DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 10: VA Healthcare System Serving Ohio, Indiana and Michigan in Cincinnati

CHIP REPORT | REPORT #20-01265-172 | JULY 1, 2021

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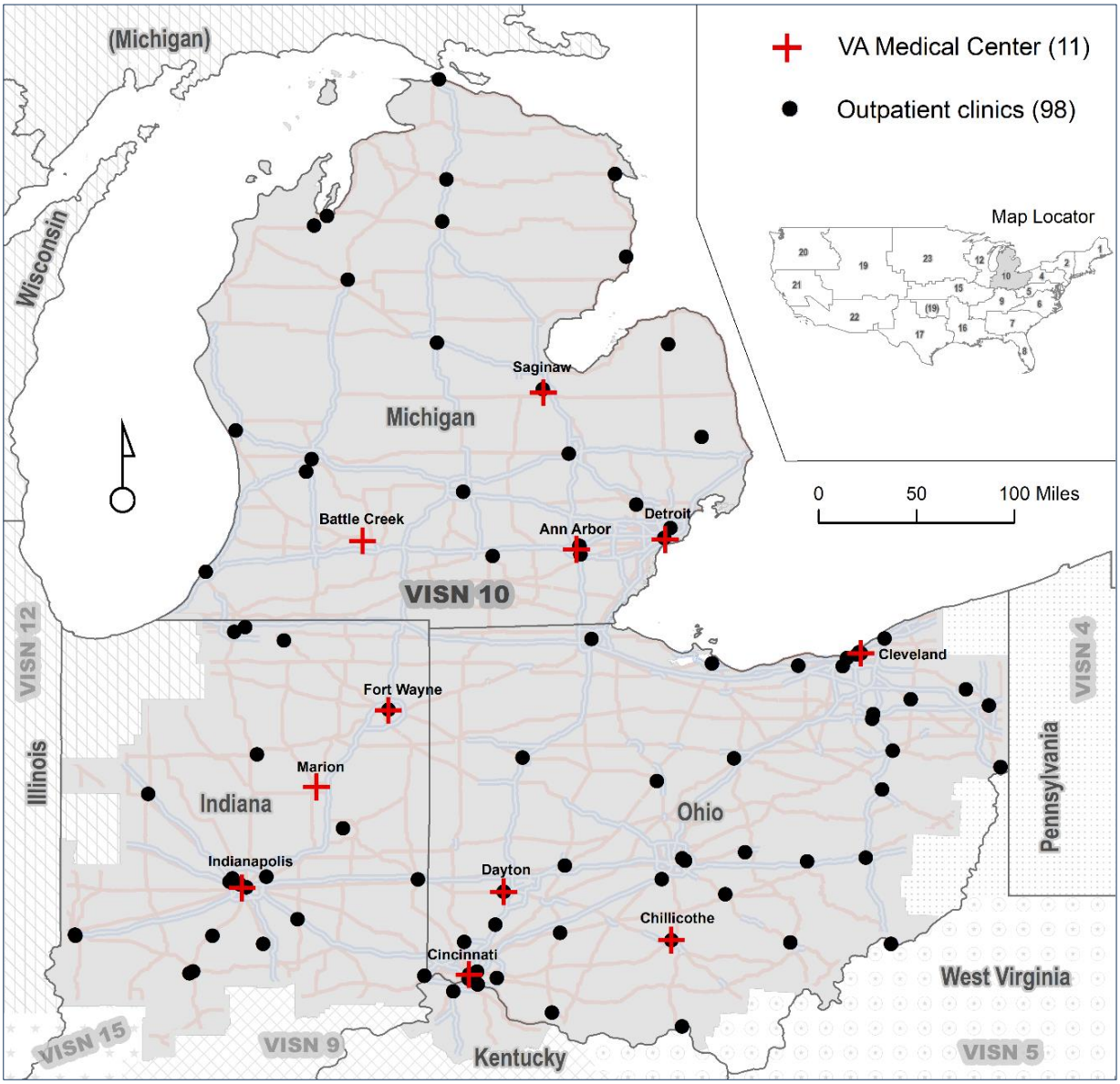


Figure 1. *Veterans Integrated Service Network 10: VA Healthcare System Serving Ohio, Indiana and Michigan. Source: Veterans Affairs Site Tracking database, July 31, 2020.*

Abbreviations

ACC	ambulatory care center
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
FTE	full-time equivalent
FY	fiscal year
HCS	health care system
OIG	Office of Inspector General
QMO	Quality Management Officer
QSV	quality, safety, and value
RME	reusable medical equipment
SAIL	Strategic Analytics for Improvement and Learning
SPS	Sterile Processing Services
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WVPM	women veterans program manager

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of leadership performance and oversight by the Veterans Integrated Service Network (VISN) 10: VA Healthcare System Serving Ohio, Indiana and Michigan. The inspection covers key clinical and administrative processes associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG selects and evaluates specific areas of focus each year.

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

1. COVID-19 pandemic readiness and response[1]
2. Quality, safety, and value
3. Medical staff credentialing
4. Environment of care
5. Medication management (targeting long-term opioid therapy for pain)
6. Women's health (examining comprehensive care)
7. High-risk processes (emphasizing reusable medical equipment)

The OIG conducted this unannounced virtual review during the week of July 27, 2020. Inspections of the following VISN 10 facilities were also performed during the weeks of July 20 and July 27, 2020:

- Aleda E. Lutz VA Medical Center (VAMC) (Saginaw, Michigan)
- Ann Arbor VAMC (Michigan)
- Battle Creek VAMC (Michigan)
- Chillicothe VAMC (Ohio)
- Cincinnati VAMC (Ohio)
- Dayton VAMC (Ohio)

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

- John D. Dingell VAMC (Detroit, Michigan)
- VA Northern Indiana Health Care System (HCS) (Marion)[2]

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient care outcomes. The findings presented in this report are a snapshot of VISN 10 and facility performance within the identified focus areas at the time of the OIG review and may help VISN leaders identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued seven recommendations that are attributable to the Network Director and Chief Medical Officer. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

The VISN leadership team consisted of the Network Director, Deputy Network Director, Chief Medical Officer, Chief Nursing Officer, and Quality Management Officer. Organizational communication and accountability were managed through a committee reporting structure, with the VISN's Executive Leadership Council overseeing the Healthcare Delivery; Healthcare Operations; Organizational Health; and Quality, Safety, and Value Committees.

At the time of the OIG's inspection, the VISN's leadership team had served together in their roles for three months. The longest tenured executive team member was the Deputy Network Director, who served in an acting role from October 2017 until permanent assignment in January 2018. The Network Director, Chief Medical Officer, and Quality Management Officer had served in the positions since 2019. The Chief Nursing Officer was assigned in April 2020.[3]

The OIG reviewed selected employee satisfaction survey results and concluded that VISN leaders were engaged and promoted a culture of safety where employees felt safe bringing forward issues and concerns. The selected VISN patient experience survey scores were similar to or higher than the Veterans Health Administration (VHA) averages, indicating a generally satisfied patient population.

The OIG's evaluation of VISN access metrics and clinical vacancies identified potential organizational risks at select facilities, with wait times approaching 20 days and clinical vacancies in certain specialties. Interviewed leaders were knowledgeable about facility efforts

[2] The VA Northern Indiana HCS is a two-campus healthcare system that includes the Fort Wayne and Marion VAMCs.

[3] The chief nursing officer position is a recent addition to the leadership team. VHA wide, there are four other Chief Nursing Officers serving at the VISN level.

taken to reduce veteran suicide in VISN 10 and shared information that highlighted efforts to develop and implement strategies for high-risk veterans.

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 with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[4]

The leadership team was knowledgeable within their scope of responsibilities about selected SAIL and community living center metrics and should continue to take actions to sustain and improve performance measures contributing to quality ratings and care provided throughout the VISN. In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

However, the OIG identified that the Network Director, Chief Medical Officer, and Quality Management Officer had opportunities to improve their oversight of facility-level quality, safety, and value; medical staff privileging; medication management; mental health; women's health; and high-risk process functions. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

COVID-19 Pandemic Readiness and Response

The results of the OIG's evaluation of the COVID-19 pandemic readiness and response were compiled and reported with other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[5]

Medical Staff Credentialing

The OIG identified weaknesses in the review and approval of physicians who had potentially disqualifying licensure actions prior to their VA appointment.

Women's Health

The VISN complied with requirements for monthly calls with facility women veterans program managers and women's health medical directors, educational gap assessments, VISN-level support staff, and access and satisfaction data analysis. However, the OIG found deficiencies

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

[5] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*, Report No. 21-01116-98, March 16, 2021.

with the appointment of a lead women veterans program manager, quarterly program updates to executive leaders, and annual site visits.

High-Risk Processes

The VISN complied with requirements for the establishment of a Sterile Processing Services management board. However, the VISN has opportunities to improve facility RME inspection processes.

