. https://www.va.gov/vetdata/docs/Demographics/VetPop_Infographic_2019.pdf. (The website was accessed on September 16, 2019.)

[129] U.S. Department of Veterans Affairs, "*Study of Barriers for Women Veterans to VA Health Care*," Final Report, April 2015. https://www.womenshealth.va.gov/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf. (The website was accessed on September 16, 2019.)

[130] U.S. Department of Veterans Affairs, Health Services Research & Development, Forum, *Concerning Trends in Suicide Among Women Veterans Point to Need for More Research on Tailored Interventions, Suicide Prevention*, Spring 2018. https://www.hsrd.research.va.gov/publications/forum/spring18/default.cfm?ForumMenu=Spring18-5. (The website was accessed on September 16, 2019.)

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

[132] VHA Directive 1330.01(3).

- o Designated Women's Health Patient Aligned Care Team established

- o Primary Care Mental Health Integration services available

- o Gynecologic care coverage available 24/7

- o Gynecology care accessible

- o Facility women health primary care providers designated

- o CBOC women's health primary care providers designated

- o Emergency contraception accessible

- Oversight of program and monitoring of performance improvement data

  - o Women Veterans Health Committee established

    - - Quarterly meetings held

    - - Core members attend

    - - Quality assurance data collected and tracked

    - - Reports made to clinical executive leaders

- Assignment of required staff

  - o Women Veterans Program Manager

  - o Women's Health Medical Director or clinical champion

  - o Maternity Care Coordinator

  - o Women's health clinical liaison at each CBOC

Women's Health Findings and Recommendations

The medical center complied with requirements for most of the provision of care indicators and each of the selected staffing elements reviewed. However, the OIG identified weaknesses with the Women Veterans Health Committee.

VHA requires that the Women Veterans Health Committee core membership include a women veterans program manager, a women's health medical director, "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [Emergency Department], radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership."[133] The OIG requested Women Veterans Health Committee minutes for April–September 2019. The committee met in May and September 2019, and lacked attendance from medical and/or surgical subspecialties, Radiology, and executive leadership. In addition, the

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[133] VHA Directive 1330.01(2).

committee lacked the required representative from the Emergency Department prior to September 2019. Inadequate multidisciplinary representation may result in a lack of expertise and oversight in the review and analysis of data, as the committee planned and conducted improvements for quality and equitable care for women veterans. The Women's Health Medical Director stated that a staffing shortage within the radiology and emergency departments prevented members from attending. In addition, the Chief of Staff acknowledged the attendance requirement by an executive member and stated that other meetings preempted attendance.

Recommendation 22

22. The Medical Center Director evaluates and determines any additional reason(s) for noncompliance and makes certain that required members consistently attend Women Veterans Health Committee meetings.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: Women Veteran Health Committee meets on a quarterly basis, with subcommittees meeting in between the quarterly meeting. Attendance was identified as an issue by some departments with conflicting responsibilities during meeting times, or members that have changed positions and new members had not been identified. The Women Veteran Health Committee Charter requires service lines to attend three out of four of the quarterly meetings and a quorum of 9 of 16 are required for voting.

In December 2019, the Women Veteran Program Manager alerted each service line of the membership requirement, requested confirmation of the designee and alternates to represent the service line, and sent calendar invitations to the designee and the alternate. The Women Veteran Program Manager monitors acceptance and unacceptance of calendar invites. Follow-up calls are made to the alternate to confirm attendance for the meeting. Service line supervisors receive email notification when the designee or alternate of their department fail to attend, with Chief of Staff copied on the notification.

Meeting attendance will be tracked in quarterly Women Veteran Health Committee meeting minutes indefinitely. Reporting of designee or alternate non-compliance with meeting attendance will be done by the Women Veteran Program Manager starting with the June 2020 Women Veteran Health Committee report to Medical Executive Committee. Monitoring of Medical Executive Committee reporting of identified non-compliance with Women Veteran Health Committee meeting attendance will be done by Women Veteran Program Manager for two consecutive quarters (June 2020 and September 2020 at the Medical Executive Committee meetings), with a target of 90 percent of members meeting the attendance requirement. The Medical Executive Committee reports to Quality, Safety, and Value Board. The Medical Center Director is a Co-Chair of this board.

DATA DEFINITION:

Numerator: The number of members compliant with Women Veteran Health Committee attendance requirement.

Denominator: The total number of Women Veteran Health Committee required members.