Conclusion

The OIG conducted a detailed inspection across eight key areas and subsequently issued seven recommendations for improvement to the Network Director and Chief Medical Officer. The number of recommendations should not be used, however, as a gauge for the overall quality of care provided within this VISN. The intent is for VISN leaders to use these recommendations as a road map to help improve operations and clinical care throughout the network of assigned facilities. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director agreed with the Comprehensive Healthcare Inspection Program findings and recommendations and provided acceptable improvement plans (see appendix G, page 53, and the responses within the body of the report for the full text of the Network Director's comments.) The OIG has received evidence of compliance and considers recommendations 1 and 2 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

Purpose and Scope

The purpose of this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to evaluate leadership performance and oversight by Veterans Integrated Service Network (VISN) 10: VA Healthcare System Serving Ohio, Indiana and Michigan. This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so that informed decisions can be made to improve care.[1]

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[2] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[3]

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual review and initiated a pandemic readiness and response evaluation. As such, to examine risks to patients and the organization, the OIG focused on core processes in the following eight areas of administrative and clinical operations:

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[4]
3. Quality, safety, and value (QSV)
4. Medical staff credentialing
5. Environment of care
6. Medication management (targeting long-term opioid therapy for pain)
7. Women's health (examining comprehensive care)
8. High-risk processes (emphasizing reusable medical equipment)

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

[2] Anam Parand et al., "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014), https://doi.org/10.1136/bmjopen-2014-005055.

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

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

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected documents and administrative and performance measure data. The team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.[5]

The inspection examined operations from January 23, 2017, through July 31, 2020, the last day of the unannounced multiday evaluation.[6] During the virtual review, the OIG did not receive any complaints beyond the scope of the inspection.

Inspections of the following VISN 10 facilities were also performed during the weeks of July 20 and July 27, 2020:

- Aleda E. Lutz VA Medical Center (VAMC) (Saginaw, Michigan)
- Ann Arbor VAMC (Michigan)
- Battle Creek VAMC (Michigan)
- Chillicothe VAMC (Ohio)
- Cincinnati VAMC (Ohio)
- Dayton VAMC (Ohio)
- John D. Dingell VAMC (Detroit, Michigan)
- VA Northern Indiana Health Care System (HCS) (Marion)[7]

The results of the OIG's evaluation of the VISN's COVID-19 pandemic readiness and response were compiled and reported with other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[8]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[9] The OIG reviews available evidence within a specified

[5] The OIG did not inspect three VISN 10 facilities (Chalmers P. Wylie VA Ambulatory Care Center (ACC), Louis Stokes Cleveland VA Medical Center, and Richard L. Roudebush VA Medical Center) due to recently-performed comprehensive healthcare inspections in fiscal year 2019.

[6] The range represents the time from the last Combined Assessment Program review of the Aleda E. Lutz VAMC to the completion of the unannounced multiday virtual CHIP visit on July 31, 2020 (see appendix D).

[7] The VA Northern Indiana HCS is a two-campus healthcare system, which includes the Fort Wayne and Marion VAMCs.

[8] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*, Report No. 21-01116-98, March 16, 2021.

[9] Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3).

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

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the VISN completes corrective actions. The Network Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that network 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. Leadership and organizational risks can affect the ability to provide care in the clinical focus areas.[10] To assess the VISN's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Access to care
5. Clinical vacancies
6. VISN efforts to reduce veteran suicide
7. Oversight inspections
8. VHA performance data

Additionally, the OIG briefed VISN managers on identified trends in noncompliance for facility virtual CHIP visits performed during the weeks of July 20 and July 27, 2020.

Executive Leadership Position Stability and Engagement

A VISN consists of a geographic area that encompasses a population of veteran beneficiaries. The VISN is defined based on VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary, and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VAMCs, clinics, and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is designed to be the basic budgetary and planning unit of the veterans' healthcare system.[11]

In 2015, VISNs 10 and 11 merged to assume oversight of veteran care in Indiana, Michigan, and Ohio. At the time of our visit, the consolidated VISN included 109 total healthcare sites: 11 medical centers and 98 outpatient clinics.[12] According to data from the VA National Center for

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

[11] Detailed explanation of VISNs provided by Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration, Department of Veterans Affairs, before the House Committee on Veterans' Affairs, May 22, 2018.

[12] Data were extracted from Veterans Affairs Site Tracking database on July 22, 2020.

Veterans Analysis and Statistics, VISN 10 had a veteran population of 1,542,112 within its borders at the end of fiscal year (FY) 2019 and a projected population of 1,499,296 by the end of FY 2020.

VISN 10 has a leadership team consisting of the Network Director, Deputy Network Director, Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and Quality Management Officer (QMO). The CMO is responsible for overseeing facility-level patient care programs. Figure 2 illustrates the VISN's reported organizational structure.[13]

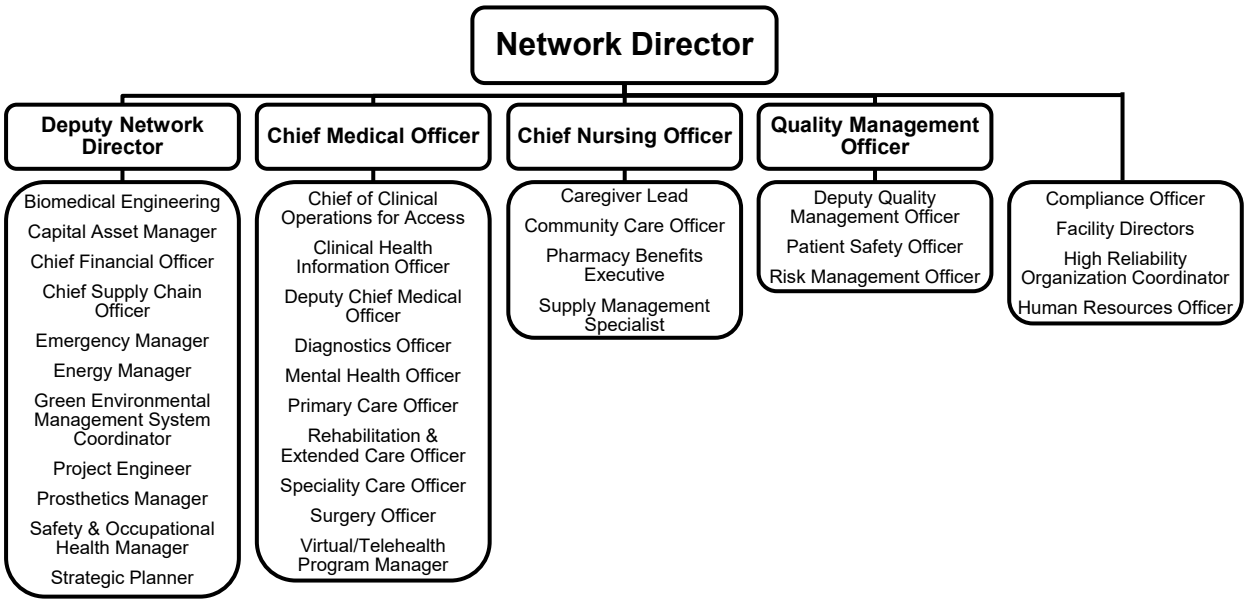


Figure 2. *VISN 10 organizational chart.*

Source: VA Healthcare System Serving Ohio, Indiana, and Michigan (received July 27, 2020).

At the time of the OIG virtual review, the VISN's leadership team had served together in their roles for three months.[14] The longest tenured executive team member was the Deputy Network Director, who served in an acting role from October 2017 until permanent assignment in January 2018. The Network Director, CMO, and QMO had served in their positions since 2019. The CNO was assigned in April 2020 (see table 1).

[13] For this VISN, the Network Director is responsible for the directors of the Aleda E. Lutz VAMC (Saginaw, MI); Battle Creek VAMC (Michigan); Chalmers P. Wylie VA ACC (Columbus, Ohio); Chillicothe, Cincinnati, Dayton, and Louis Stokes Cleveland VAMCs (Ohio); Richard L. Roudebush VAMC (Indianapolis, Indiana); John D. Dingell VAMC (Detroit, Michigan); Ann Arbor VAMC (Michigan); and VA Northern Indiana HCS (Marion).

[14] The CNO position is a recent addition to the leadership team. VHA wide, there are four other CNOs serving at the VISN level.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network Director	October 27, 2019
Deputy Network Director	January 21, 2018
Chief Medical Officer	September 15, 2019
Chief Nursing Officer	April 12, 2020
Quality Management Officer	June 23, 2019

Source: VA Healthcare System Serving Ohio, Indiana and Michigan (received July 28, 2020).

To help assess VISN executive leaders' engagement, the OIG interviewed the Network Director, Deputy Network Director, CMO, CNO, and QMO 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 factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. Leaders also had a sound understanding of Community Living Center (CLC) SAIL metrics. In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

The leaders are members of the VISN's Executive Leadership Council, which is responsible for processes that enhance network performance through

- organizational values and strategic direction,
- policy development and decision making,
- compliance and financial performance,
- creation and balancing of values for patients and other stakeholders,
- regular review of organizational performance and capabilities,
- priorities for improvement and opportunities for innovation, and
- communication and development of organizational goals/objectives across the network.

The Network Director serves as the chairperson of the Executive Leadership Council, which has oversight of the Healthcare Delivery, Healthcare Operations, Organizational Health, and QSV Committees (see figure 3).

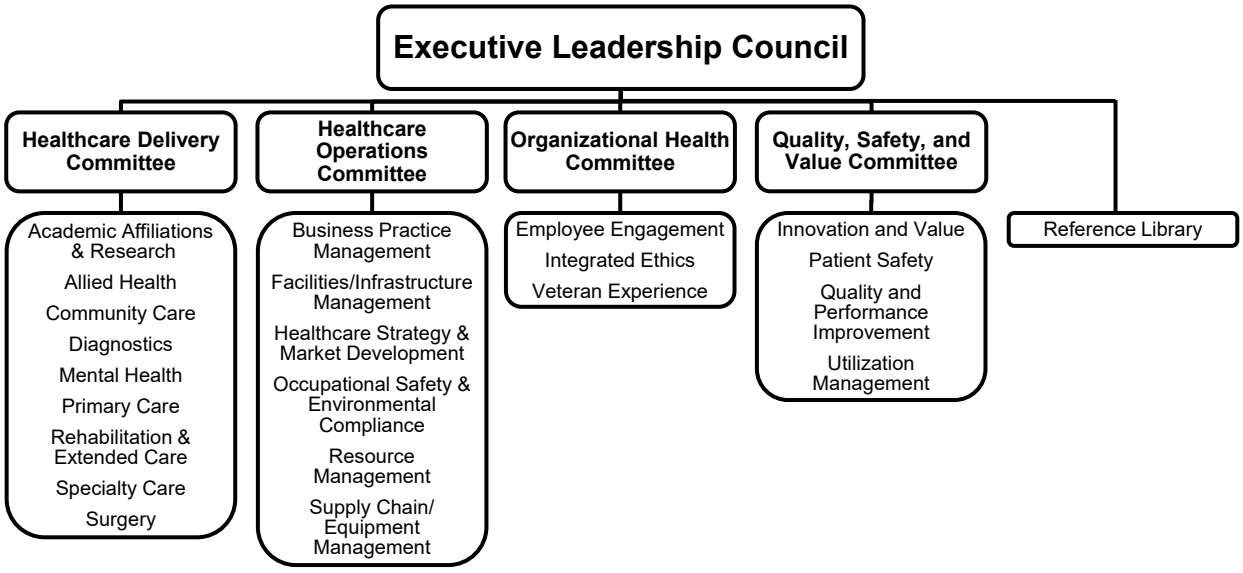


Figure 3. *VISN 10 committee reporting structure.*

Source: VA Healthcare System Serving Ohio, Indiana and Michigan (received July 27, 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.[15] 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 VISN leadership.

To assess employee attitudes toward VISN 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.[16] Table 2 summarizes employee attitudes as expressed in VHA's All Employee Survey for VHA, the VISN office, and leaders. The OIG found the VISN office and leaders' average scores for the selected survey leadership questions were higher than the VHA averages; however, the 2019 All Employee Survey results are not fully reflective of employee satisfaction

[15] "AES Survey History," VA Workforce Surveys Portal, VHA Support Service Center, accessed May 3, 2021, http://aes.vssc.med.va.gov/Documents/04_AES_History_Concepts.pdf. (This is an internal website not publicly accessible.)

[16] Ratings are based on responses by employees who report to or are aligned under the Network Director, Deputy Network Director, and CMO. Data are not available for the CNO and QMO.

with the current leaders, who had either not yet assumed their positions or had only been in their positions for a short time when the survey was administered.[17]

Table 2. Survey Results on Employee Attitudes toward VISN 10 Leadership (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	VISN 10 Office Average	Network Director Average	Deputy Network Director Average	CMO Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where HIGHER scores are more favorable	72.6	78.6	–†	87.9	81.9
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	3.8	4.8	3.8	4.1
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.9	4.6	4.1	4.2
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.9	4.6	3.9	4.0

Source: VA All Employee Survey (accessed June 23, 2020).

**The Servant Leader Index is a summary measure based on respondents' assessments of their supervisors' listening, respect, trust, favoritism, and response to concerns.*

†*Data were not available for the question.*

[17] 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.

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The leadership team averages for employee attitudes toward the workplace were better than the VHA averages. Executive leaders shared survey results with staff and created employee workgroups to identify improvement goals for the coming year. Overall, VISN leaders appeared to maintain an environment where employees felt safe bringing forth issues and concerns.

Table 3. Survey Results on Employee Attitudes toward the VISN 10 Workplace (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	VISN10 Office Average	Network Director Average	Deputy Network Director Average	CMO 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	4.2	4.6	4.4	4.2
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	4.4	4.4	4.2
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) lower is better.	1.4	1.1	1.2	1.1	1.2

Source: VA All Employee Survey (accessed June 23, 2020).

Patient Experience

To assess patient attitudes toward their healthcare experiences, the OIG reviewed patient experience survey results that relate to the period of October 1, 2018, through September 30, 2019. VHA's Patient Experiences Survey Reports provide results from the Survey

of Healthcare Experience of Patients 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.

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward the quality of health care received. Table 4 provides relevant survey results for VISN 10 and compares the results to the overall VHA averages.[18] The VISN average for each of the selected survey questions was similar to or higher than the VHA average, indicating that VISN 10 patients are as or more satisfied than VHA patients in general.

Table 4. Survey Results on Patient Attitudes within VISN 10 (October 1, 2018, through September 30, 2019)

Questions	Scoring	VHA Average	VISN 10 Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.3	68.3
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	84.9
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	79.8
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	79.5

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

[18] Ratings are based on responses by patients who received care within the VISN.

VISN leaders acknowledged lower-than-average scores for various facilities (see appendix C). To improve patient satisfaction scores, the VISN used Veteran Signals (VSignals), a survey sent to randomly selected veterans about recent encounters with outpatient services.[19]

The VISN Veteran Experience Officer reported the patient satisfaction scores to facility directors biweekly and held monthly committee meetings to review the data. The VISN also promoted VA's "Own the Moment" program, which encourages employees to make veteran and family interactions the best possible.[20] The "Own the Moment" program at the Detroit VAMC was credited with improving patient-centered medical home provider ratings from 62.0 percent in FY 2019 to an average of 75.1 percent in FY 2020 as of April 2020.

Access to Care

Achieving and maintaining an optimal workforce to ensure timely access to the best care and benefits for our nation's veterans is a VA priority. VHA has a goal of providing patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[21] VHA has used various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates.[22] Wait time measures based on "create date" have the advantage of not relying on the accuracy of the "preferred date" entered into the scheduling system and are particularly applicable for new primary care patients where the care is not initiated by referral, or consultation, that includes a "clinically indicated date." The disadvantage of "create date" metrics is that wait times do not account for specific patient requests or availability. Wait time measures based on patient preferred dates consider patient

[19] VA, "VA Customer Profile and Veterans Signals programs recognized by FedHealthIT," *VAntage Point* (blog), April 24, 2020, https://www.blogs.va.gov/VAntage/61703/va-customer-profile-veterans-signals-programs-recognized-fedhealth/. Veterans Signals is a VHA survey sent to veterans who received outpatient services within the previous week. Surveys remain open for two weeks after the invitation is sent. The feedback veterans submit is used to quickly help inform opportunities for service recovery and performance improvement.

[20] VA, "VA building trust with Veterans through customer experience improvements," *VAntage Point* (blog), May 9, 2019, https://blogs.va.gov/VAntage/60050/. "'Own the Moment' training enables a cultural change to make employees aware and empowered to own the moment. They have the ability to make the experience for the veteran and their family members the best they can." "'Own the Moment' sessions cover the effectiveness, ease, and emotion involved with Veteran customer interactions and help staff connect their motivation in working at VA and how they can consistently deliver the best experience for Veterans and their families."

[21] VHA Directive 1230(3), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended January 7, 2021. The "Clinically Indicated Date (CID) is the date an appointment is deemed clinically appropriate by a VA health care provider. The CID is contained in a provider entered Computerized Patient Record System (CPRS) order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request…The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity."