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have a Sterile Processing Services (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment…"[134] The goal of SPS is to "...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[135] To ensure this, VHA requires facilities to conduct the following activities:

- Maintain a current inventory list of all RME

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

- Use CensiTrac® Instrument Tracking System for tracking reprocessed instruments[136]

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

- Monitor data for reprocessing and storing RME

- Conduct annual airflow/ventilation system inspections[137]

VHA requires strict controls that closely monitor climate, storage, and sterilization parameters and additionally requires that quality assurance documentation of this monitoring be maintained for a minimum of three years.[138] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[139]

In addition, RME reprocessing areas must be clean, restricted, and airflow-controlled. All areas where RME reprocessing occurs must have safety data sheets, an unobstructed eyewash station, personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[140]

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

[135] Association for Professionals in Infection Control and Epidemiology, *APIC Text of Infection Control and Epidemiology*, Chapter 107: Sterile Processing, April 26, 2019. https://text.apic.org/toc/infection-prevention-for-support-services-and-the-care-environment/sterile-processing#book_section_17348. (The website was accessed on May 14, 2019.)

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

[137] VHA Directive 1116(2).

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

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

[140] VHA Directive 1116(2).

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued annual and essential staff competency assessments, and monthly continuing education. This ensures that staff have sufficient aptitude, knowledge, and skills to effectively and safely reprocess and sterilize RME.[141]

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

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

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[141] VHA Directive 1116(2).

- Completion of staff training, competency, and continuing education

  o Required training completed in a timely manner

  o Competency assessments performed

  o Monthly continuing education received

High-Risk Processes Findings and Recommendations

The medical center did not meet many of the requirements for the proper operations and management of reprocessing RME. The OIG identified deficiencies with the annual risk analysis, airflow checks, eating or drinking in prohibited areas, and proper storage of equipment.

VHA requires that SPS perform an annual risk analysis and that the analysis be reported to the VISN Sterile Processing Service Management Board.[142] The medical center staff completed the required FY 2019 risk analysis; however, the OIG found no evidence that the risk analysis was reported to the VISN Sterile Processing Service Management Board. When VISN SPS leadership does not receive the annual risk analysis, the leaders may not be fully aware of potential problems/failures that could lead to inadequate resources and/or actions to improve and support the SPS program. The Associate Chief Nurse, Perioperative/SPS, stated that the VISN had not requested the report but also was unable to provide a reason for not following the directive.

Recommendation 23

23. The Associate Director for Patient Care Services evaluates and determines any additional reason(s) for noncompliance and makes certain that Sterile Processing Services reports the annual risk analysis to the Veterans Integrated Service Network Sterile Processing Services Management Board.

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[142] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Associate Director for Patient Care Services and the Chief, Sterile Processing Service evaluated additional reasons for noncompliance with the annual risk analysis being sent to VISN per VHA Directive 1116(2). This was an oversight on behalf of the Chief, Sterile Processing Service. At the VISN Sterile Processing Service Chief Conference, this was identified as a gap as well. A process has been established between the VISN and Medical Center Sterile Processing Service Chiefs to document and track the annual risk analysis going forward. The submission of the annual risk analysis will be reported through local Reusable Medical Equipment Committees and to the VISN Sterile Processing Service Sub-Committee.

The annual Risk Analysis was submitted to VISN Sterile Processing Service Lead on November 22, 2019. On March 2020, the VISN 15 Sterile Processing Service Management Board reviewed all medical center strength, weakness, opportunities and threat (SWOT) analysis.

The Chief of Sterilization Processing Services will submit an annual Risk Analysis to VISN 15 Sterile Processing Service Sub-Committee which then is reported to the VISN Sterile Processing Management Board as required. Submission to VISN 15 will be communicated and documented through the medical center Reusable Medical Equipment Committee that meets monthly. The Risk Analysis has been added to the Reusable Medical Equipment Committee agenda for annual review with a note to be sent to VISN following review/approval. The Associate Director for Patient Care Services is a member of the Reusable Medical Equipment Committee.