[22] "Completed appointments cube data definitions," VA Business Intelligence Office, accessed March 28, 2019, https://bioffice.pa.cdw.va.gov/. (This is an internal VA website not publicly accessible.)

preferences but rely on appointment schedulers accurately recording the patients' wishes into the scheduling software.[23]

When patients could not be offered appointments within 30 days of clinically indicated or preferred dates, they became eligible to receive non-VA (community) care through the VA Choice program. Eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.[24] However, with the passage of the VA MISSION Act of 2018 on June 6, 2018, and subsequent enactment on June 6, 2019, eligibility criteria for obtaining care in the community now include average drive times and appointment wait times:[25]

- Average drive time
    - 30-minute average drive time for primary care, mental health, and non-institutional extended care services
    - 60-minute average drive time for specialty care
- Appointment wait time
    - 20 days for primary care, mental health care, and non-institutional extended care services, unless the veteran agrees to a later date in consultation with a VA health care provider
    - 28 days for specialty care from the date of request, unless the veteran agrees to a later date in consultation with a VA health care provider

To examine access to primary and mental health care within VISN 10, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics for the most recently completed quarter. Tables 5 and 6 provide wait time statistics for completed primary care and mental health appointments from January 1 through March 30, 2020.[26]

[23] Office of Veterans Access to Care, *Specialty Care Roadmap*, November 27, 2017.

[24] VHA Directive 1700, *Veterans Choice Program*, October 25, 2016.

[25] VA MISSION Act of 2018, Pub. L. No. 115-182, Stat. 1393; VA Office of Public Affairs Media Relations, *Fact Sheet: Veteran Community Care – Eligibility, VA MISSION Act of 2018*, April 2019.

[26] Reported primary care wait times are for appointments designated as clinic stop 323, Primary Care Medicine, and records visits for comprehensive primary care services. Reported mental health wait times are for appointments designated as clinic stop 502, Mental Health Clinic Individual, and records visits for the evaluation, consultation, and/or treatment by staff trained in mental diseases and disorders.

Table 5. Primary Care Appointment Wait Times (January 1 through March 30, 2020)

Facility	New Patient Appointments	Average New Patient Wait from Create Date
VA Healthcare System Serving Ohio, Indiana and Michigan	9,279	12.7
Aleda E. Lutz VAMC (Saginaw, Michigan)	644	15.0
Ann Arbor VAMC (Michigan)	1,098	18.8
Battle Creek VAMC (Michigan)	664	14.7
Chalmers P. Wylie VA ACC (Columbus, Ohio)	856	12.4
Chillicothe VAMC (Ohio)	389	7.2
Cincinnati VAMC (Ohio)	684	11.3
Dayton VAMC (Ohio)	934	8.9
John D. Dingell VAMC (Detroit, Michigan)	743	10.9
Louis Stokes Cleveland VAMC (Ohio)	1,567	11.2
Richard L. Roudebush VAMC (Indianapolis, Indiana)	1,030	7.8
VA Northern Indiana HCS (Marion)	670	18.8

Source: VHA Support Service Center (accessed June 24. 2020).

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

Table 6. Mental Health Appointment Wait Times (January 1, 2020, through March 30, 2020)

Facility	New Patient Appointments	Average New Patient Wait from Create Date
VA Healthcare System Serving Ohio, Indiana and Michigan	2,244	13.4
Aleda E. Lutz VAMC (Saginaw, Michigan)	204	17.3
Ann Arbor VAMC (Michigan)	198	20.3
Battle Creek VAMC (Michigan)	199	13.1
Chalmers P. Wylie VA ACC (Columbus, Ohio)	291	7.5
Chillicothe VAMC (Ohio)	136	10.5
Cincinnati VAMC (Ohio)	133	13.0
Dayton VAMC (Ohio)	147	16.8
John D. Dingell VAMC (Detroit, Michigan)	171	8.9
Louis Stokes Cleveland VAMC (Ohio)	374	11.4

Facility	New Patient Appointments	Average New Patient Wait from Create Date
Richard L. Roudebush VAMC (Indianapolis, Indiana)	197	14.4
VA Northern Indiana HCS (Marion)	194	15.5

Source: VHA Support Service Center (accessed June 24, 2020).

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

Based on wait times alone, the MISSION Act may improve access to primary care for patients in the Ann Arbor VAMC and the VA Northern Indiana HCS, where the average wait time for new primary care appointments at both facilities was 18.8 days; and mental health at the Aleda E. Lutz, Ann Arbor, and Dayton VAMCs, where the average wait times for new mental health appointments were 17.3, 20.3, and 16.8 days, respectively. Wait times also highlight opportunities for these facilities to improve the timeliness of primary care provided "in house" and thus decrease the potential for fragmented care among patients referred to community providers.

According to VISN leaders, the implementation of the MISSION Act resulted in an increase in community care consults, and the novel coronavirus disease 2019 (COVID-19) has caused a backlog of referrals to community providers.[27] VISN and facility staff monitor VA wait times and community care consult wait times. The VISN had backlog reduction plans for the VA Northern Indiana HCS and Aleda E. Lutz VAMC that analyze where excess capacity exists and identify the potential to increase or change clinic hours, increase telehealth, and use resource sharing.

To ensure timely access to care, the VISN had clinical resource hubs at the Louis Stokes Cleveland VAMC and the Chalmers P. Wylie VA ACC to provide telehealth gap coverage for primary care and mental health clinics in need of back-up. As of August 3, 2020, eight primary care staff and eight mental health staff had provided care to over 2,200 patients. Based on this success, the VISN primary care lead recommended a significant increase in clinical resource hub clinicians and administrative staff for FY 2021.

[27] "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," World Health Organization, accessed August 25, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 (coronavirus disease) is an infectious disease caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)."A consult is a request for clinical services created by a physician or other healthcare provider on behalf of a patient, seeking opinion, advice, or expertise regarding evaluation or management of a specific patient problem. Medical center community care departments are set up to timely process and coordinate appropriate community care.

Clinical Vacancies

Within the healthcare field, there is general acceptance that staff turnover—or instability—and high clinical vacancy rates negatively affect access to care, quality, patient safety, and patient and staff satisfaction. Turnover can directly affect staffing levels and further reduce employee and organizational performance through the loss of experienced staff.[28]

To assess the extent of clinical vacancies across VISN 10 facilities, the OIG held discussions with the Human Resources Officer and reviewed the total number of vacancies by facility, position, service or section, and full-time equivalent (FTE) employees. Table 10 provides the vacancy rates across the VISN as of July 29, 2020.

Table 7. Reported Vacancy Rates for VISN 10 Facilities (as of July 28, 2020)

Facility	Clinical Vacancies	Clinical Vacancy Rate (%)	Total Vacancy Rate (%)
Aleda E. Lutz VAMC (Saginaw, Michigan)	31.0	8.3	9.8
Ann Arbor VAMC (Michigan)	154.4	15.3	8.8
Battle Creek VAMC (Michigan)	56.2	11.6	11.5
Chalmers P. Wylie VA ACC (Columbus, Ohio)	41.8	8.9	5.2
Chillicothe VAMC (Ohio)	29.6	7.3	1.1
Cincinnati VAMC (Ohio)	81.2	9.2	11.4
Dayton VAMC (Ohio)	72.5	8.9	9.8
John D. Dingell VAMC (Detroit, Michigan)	93.1	13.0	11.9
Louis Stokes Cleveland VAMC (Ohio)	121.1	7.0	6.7
Richard L. Roudebush VAMC (Indianapolis, Indiana)	174.6	15.2	10.2
VA Northern Indiana HCS (Marion)	49.3	9.3	9.1

Source: VA Healthcare System Serving Ohio, Indiana and Michigan Human Resources Officer (received July 28, 2020).

The OIG found the following primary care clinical vacancies across VISN 10:

- Physicians: ~41 FTE
- Physician assistants: ~3 FTE
- Nurse practitioners: ~12 FTE
- Nurses: ~17 FTE

[28] James Buchanan, "Reviewing the Benefits of Health Workforce Stability," *Human Resources for Health* 8, no. 29 (December 2010).

Clinical staffing may be a contributing factor in wait time challenges at the VA Northern Indiana HCS, where three physician and four nurse practitioner FTE positions were vacant.

For mental health, the OIG found the following clinical vacancies:

- Psychiatrists: ~25 FTE
- Psychologists: ~54 FTE
- Nurse practitioners: ~8 FTE
- Nurses: ~3 FTE
- Social workers: ~13 FTE

Given the noted potential opportunities to improve mental health wait times, clinical staffing may be a contributing factor at the Aleda E. Lutz VAMC, where almost two psychologist FTE positions were vacant; at the Ann Arbor VAMC, where two psychiatrist and five psychologist FTE positions were vacant; and at the Dayton VAMC, where almost three psychiatrist and six psychologist FTE positions were vacant.

The Human Resources Officer reported holding regular meetings with the network and facility directors to gauge progress on hiring new staff to fill existing vacancies, reviewing the "time to hire" report, and tracking timeliness of human resource actions. The VISN also conducted a registered nurse job fair at the Ann Arbor VAMC in August 2019. In the 120 days preceding the OIG's virtual review, the VISN used VA's rapid hiring processes to increase facility staffing levels by approximately 1,920 FTE, with an additional 370 staff expected to on-board by the end of August 2020.