VHA requires "commercial airflow directional devices …be utilized to enable SPS staff to verify the direction of airflow." This minimizes "movement of microorganisms from dirty areas to clean areas".[143] The OIG found that SPS reprocessing areas, which recently became operational on September 3, 2019, had commercial airflow directional devices in use; however, facility staff noted inconsistencies between the commercial airflow device's readings and staff's manual testing results. On November 15, 2019, a contracted vendor evaluated items requiring repair, which included parts that can affect airflow. Failure to achieve air quality standards can lead to the spread of healthcare-associated infections.[144]

The Associate Chief Nurse Perioperative/SPS reported that due to concerns about inaccurate readings from the commercial air flow device, SPS staff had assessed directional airflow

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[143] VHA Directive 1116(2).

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

manually,[145] maintained paper logs, and placed work order requests for repairs as needed. Additionally, the Associate Chief Nurse Perioperative/SPS stated if airflow concerns arose for the prep room (where final processing and packaging of the equipment occurs), a shutdown would occur until corrective actions were taken. The Chief of Engineering reported deficiencies related to recent construction projects in this new SPS area affected directional airflow and that the medical center was actively working with vendors and staff to correct the issues.

Subsequent to the site visit, the OIG learned through a newspaper article published February 8, 2020,[146] that processing of RME was halted at the facility. The OIG initiated follow-up and received a response from medical center staff on February 11, 2020, reporting that the area had been closed on January 29, 2020, after continued monitoring and inability to correct airflow concerns.

Recommendation 24

24. The Associate Director for Patient Care Services evaluates and determines any additional reason(s) for noncompliance and ensures that Sterile Processing Services maintain required airflow parameters for areas where reusable medical equipment is reprocessed.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: From November 2019 through January 2020, the Chief, Sterile Processing Service continued monitoring of air flow and noted and reported intermittent compliance and inability to correct issues and maintain proper air flow to Facilities Management staff. On January 29, 2020, the Chief, Sterile Processing Service reported continued air flow deficiencies to executive leadership, who made the decision to close Sterile Processing Service Services due to proper air flow deficiencies. The Chief, Facilities Management ensured temporary construction modifications were completed between January 29, 2020, through February 9, 2020, to resolve Sterile Processing Service air flow issues. On February 10, 2020, Sterile Processing Service reopened after temporary modifications were completed and proper air flow was confirmed and maintained as evidenced by a visual airflow monitor that accurately reflects true airflow direction. Continuous monitoring of airflow within Sterile Processing Service is now done using the Siemens system, which is monitored by Facilities Management staff, as well as the visual airflow monitor located in Sterile Processing Service. On March 11, 2020, the final modifications and sealing of equipment was completed by contractors. On March

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[145] Facility staff visualized the directional airflow using a smoke test product. If the area is under negative pressure, the smoke will be pulled into the room. If the room is under positive pressure, the smoke will be blown away from the room.

[146] The Kansas City Star, "Unsure that medical equipment was sterile, Wichita VA quietly shut operating rooms," new release, February 8, 2020, https://www.kansascity.com/news/politics-government/article240054088.html.

12, 2020, assessment, modifications and adjustments were made to the air handling system by contractors. On March 19, 2020, education and diagrams were provided to Sterile Processing Service by engineering for reference and clarification of the system. On March 26, 2020, the final test, adjustment and balance report was conducted by contractors. On April 1, 2020, engineering, in conjunction with contractors, performed overnight monitoring of the airflow system to assess for discrepancies and issues. Monitors that did not respond appropriately were replaced. People flow was observed, and it was noted that various medical center staff were leaving doors open, which directly affected the airflow. Differences between alarm levels and the computer were noted and addressed. Just-in-time education was provided to all staff that access the area. Since April 1, 2020, no clinically significant, on-going airflow issues have been noted. A visual monitor has accurately reflected new air flow monitors and true direction of air flow.

In February 2020, a cross-functional team was appointed to review this incident to identify any additional opportunities for improvement. This team identified communication as a significant opportunity for improvement and developed and implemented a communication plan which has resulted in significant improvement in interdepartmental communication and has positively impacted the collaborative response to issues and alarms.

The Chief of Sterilization Processing Services Retired April 30, 2020 and the Reusable Medical Equipment Coordinator was detailed to the Acting Chief of Sterilization Processing Services. In May 2020, the Acting Chief, Sterile Processing Service developed a standard operating procedure and risk assessment for air flow non-compliance. The standard operating procedure and risk assessment will be reviewed for approval at the June 23, 2020, Reusable Medical Equipment Committee meeting. Risks identified via the risk assessment will have appropriate mitigating actions implemented and these risks and actions taken will be reported to the Reusable Medical Equipment committee as completed. The Acting Chief, Sterile Processing Service will audit airflow data in the prep and decontamination areas of SPS monthly and report to the RME committee until 2 quarters of 90% sustained compliance. The Associate Director of Patient Care Services is a member of the RME Committee.