VISN Efforts to Reduce Veteran Suicide

Suicide is a leading cause of death in the United States, and suicide rates in almost all states increased from 1999 through 2016.[29] Although the unadjusted rate of suicide among veterans decreased from 30.5 to 30.1 per 100,000 veterans from 2015 to 2016, the suicide rate for veterans age 18 to 34 has risen substantially since 2005. With approximately 20 million veterans in United States, the number of veterans who die by suicide annually is significant.[30]

VA has made suicide prevention its top priority, with the Office of Mental Health and Suicide Prevention implementing significant suicide prevention initiatives: expansion of the Veterans Crisis Line to three call centers, release of a suicide prevention training video, launch of the

[29] "*CDC Vitalsigns™,"* Centers for Disease Control and Prevention, accessed March 10, 2020, https://www.cdc.gov/vitalsigns/suicide/index.html.

[30] "Mental Health," Department of Veterans Affairs, accessed June 22, 2020, https://www.mentalhealth.va.gov/suicide_prevention/.

Mayor's Challenge, and partnerships with the Departments of Defense and Homeland Security to support veterans during their transition from military to civilian life.[31]

The OIG found that VISN 10 leaders were knowledgeable about facilities' efforts to reduce veteran suicide and noted that they shared information highlighting endeavors to develop and implement strategies for high-risk veterans. VISN 10 leaders appeared engaged and supportive of facilities' efforts to prevent veteran suicides. They highlighted the following: filled suicide prevention coordinator positions at all facilities, an established evidenced-base psychotherapy hub at the Ann Arbor VAMC, and oversight and tracking of all VISN 10 sites' suicide prevention action plans and implementation efforts.[32]

VISN leaders opined that resources and funding for VHA suicide prevention efforts were generally satisfactory; however, the leaders suggested that designing regional strategies for suicide prevention and opioid overdose prevention may have the most effect on prevention efforts.

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders respond to identified problems. Except for one recommendation made in a recently published report, VISN and facility leaders have closed all recommendations for improvement listed in appendix D.[33]

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 with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of

[31] VA Office of Public and Intergovernmental Affairs, "VA continues community suicide-prevention challenge," news release, April 1, 2019, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5230. "The Mayor's Challenge was launched in March 2018, bringing together representatives of eight cities to develop local action plans to prevent Veteran suicide. Since then, the Mayor's Challenge program has expanded to a total of 24 cities. An inaugural Governor's Challenge that involved seven state teams took place in February, replicating the effort on the state level. Participants in both programs form interagency teams to bolster Veteran suicide-prevention efforts in their communities." VA Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016,* September 2018.

[32] Key milestones for the Hub include recruiting additional therapists, processing inter-facility consults, and sharing best practices. As of June 14, 2020, 228 veterans had been referred to the psychotherapy hub.

[33] A "closed" status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations.

clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[34]

Figure 4 illustrates the VISN's quality of care and efficiency metric rankings and performance as of December 31, 2019. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of mental health (MH) continuity (of) care, rating (of) hospital, and care transition). Metrics that need improvement are denoted in orange (for example, healthcare (HC) associated (assoc) infections).[35]

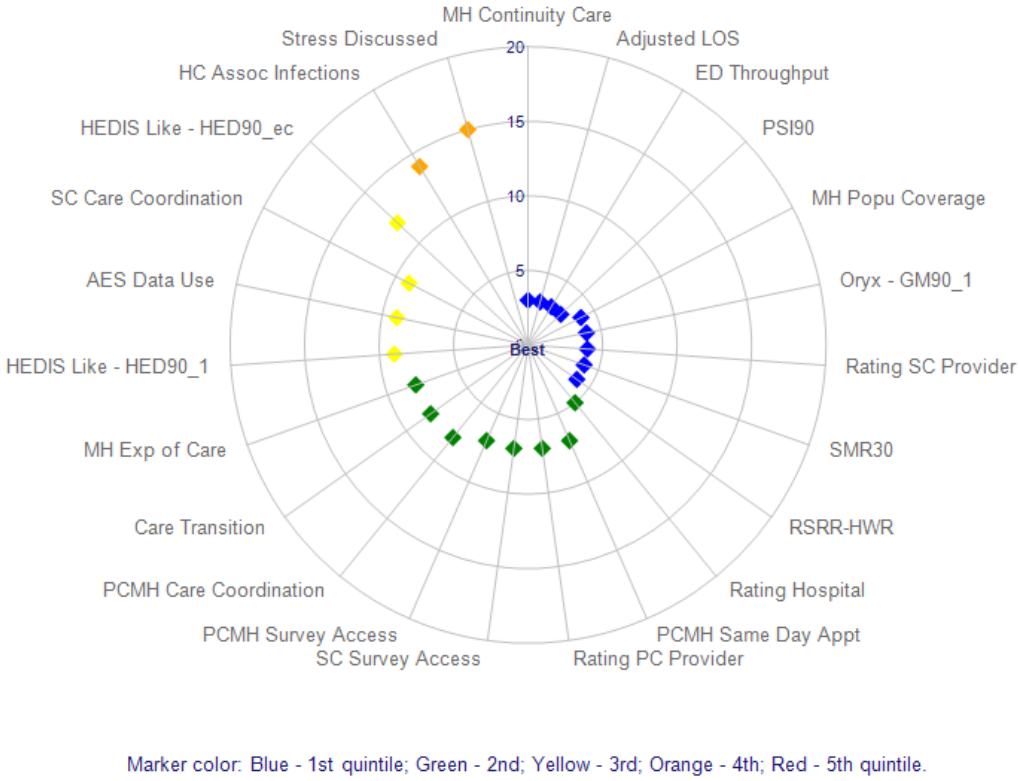


Figure 4. *Facility quality of care and efficiency metric rankings for FY 2020 quarter 1 (as of December 31, 2019).*

Source: VHA Support Service Center.

Note: The OIG did not assess VA's data for accuracy or completeness. Data definitions are provided in appendix E.

VISN leaders pointed out that none of the quality measures fell within the fifth quintile for performance. For the "stress discussed" measure in the fourth quintile, the VISN SAIL team identified best practices at the Chalmers P. Wylie VA ACC that improved scores from the fifth

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

[35] For information on the acronyms in the SAIL metrics, please see appendix E.

quintile in 2018 to the second quintile in December 2019. The Chalmers P. Wylie VA ACC's best practices included distribution of wristbands labeled with anti-stress messages, nurse reminders, message boards, and the addition of stress questions to pre-visit questionnaires.

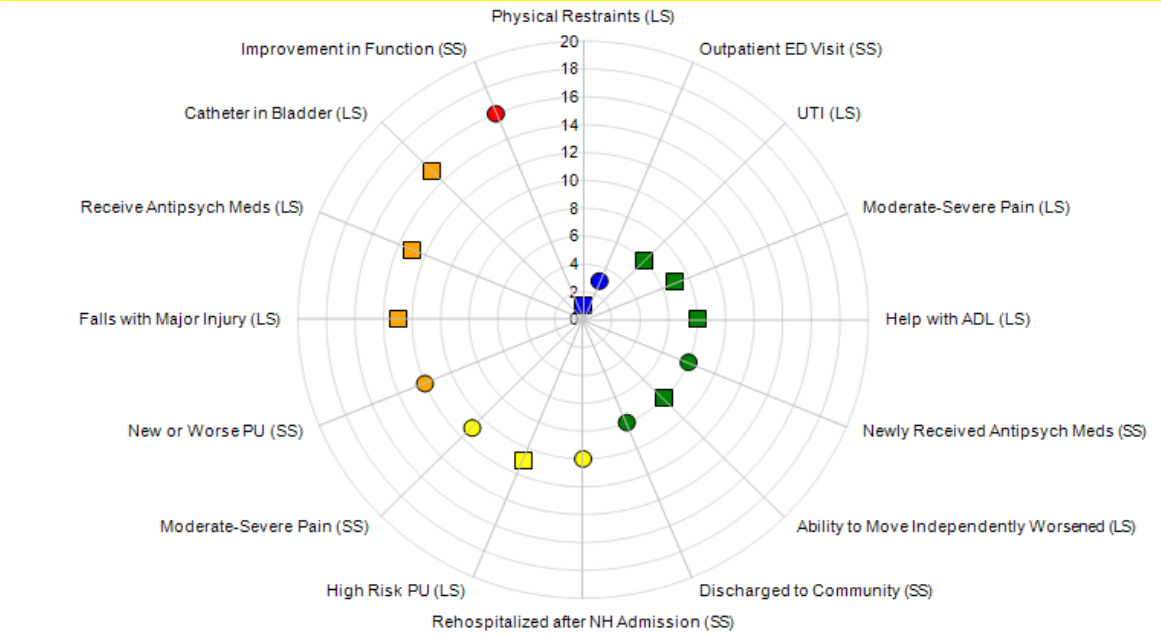
To improve the healthcare associated infections performance measure, the Dayton VAMC and VISN SAIL team reviewed catheter-associated urinary tract, methicillin-resistant staphylococcus aureus, clostridium difficile, and ventilator-associated infections and made process improvements that affected infection rates. The VISN noted that scores at the Dayton VAMC improved from the fourth quintile in FY 2018 quarter 2 to the second quintile in the FY 2019 quarter 1 and that those best practices were shared with other facilities.

The SAIL Value Model also includes "SAIL CLC," which is a tool to "summarize and compare the performance of CLCs in the VA." The SAIL model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' *Nursing Home Compare*. The SAIL CLC provides a single resource "to review quality measures and health inspection results."[36]

The SAIL CLC includes a radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 5 illustrates the VISN's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2019. The figure uses blue and green data points to indicate high performance (for example, in the areas of physical restraints–long-stay (LS), moderate-severe pain (LS), and discharged to community–short-stay (SS)). Measures that need improvement are denoted in orange and red (for example, falls with major injury (LS), catheter in bladder (LS), and improvement in function (SS)).[37]

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

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



Blue - 1st Quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th Quintile

Figure 5. *CLC Quality Measure Rankings for FY 2020 quarter 1 (as of December 31, 2019).*

LS = Long-Stay Measure SS = Short-Stay Measure

Source: VHA Support Service Center.

Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see appendix F.

Additionally, the OIG noted that the Long Term Care Institute's unannounced survey scores revealed opportunities for improvement at CLCs in Chillicothe; Cleveland; Dayton; and Marion, Indiana.[38] The VISN leaders acknowledged the deficiencies identified during the unannounced surveys and the poorly performing SAIL CLC quality measures, assisted facilities in developing action plans, and monitored for improvement. The VISN also initiated mock unannounced surveys at CLCs to identify opportunities for improvement in patient care and assisted with the development of facility action plans for sustained improvement.

Observed Trends in Noncompliance

The OIG identified that the Network Director, CMO, and QMO had opportunities to improve their oversight of facility-level QSV, medical staff privileging, medication management (targeting long-term opioid therapy for pain), mental health (focusing on suicide prevention), women's health (examining comprehensive care), and high-risk process functions (emphasizing reusable medical equipment).

[38] "About Us," The Long Term Care Institute, accessed on May 5, 2020, https://www.ltciorg.org/about-us/. The Long Term Care Institute provides evaluation and monitoring of patient care services for healthcare entities and government agencies.

During virtual CHIP visits of the VISN 10 facilities performed during the weeks of July 20 and July 27, 2020, the OIG noted trends in noncompliance for the following areas:

- QSV
  - Recommendation, implementation, and monitoring of action items when problems or opportunities for improvement are identified
- Medical staff privileging
  - Use of service-specific ongoing professional practice evaluations
  - Completion of professional practice evaluations by providers with similar training and privileges
  - Timely completion of provider exit review forms
  - Review of professional practice evaluations by clinical executive boards in the decision to recommend new or continuing privileges
- Medication management (specifically long-term opioid therapy for pain)
  - Monitoring of the quality of pain assessments and pain management intervention effectiveness by facility pain committees
- Mental health (focusing on the suicide prevention program)
  - Timely follow-up appointments
  - Timely completion of safety plans
  - Annual suicide prevention training for staff
- Women's health (examining comprehensive care)
  - Attendance and participation of required members in women veterans health committees
  - Assignment of full-time women veterans program managers who are free of collateral duties
  - Assignment of designated maternity care coordinators
- High-risk processes (emphasizing reusable medical equipment)
  - Staff completion of monthly continuing education
  - Alignment of standard operating procedures with manufacturers' instructions
  - Staff completion of Level 1 training within 90 days of hire

In response to these trends, the Network Director noted that VISN staff will follow up with responsible facility directors, chiefs of staff, associate directors for patient care services, and associate directors.

Leadership and Organizational Risks Conclusion

The VISN's executive leadership team appeared stable at the time of the OIG virtual review given that all members were permanently assigned. The Network Director, CMO and QMO assumed their positions in 2019. The Deputy Network Director had served in an acting role from October 2017 until permanent assignment in January 2018. The newest member of the team was the CNO, assigned in April 2020.

Selected survey scores related to employees' satisfaction with the VISN executive team leaders were consistently better than VHA averages. In review of patient experience survey data, the OIG noted VISN averages for each of the selected survey questions were similar to or higher than VHA averages. The VISN leaders appeared actively engaged with employees and patients and were working to sustain and further engagement and satisfaction.

The executive team leaders seemed to support facility efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as helping to reduce the backlog of community care consults at select facilities, modifying clinic hours, increasing telehealth opportunities for patients, and planning for additional telehealth staff).

The OIG's review of access metrics and clinical vacancies identified potential organizational risks at select facilities, with wait times approaching 20 days and clinical vacancies in certain specialties. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and CLC metrics and should continue to take actions to sustain and improve performance.

Further, the OIG identified that the Network Director, CMO, and QMO had opportunities to improve their oversight of facility-level QSV, medical staff privileging, medication management, mental health, women's health, and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[39] VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.[40]

During this time, VA continued providing for veterans' healthcare needs and engaged its fourth mission, "the provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have eligibility to receive such care and services."[41] "In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans."[42]

Due to VHA's mission-critical work in supporting both veteran and civilian populations during the pandemic, the OIG conducted an evaluation of the pandemic's effect on VISN 10 and its leaders' subsequent response. The OIG analyzed performance in the following domains:

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

The results of the OIG's evaluation of the COVID-19 pandemic readiness and response were compiled and reported with other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[43]

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[39] "WHO Director General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, accessed March 23, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

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

[41] 38 U.S.C § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission for the provision of hospital care and medical services during certain disasters and emergencies: "During and immediately following a disaster or emergency…VA under 38 U.S.C § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

[42] VA OIG, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness, March 19–24, 2020*, Report No. 20-02221-120, March 26, 2020.

[43] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*, Report No. 21-01116-98, March 16, 2021.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.[44] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[45] Designated leaders are directly accountable for program integration and communication within their level of responsibility. Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[46]

To determine whether the VISN implemented and incorporated OIG-identified key processes for quality and safety, the inspection team interviewed VISN managers and reviewed meeting minutes and other relevant documents. Specifically, OIG inspectors examined completion of the following:

- Written utilization management plan[47]
- Annual utilization management program summary reviews[48]
- Collection, analysis, and action, as appropriate, in response to VISN peer review data[49]
    - Facility outlier data monitored and follow-up actions communicated to the VISN Director and System/VAMC Director
    - Quarterly VISN peer review data analysis reports submitted to the Office of Quality, Safety, and Value
- Institutional disclosures for each facility reported quarterly[50]

Quality, Safety, and Value Findings and Recommendations

Generally, the VISN achieved the requirements listed above. The OIG made no recommendations.

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

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

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

[47] VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019. (This directive was rescinded and replaced with VHA Directive 1117, *Utilization Management Program*, October 8, 2020.)

[48] VHA Directive 1117(2).

[49] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018.

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

Medical Staff Credentialing

VHA has defined procedures for the credentialing of medical staff—"the systematic process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training and experience, and current competence and health status."[51] When certain actions are taken against one of a physician's licenses, the Chief of Human Resources Management Service, or Regional Counsel, must determine whether the physician meets licensure requirements for VA employment.[52] Further, physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued, and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review" with Regional Counsel and concurrence and approval of the appointment by the VISN chief medical officer (CMO). The Deputy Under Secretary for Health Operations and Management is responsible for "ensuring that VISN directors maintain an appropriate credentialing and privileging process consistent with VHA policy," which includes VISN CMO oversight of facility processes.[53]

The OIG inspection team reviewed VISN facility physicians hired after January 1, 2018.[54] When reports from the National Practitioner Data Bank and/or Federation of State Medical Boards appear to confirm that a physician has a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined evidence of the

- Chief of Human Resources Management Service or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements,
- Regional Counsel or designee's documented review to determine if the physician meets appointment requirements, and
- VISN CMO concurrence and approval of the Regional Counsel or designee's review.

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

[52] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012.

[53] VHA Handbook 1100.19.

[54] GAO, *Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*, GAO-19-6, February 2019. VHA Central Office directed VHA-wide licensure reviews that were "started and completed in January 2018, focused on the approximately 39,000 physicians across VHA and used licensure-action information from the Federation of State Medical Boards." The OIG reviewed VISN facility physicians hired after January 1, 2018, to continue efforts to identify staff not meeting VHA employment requirements since "VHA officials told us [GAO] these types of reviews are not routinely conducted…[and] that the initial review was labor intensive."