DATA DEFINITIONS:

PREP AREA OF Sterile Processing Service

Sample Size: 100% of days in month.

Numerator: Number of days with proper airflow in prep area of Sterile Processing Service.

Denominator: Number of days in the month.

DECONTAMINATION AREA OF Sterile Processing Service

Sample Size:100% of days in month.

Numerator: Number of days with proper airflow in decontamination area of Sterile Processing Service.

Denominator: Number of days in the month.

VHA specifies that "eating, drinking, or the storage of food items (including beverages) are not permitted in SPS where the processes of decontamination, sterilization or clean/sterile storage are performed."[147] The OIG found that staff in the endoscopy area had drinks at their desk adjacent to the scope storage cabinet. Restricting eating and drinking in sterile processing and storage areas reduces the likelihood of cross-contamination. The Associate Chief Nurse of Perioperative/SPS stated lack of staff oversight in the environment as the reason for noncompliance.

Recommendation 25

25. The Associate Director for Patient Care Services evaluates and determines any additional reason(s) for noncompliance and ensures that staff avoid eating, drinking, and/or storing food items in areas where decontamination, sterilization, or clean/sterile storage occurs.[148]

Medical center concurred.

Target date for completion: June 10, 2020 (closed)

Medical center response: The Endoscopy Nurse Manager evaluated additional reasons for noncompliance. A review of the findings, including discussions with staff was completed. It was confirmed that there were no specific issues other than the Nurse Manager and staff believed the area cited in the findings were considered office space, and therefore it was okay for staff to have drink/food in their office space.

The Endoscopy Nurse Manager met with staff immediately to ensure staff did not have food or drinks at their desks in the endoscopy core area or around the scope storage. On December 12, 2019, the Endoscopy Nurse Manager once again addressed food/drink issues in the staff meeting and provided additional education via follow-up email. On February 26, 2020, Endoscopy staff were relocated to a dedicated office area, away from patient care, storage of scopes and common areas. Effective June 10, 2020 the scope storage cabinets were moved to a dedicated storage room (room 201K-34) away from the common areas as well.

The Associate Director of Patient Care and the Endoscopy Nurse Manager provided oversight of the move of the Endoscopy staff to a dedicated office area, and the move of the storage of scopes to a dedicated storage room. Closure of this recommendation is requested.

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[147] VHA Directive 1116(2).

[148] The OIG reviewed evidence sufficient to demonstrate that the medical center had completed improvement actions and therefore closed the recommendation before publication of the report.

VHA requires that high-level disinfected endoscopes "be hung so that no part of the scope touches the bottom of the cabinet and in sufficient space for storage of multiple endoscopes without touching."[149] The OIG found three high-level disinfected endoscopes were touching other scopes. Correct storage of endoscopes reduces the risk of contamination and damage to equipment. The Associate Chief Nurse of Perioperative/SPS stated that SPS staff are responsible for the proper storage of endoscopes in the endoscopy cabinet and that endoscopy area competency training does not include storage of endoscopes.

Recommendation 26

26. The Associate Director for Patient Care Services determines reason(s) for noncompliance and ensures that staff properly store endoscopes.

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: The Endoscopy Nurse Manager and Chief, SPS will ensure all GI scopes are hanging freely and not touching. On December 18, 2019, the Endoscopy Nurse Manager provided re-education to staff on the proper storage and hanging of endoscopes. On February 27, 2020, 100 percent of Sterile Processing Service staff attended an in-service on proper storage and hanging of scopes and re-education to visually check each time the cabinet is accessed. On June 1, 2020, daily monitoring of proper storage and hanging was added to the SPS checklist. If a scope is found to be improperly stored, at any time, it will be immediately removed from the cabinet and returned to SPS for full reprocessing and high-level disinfection. Currently, the purchase of five EndoDry Storage and Drying Cabinets is in contracting. The use of these cabinets will allow for scopes to be enclosed on individual horizontal shelves with continuous air flow. The daily monitoring of proper storage and hanging will be conducted until these cabinets are in use by SPS staff. The RME Coordinator will review data monthly and report quarterly to the RME committee until 90 percent or greater compliance is maintained for two consecutive quarters of data. The Associate Director of Patient Care Services is a member of the RME committee.