Medical Staff Credentialing Finding and Recommendation

The OIG identified weaknesses in the review and approval of physicians who had potentially disqualifying licensure actions prior to their VA appointment.

VHA policy states that physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review."[55] The physicians' "credentials file[s] must be reviewed with Regional Counsel, or designee, [and]...the review and the rationale for the conclusions must be forwarded to the VISN CMO for concurrence and approval of the appointment."[56]

The OIG reviewed licensure information for 517 physicians using publicly-available data and VetPro, and did not find evidence that Regional Counsel, or a designee, reviewed the credentials files for six physicians who had a potentially disqualifying licensure action or that the VISN CMO approved the VA appointment.[57] The previous adverse licensure actions included two suspensions, two probations, and two denials. A failure to conduct a documented review of licensure actions could lead to inappropriate hiring of physicians that could subsequently affect the provision of quality care. The CMO was unaware of the noncompliance but acknowledged that facility staff were not routinely providing licensure action information to the VISN.

Recommendation 1

1. The Chief Medical Officer evaluates and determines any additional reasons for noncompliance and ensures the credentials files of physicians who had a potentially disqualifying licensure action are reviewed with Regional Counsel, or a designee, and submitted for approval of VA appointment.[58]

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

[56] VHA Handbook 1100.19.

[57] "Physician Data Center," The Federation of State Medical Boards, accessed April 21, 2021, https://www.fsmb.org/PDC/. This is a publicly available website with a database representing state medical and osteopathic regulatory boards. It is designed to "protect the public and promote quality health care" by listing formal actions taken against physicians. VHA Handbook 1100.19. "VetPro is an Internet enabled data bank for the credentialing of VHA health care practitioners that facilitates completion of a uniform, accurate, and complete credentials file."

[58] The OIG reviewed evidence sufficient to demonstrate that the VISN completed improvement actions and therefore closed the recommendation before publication of the report.

VISN concurred.

Target date for completion: Completed

VISN response: The VISN 10 Chief Medical Officer reviewed and determined there were opportunities to further standardize the process for review and submission of credential files of physicians who had a potentially disqualifying licensure action. Per 38 U.S.C. § 7402 (b), providers are ineligible for VA appointment if they do not have a full and unrestricted license, had a revoked license without it being fully restored, or a surrendered license in lieu of a revocation. VISN 10 follows the Memorandum dated January 2, 2018, Documentation of Actions Taken on Licensure, Registration, or Certification from the Acting Deputy Under Secretary for Health for Operations and Management.

Standard operating procedures for conducting and documenting Chief Medical Officer Credential reviews were developed and implemented effective October 2, 2020 and November 9, 2020, respectively. A Determination of Qualifications for VA Appointment form is initiated by the Credentialing Manager and completed by HRMS [Human Resources Management Service] and District Counsel. The facilities then use the Credentialing Tracker sheet to notify the CMO of the licensing issue. The six physicians found with potential disqualifying licensure actions during OIG's inspection were immediately reviewed, completed and reported separately to the OIG. Since the inspection, there have been four providers found with potential disqualifying licensure actions, three of which required review by the Chief Medical Officer. In 100% (3/3) of these cases, the correct process was followed with a completed review by the Chief Medical Officer. VISN 10 actively monitors these actions for compliance through a monthly facility suspense and requests closure of this recommendation with the evidence provided.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires that veterans, their families, visitors, and employees in VHA healthcare facilities be provided a safe, clean, and functional environment of care in accordance with applicable Joint Commission Environment of Care standards, federal regulatory requirements, and applicable VA and VHA requirements.[59] The goal of the 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. To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.[60] VHA also provides policy, mandatory procedures, and operational requirements for implementing an effective VHA supply chain management program at VA medical facilities, which includes VISN-level oversight responsibility.[61]

The OIG inspection team reviewed relevant documents and interviewed VISN managers. Specifically, inspectors examined the following VISN-level requirements:

- Establishment of a policy that maintains a comprehensive environment of care program at the VISN level
- Establishment of a VISN Emergency Management Committee[62]
    - Met at least quarterly
    - Documented an annual review within the previous 12 months of the VISN's
        - Emergency Operations Plan
        - Continuity of Operations Plan
        - Hazards Vulnerability Analysis
    - Conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leaders for review and approval

[59] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program,* February 1, 2016. VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[60] VHA Directive 1608.

[61] VHA Directive 1761(2), *Supply Chain Inventory Management*, October 24, 2016, amended October 26, 2018. (This directive was rescinded and replaced by VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.)

[62] VHA Directive 0320.01.

- Assessment of inventory management programs through a quality control review once per FY[63]

Environment of Care Findings and Recommendations

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

[63] VHA Directive 1761(2).

Medication Management: Long-Term Opioid Therapy for Pain

VHA has established pain management as a national priority. The VHA National Pain Management Strategy was initiated in November 1998, with its main objective being to "develop a comprehensive, multicultural, integrated, system-wide approach to pain management that reduces pain and suffering and improves quality of life for Veterans experiencing acute and chronic pain associated with a wide range of injuries and illnesses, including terminal illness."[64]

The VHA National Pain Management Program Office is responsible for policy development, coordination, oversight, and monitoring of the VHA National Pain Management Strategy. VHA requires VISNs to implement the Pain Management Strategy throughout VISN facilities. VHA also requires a VISN-level pain management point of contact to annually "describe [the] progress in implementing the Pain Management Strategy" to the VISN director and establish a "VISN pain committee to develop timelines for achieving and maintaining pain management standards." In addition, VHA requires VISNs have at least one Commission on Accreditation of Rehabilitation Facilities-accredited tertiary, interdisciplinary pain care program.[65]

To determine whether the VISN complied with OIG-selected VHA requirements for pain management, the inspection team reviewed relevant documents and interviewed VISN managers on the following requirements:

- Appointment of a VISN-level pain management point of contact
- Annual reporting of the Pain Management Strategy implementation progress
- Establishment of a VISN-level Pain Committee
    - Monitoring of pain management standards
- Availability of a Commission on Accreditation of Rehabilitation Facilities-accredited tertiary interdisciplinary pain care program

Medication Management Findings and Recommendations

Generally, the VISN achieved the requirements listed above. The OIG made no recommendations.

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

[65] VHA Directive 2009-053. 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 CARF [the Commission on Accreditation of Rehabilitation Facilities] to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs."

Women's Health: Comprehensive Care

Women were estimated to represent approximately 10 percent of the veteran population as of September 30, 2019.[66] 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.[67] To help the VA better understand the needs of the growing women veterans population, VHA has made efforts to examine "health care use, preferences, and the barriers Women Veterans face in access to VA care."[68] Additionally, a 2016 VA report 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."[69]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive health care services in all VA medical facilities.[70] VHA also requires that VISNs appoint a lead women veterans program manager (WVPM) to serve as the VISN representative on women veterans' issues and identify gaps through "VISN-wide needs assessments, site visits, surveys, and/or other means, including conducting yearly site visits at each facility within the VISN."[71]

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

- Appointment of a lead WVPM
- Establishment of a multidisciplinary team for comprehensive care
- Execution of interdisciplinary comprehensive strategic planning for women's health at the VISN level

[66] "Veteran Population, " Table 1L, VetPop2018 Living Veterans by Age Group, Gender, 2018-2048, National Center for Veterans Analysis and Statistics, accessed November 30, 2020, https://www.va.gov/vetdata/Veteran_Population.asp.

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

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

[69] Claire Hoffmire, "Concerning Trends in Suicide Among Women Veterans Point to Need for More Research on Tailored Interventions," Suicide Prevention, Forum Spring 2018, https://www.hsrd.research.va.gov/publications/forum/spring18/default.cfm?ForumMenu=Spring18-5.

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

[71] VHA Directive 1330.02, *Women Veterans Program Manager*, August 10, 2018.

- Provision of quarterly program updates to executive leaders
- Monthly calls held with facility WVPMs and women's health medical directors
- Completion of annual site visits
  - Needs assessment conducted
  - Progress towards implementation of recommended interventions tracked
- Assessments to identify staff education gaps
  - Development of educational programs and/or resources when needs identified
- Availability of VISN-level support staff for implementing performance improvement projects
- Analysis of women veterans access and satisfaction data
  - Implementation of improvement actions when recommended

Women's Health Findings and Recommendations

The VISN complied with many of the requirements listed above. However, the OIG identified weaknesses with the appointment of a lead WVPM, quarterly program updates to executive leaders, and annual site visits.

VHA requires each VISN director to be responsible for appointing a "Lead WVPM to serve as [a] VISN leader on women Veterans needs."[72] The OIG found that the VISN did not have a permanent lead WVPM. The Dayton VAMC WVPM reported serving as the VISN co-lead from 2017 to 2019, and sole acting VISN WVPM since July 2019. Dual VISN and facility assignments could prevent the program manager from fully satisfying oversight responsibilities. Insufficient oversight could result in missed opportunities for additional VISN-level support and intervention. The acting Lead WVPM cited leadership instability over the last few years as a likely reason for the VISN not having a permanent WVPM. The program manager also stated that the VISN is in the process of hiring a full-time special populations program manager who will have oversight for women's health.