DATA DEFINITION:

Sample size: 100% of scopes assessed.

Numerator: The number scopes found properly hanging.

Denominator: The number of scopes available at the time of assessment.

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[149] VHA Directive 1116(2).

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• Root cause analyses include all required review elements. • Root cause analyses actions are implemented and properly documented in the VHA Patient Safety Information System.	• All required representatives consistently participate in interdisciplinary reviews of utilization management data. • The Patient Safety Manager or designee provides an annual patient safety report to medical center leaders.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• Clinical managers define in advance, communicate, and document expectations for FPPEs in provider profiles. • Reprivileging decisions are based on service-specific OPPE data. • Clinical managers consistently collect and review OPPE data. • Providers with similar training and privileges complete OPPEs of licensed independent practitioners.	• Medical Professional Standards Board meeting minutes consistently reflect the review of professional practice evaluation results when recommending continuation of privileges. • Provider exit review forms are completed within seven calendar days of licensed healthcare professionals' departing the medical center. • Departing licensed healthcare professional's first- or second-line supervisor appropriately signs the exit review form.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Medical center
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Accommodation and privacy for women veterans
	  ○ Logistics
	• Inpatient mental health unit
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Accommodation for women veterans
	  ○ Logistics
	• Community-based outpatient clinic
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Privacy for women veterans
	  ○ Logistics
		• A safe and clean environment is maintained throughout the medical center.
		• Personally identifiable information is protected when transporting information or specimens from the clinics to the medical center.
			• Patient care supply areas are properly designated, and adequate temperature and humidity controls are continuously monitored and maintained.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• Clinicians complete a behavioral risk assessment that includes a history of substance abuse, psychological disease, and aberrant drug-related behaviors on patients prior to initiating long-term opioid therapy. • Healthcare providers consistently obtain and document informed consent for patients who are initiating long-term opioid therapy. • Healthcare providers follow up with patients within three months after initiating long-term opioid therapy.	• None
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements	• Clinicians conduct four follow-up appointments within the required time frame and document the patient's preference for telephonic follow-up, if warranted. • Clinicians complete safety plans in a timely manner and that all required elements—including firearm and opioid safety—are assessed for patients with HRS PRFs.	• Clinical and nonclinical staff receive annual suicide prevention refresher training.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• None	• A multidisciplinary committee responsible for LSTD reviews is appointed that includes representatives from three or more different disciplines.
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• None	• Required members consistently attend Women Veterans Health Committee meetings.
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Data monitoring • Physical inspection • Staff training	• SPS maintains required airflow parameters for areas where RME is reprocessed. • Staff avoid eating, drinking, and/or storing food items in areas where decontamination, sterilization, or clean/sterile storage occurs. • Staff properly store endoscopes.	• SPS reports the annual risk analysis to the VISN SPS Management Board.

Appendix B: Medical Center Profile

The table below provides general background information for this medium complexity (2) affiliated[1] medical center reporting to VISN 15.[2]

Table B.1. Profile for Robert J. Dole VA Medical Center (589A7)
(October 1, 2016, through September 30, 2019)

Profile Element	Medical Center Data FY 2017[3]	Medical Center Data FY 2018[4]	Medical Center Data FY 2019[5]
Total medical care budget	$212,118,212	$231,377,963	$251,750,727
Number of:			
• Unique patients	28,329	28,026	29,864
• Outpatient visits	311,951	322,362	358,550
• Unique employees[6]	745	873	1055
Type and number of operating beds:			
• Community living center	40	40	40
• Medicine	29	29	29
• Surgery	12	12	12
Average daily census:			
• Community living center	31	28	28
• Medicine	18	20	20
• Surgery	4	3	2

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

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[1] Associated with a medical residency program.

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

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

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

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

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

Appendix C: VA Outpatient Clinic Profiles[1]

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Dodge City, KS	589G2	2,600	572	Hematology/ Oncology Poly-Trauma Pulmonary/ Respiratory Disease	n/a	Nutrition Social Work Weight management
Liberal, KS	589G3	464	79	Hematology/ Oncology	n/a	Nutrition Social Work Weight management

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[1] Includes all outpatient clinics in the community that were in operation as of August 27, 2019. The OIG omitted (589QB) Sedgwick County, KS, and (589QC) South Parklane, KS as no workload/encounters or services were reported.

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

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

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Hays, KS	589G4	2,948	1,130	Hematology/ Oncology Neurology Podiatry Poly-trauma Pulmonary/ Respiratory disease	n/a	Nutrition Prosthetics Social work Weight management
Parsons, KS	589G5	3,237	1,507	Endocrinology Hematology/ Poly-trauma Oncology Pulmonary/ Respiratory disease	n/a	Social work Weight management Nutrition
Hutchinson, KS	589G7	4,066	1,419	Hematology/ Oncology Poly-trauma	n/a	Nutrition Social work Weight management
Salina, KS	589GW	6,283	1,744	Endocrinology Hematology/ Oncology Nephrology Podiatry Poly-trauma Pulmonary/ Respiratory disease	n/a	Nutrition Social work Weight management

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

Appendix D: Patient Aligned Care Team Compass Metrics[1]
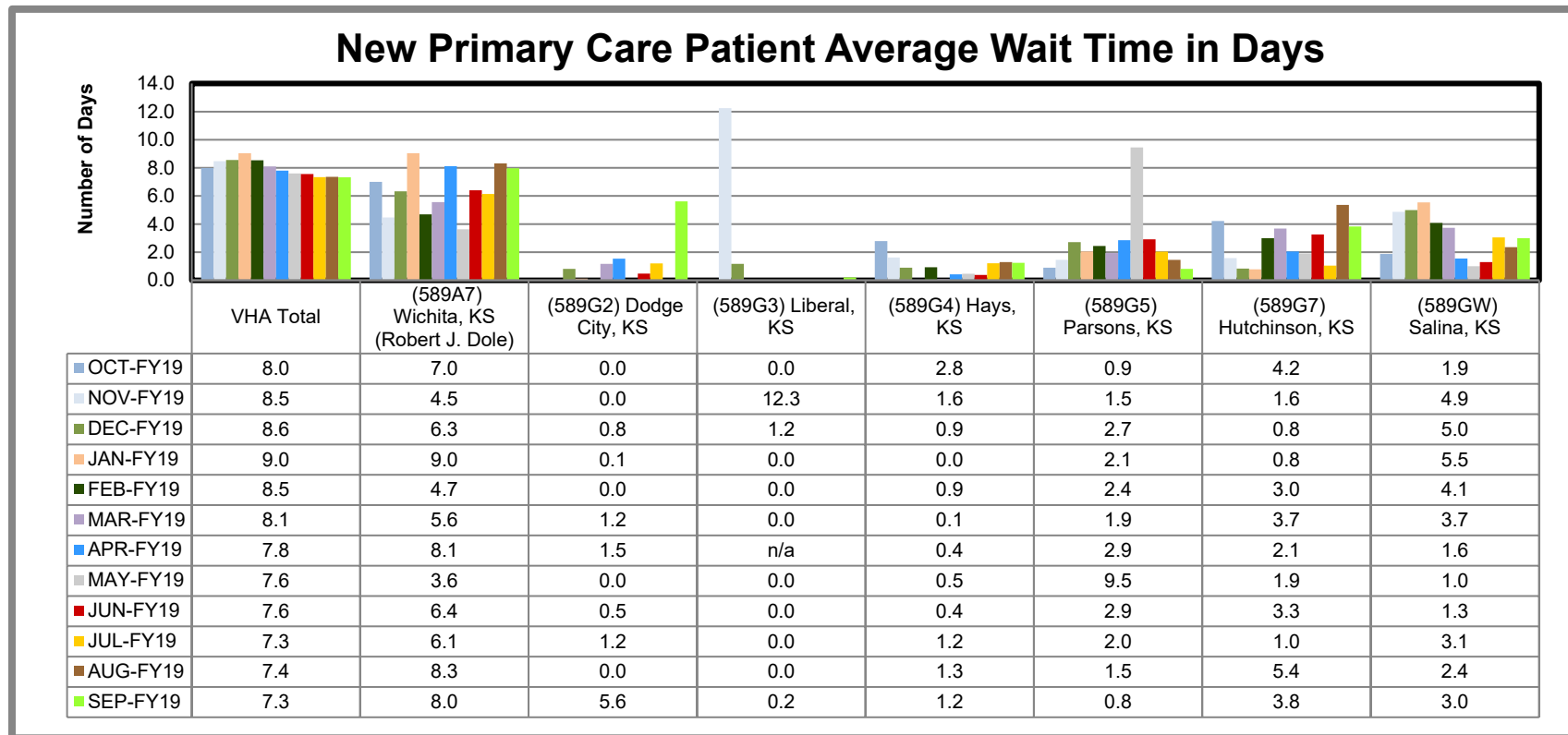
New Primary Care Patient Average Wait Time in Days

	VHA Total	(589A7) Wichita, KS (Robert J. Dole)	(589G2) Dodge City, KS	(589G3) Liberal, KS	(589G4) Hays, KS	(589G5) Parsons, KS	(589G7) Hutchinson, KS	(589GW) Salina, KS
OCT-FY19	8.0	7.0	0.0	0.0	2.8	0.9	4.2	1.9
NOV-FY19	8.5	4.5	0.0	12.3	1.6	1.5	1.6	4.9
DEC-FY19	8.6	6.3	0.8	1.2	0.9	2.7	0.8	5.0
JAN-FY19	9.0	9.0	0.1	0.0	0.0	2.1	0.8	5.5
FEB-FY19	8.5	4.7	0.0	0.0	0.9	2.4	3.0	4.1
MAR-FY19	8.1	5.6	1.2	0.0	0.1	1.9	3.7	3.7
APR-FY19	7.8	8.1	1.5	n/a	0.4	2.9	2.1	1.6
MAY-FY19	7.6	3.6	0.0	0.0	0.5	9.5	1.9	1.0
JUN-FY19	7.6	6.4	0.5	0.0	0.4	2.9	3.3	1.3
JUL-FY19	7.3	6.1	1.2	0.0	1.2	2.0	1.0	3.1
AUG-FY19	7.4	8.3	0.0	0.0	1.3	1.5	5.4	2.4
SEP-FY19	7.3	8.0	5.6	0.2	1.2	0.8	3.8	3.0

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (589QB) Sedgwick County, KS, and (589QC) South Parklane, KS as no workload/encounters or services were reported.

Data Definition: "The average number of calendar days between a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Note that prior to FY15, this metric was calculated using the earliest possible create date.

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

Established Primary Care Patient Average Wait Time in Days

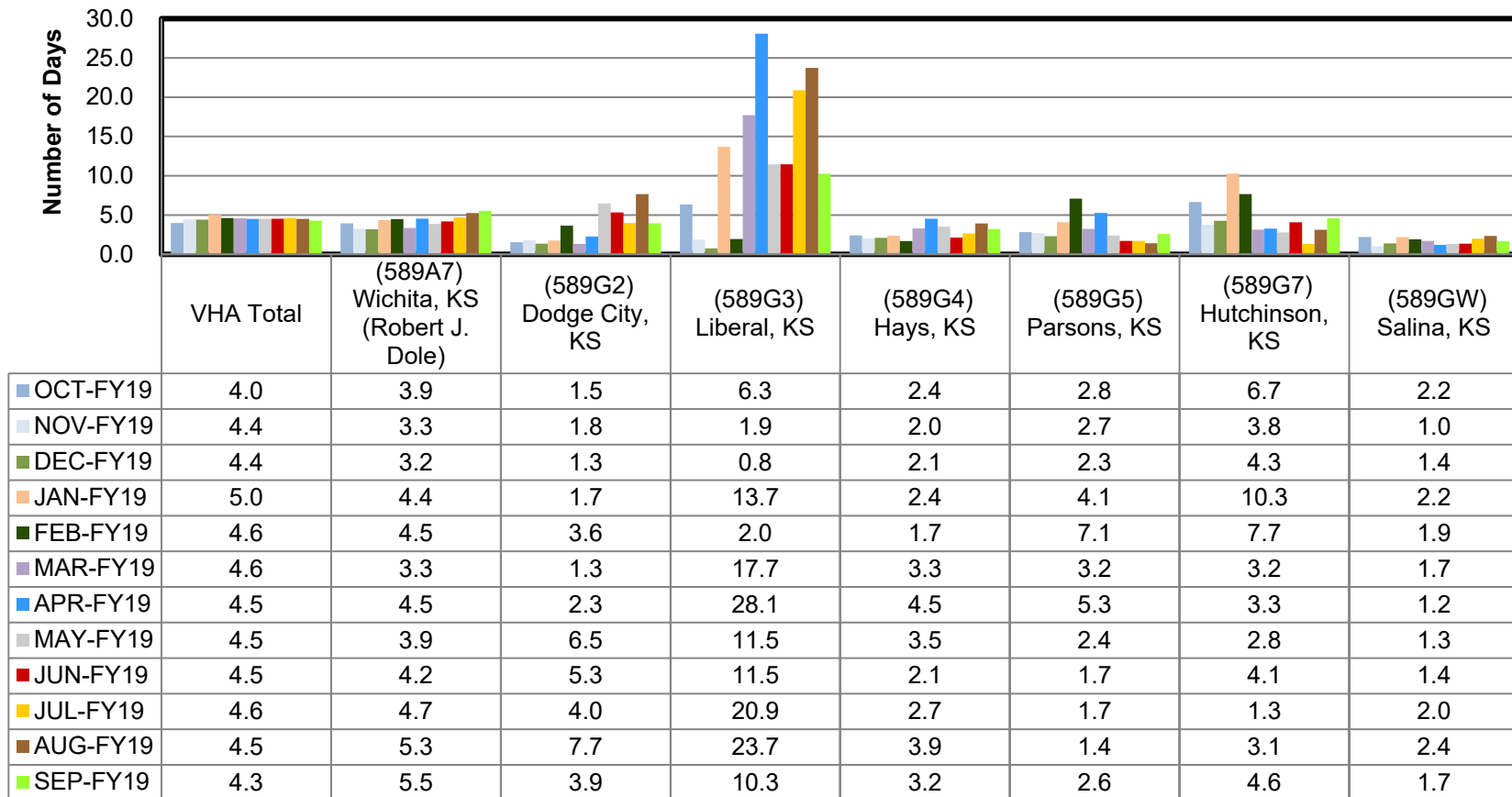|	VHA Total	(589A7) Wichita, KS (Robert J. Dole)	(589G2) Dodge City, KS	(589G3) Liberal, KS	(589G4) Hays, KS	(589G5) Parsons, KS	(589G7) Hutchinson, KS	(589GW) Salina, KS
OCT-FY19	4.0	3.9	1.5	6.3	2.4	2.8	6.7	2.2
NOV-FY19	4.4	3.3	1.8	1.9	2.0	2.7	3.8	1.0
DEC-FY19	4.4	3.2	1.3	0.8	2.1	2.3	4.3	1.4
JAN-FY19	5.0	4.4	1.7	13.7	2.4	4.1	10.3	2.2
FEB-FY19	4.6	4.5	3.6	2.0	1.7	7.1	7.7	1.9
MAR-FY19	4.6	3.3	1.3	17.7	3.3	3.2	3.2	1.7
APR-FY19	4.5	4.5	2.3	28.1	4.5	5.3	3.3	1.2
MAY-FY19	4.5	3.9	6.5	11.5	3.5	2.4	2.8	1.3
JUN-FY19	4.5	4.2	5.3	11.5	2.1	1.7	4.1	1.4
JUL-FY19	4.6	4.7	4.0	20.9	2.7	1.7	1.3	2.0
AUG-FY19	4.5	5.3	7.7	23.7	3.9	1.4	3.1	2.4
SEP-FY19	4.3	5.5	3.9	10.3	3.2	2.6	4.6	1.7

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (589QB) Sedgwick County, KS, and (589QC) South Parklane, KS as no workload/encounters or services were reported.
Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL)), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

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

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

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

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

Source: VHA Support Service Center

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

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

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

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 19, 2020

From: Director, VA Heartland Network (10N15)

Subj: Comprehensive Healthcare Inspection of the Robert J. Dole VA Medical Center in Wichita, Kansas

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

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

Attached is the facility's response to the Comprehensive Healthcare Inspection of the Robert J. Dole VA Medical Center, Wichita, KS draft report.

I have reviewed and concur with the facility's response to the findings, recommendations, and submitted action plans.

(Original signed by:)

William P. Patterson, M.D., MSS

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: June 16, 2020

From: Interim Medical Center Director, Robert J. Dole VA Medical Center (589/00)

Subj: Comprehensive Healthcare Inspection of the Robert J. Dole VA Medical Center in Wichita, Kansas

To: Director, VA Heartland Network (10N15)

1. Thank you for the opportunity to review the draft CHIP report for the Robert J. Dole VA Medical Center. I appreciate the Office of Inspector General's (OIG) extensive work that was done in collaboration with our staff.

2. I have reviewed and concur with the recommendations in the draft report. Corrective action plans have been developed and implemented and are outlined in the attached report.

(Original signed by:)

Dana Foley, PhD

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