[72] VHA Directive 1330.02, *Women Veterans Program Manager,* August 10, 2018.

Recommendation 2

2. The Network Director evaluates and determines any additional reasons for noncompliance and appoints a Veterans Integrated Service Network lead women veterans program manager.[73]

VISN concurred.

Target date for completion: Completed

VISN response: The Network Director and Chief Medical Officer reviewed and determined that there were no additional reasons for noncompliance. A selection for the Special Populations Program Manager was made and the employee has been performing the duties of the position effective March 28, 2021. This individual serves as the Lead Women Veterans Program Manager and maintains a minimum of 0.5 FTEE [full-time equivalent employee] for job responsibilities related to the Women's Health program per VHA Directive 1330.01(4). VISN 10 requests closure of this recommendation with the evidence provided.

VHA requires that the VISN Director ensure the lead WVPM provides at least quarterly program updates directly to the Network Director or the CMO.[74] The OIG did not find evidence of quarterly program updates to executive leaders, based on an interview with the acting Lead WVPM. Failure to provide routine updates could prevent key information on women veterans care from being shared, potentially affecting VISN resource allocation. The acting Lead WVPM cited unawareness of the requirement and competing priorities as reasons for noncompliance. The acting Lead WVPM also reported holding impromptu, informal meetings with the CMO and Network Director throughout the year to maintain communication.

Recommendation 3

3. The Network Director evaluates and determines any additional reasons for noncompliance and ensures the lead women veterans program manager provides quarterly program updates to executive leaders.

[73] The OIG reviewed evidence sufficient to demonstrate that the VISN completed improvement actions and therefore closed the recommendation before publication of the report.

[74] VHA Directive 1330.01(2). (This directive was in place for the time frame of the requested program updates. The directive was amended on June 29, 2020 (1330.01(3)), and January 8, 2021 (1330.01(4)). All versions contain similar language regarding the VISN Lead WVPM quarterly updates.)

VISN concurred.

Target date for completion: July 31, 2021

VISN response: The Network Director and Chief Medical Officer reviewed and determined that the current organizational structure does not support compliance with VHA Directive 1330.02, which requires the VISN Lead Women Veterans Program Manager to report to the Network Director or Chief Medical Officer. The VISN 10 Lead Women Veterans Program Manager will begin reporting to the VISN 10 Chief Medical Officer. Since the OIG inspection, Women's Health program updates were provided to the VISN 10 Healthcare Delivery Council, chaired by the Chief Medical Officer, at least quarterly through the Primary Care Subcommittee report.

VHA also requires the lead WVPM to be responsible for conducting "yearly site visits at each facility within the VISN and additional site visits as needed."[75] The OIG interviewed the acting Lead WVPM and found that a problem-focused visit was conducted at the Battle Creek and Aleda E. Lutz VAMCs with facility women veterans program staff and a VA Central Office representative in February and October 2019, respectively. However, the acting Lead WVPM reported not conducting site visits at the remaining facilities. Failure to conduct yearly site visits could hinder the identification of facility concerns warranting VISN-level intervention. The acting Lead WVPM cited collateral duties and time constraints as the reasons for noncompliance.

Recommendation 4

4. The Network Director evaluates and determines any additional reasons for noncompliance and makes certain that the lead women veterans program manager completes annual site visits at each facility within the Veterans Integrated Service Network.

VISN concurred.

Target date for completion: September 30, 2021

VISN response: The Network Director and Chief Medical Officer reviewed and determined that there were no additional reasons for noncompliance. The Lead Women Veterans Program Manager has initiated virtual site visits using the VHA Women Veterans Program virtual site visit toolkit. Site visits will be completed at all VISN 10 facilities prior to the end of FY 21, and annually thereafter.

[75] VHA Directive 1330.02.

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. The goal of Sterile Processing Services (SPS) is to "provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[76]

VHA requires VISNs to appoint and maintain a VISN SPS management board charged with oversight of SPS and all reprocessing of critical and semi-critical RME at VISN facilities.[77] VHA also requires VISNs to conduct facility inspections using the RME Inspection Tool, provide the results for review by a VISN-level committee or board, and post the results to the RME SharePoint site within 30 days of the completed inspection. VISN SPS leads must ensure development of corrective action plans within 30 days of the completed inspections and track the action plans until all items are closed.[78]

The OIG examined relevant documents and interviewed key managers to determine the VISN's compliance with the following requirements:

- Establishment of a VISN SPS management board
- VISN-led RME inspection at each facility
  - Use of RME Inspection Tool
  - Documentation review of climate control
  - Reporting of inspection results to executive leaders
  - Posting of inspection results within the required time frame
  - Tracking of corrective action plans

High-Risk Processes Findings and Recommendations

The VISN complied with the requirements for a VISN SPS management board. However, the OIG identified weaknesses with VISN-led RME inspections.

[76] Julie Jefferson, Martha Young. *APIC Text of Infection Control and Epidemiology*. Association for Professionals in Infection Control and Epidemiology, 2019. "Chapter108: Sterile Processing."

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

[78] VHA Deputy Under Secretary for Health and Operations Management (DUSHOM) Memorandum, *Information and Instructions for Fiscal Year 2019 Sterile Processing Services Inspections*, December 11, 2018.

VHA requires that VISN-led facility RME inspection results be provided to executive leaders for review.[79] The OIG found that the VISN SPS Lead provided RME program updates to the Healthcare Delivery Committee in July 2020 but did not include VISN-led RME inspection results. A lack of communication to VISN leaders about RME inspection results could impede the allocation of resources toward remediating identified issues. The VISN SPS Lead reported being unaware of the requirement.

Recommendation 5

5. The Network Director evaluates and determines any additional reasons for noncompliance and ensures the Veterans Integrated Service Network Sterile Processing Services Lead provides network-led facility reusable medical equipment inspection results to executive leaders.

VISN concurred.

Target date for completion: July 30, 2021

VISN response: The Network Director, Chief Nursing Officer and Quality Management Officer reviewed and determined that the governance structure in place at the time of OIG's inspection did not support VISN leadership's visibility of VISN-led RME inspection results. The governance structure was updated to transition oversight of the SPS Management Community of Practice (formerly the SPS Management Board) to the VISN 10 Executive QSV Committee, which is co-chaired by the Network Director and Quality Management Officer. This transition went into effect with the January 12, 2021, Executive QSV Committee meeting. VISN-led RME inspections for fiscal year 2021 resumed January 25, 2021, and have been completed at eight of eleven VISN 10 facilities to date. The SPS Management Community of Practice reported VISN-led RME inspection results at the April 13, 2021, Executive QSV Committee meeting and will continue to report these results to the Executive QSV Committee on a quarterly schedule until all visits are completed. VISN 10 will request closure of this recommendation when compliance has been achieved for two consecutive quarters.

VHA also requires that VISN-led inspection results be posted to the RME SharePoint within 30 days of completion.[80] The OIG found that VISN staff did not post results for the VA Northern Indiana HCS or the Ann Arbor, Aleda E. Lutz, Cleveland, and Richard L. Roudebush VAMCs to the RME SharePoint site within 30 days of the completed inspections. A failure to post results timely could delay execution of corrective measures to mitigate identified issues. The Supply

[79] VHA DUSHOM Memorandum, *Information and Instructions for Fiscal Year 2019 Sterile Processing Services Inspections*, December 11, 2018.

[80] DUSHOM Memorandum, *Information and Instructions for Fiscal Year 2019 Sterile Processing Services Inspections*. Microsoft SharePoint is a secure web-based software used for internal tracking from any device.

Management Specialist explained that the facilities' inspection results were posted within 30 days and reported being unsure of why the correct dates were not reflected on the RME SharePoint site.

Recommendation 6

6. The Network Director determines the reasons for noncompliance and makes certain that Veterans Integrated Service Network staff post inspection results to the reusable medical equipment SharePoint site within the required time frame.

VISN concurred.

Target date for completion: August 31, 2021

VISN response: The Network Director and Chief Nursing Officer reviewed and determined that there were opportunities to improve redundancy in this process to ensure posting of inspection results to the reusable medical equipment SharePoint site within the required timeframe. A back up point of contact to upload the inspection reports was established and confirmation of report submissions is being tracked per a VISN-led Inspection Report tracker. VISN-led RME inspections for fiscal year 2021 resumed January 25, 2021, and have been completed at eight of eleven VISN 10 facilities to date. 100% (8/8) inspection results were posted to the reusable medical equipment SharePoint site within the required timeframe. VISN 10 will request closure of this recommendation when 90% compliance has been maintained for two consecutive quarters.

Additionally, VHA requires that corrective action plans are developed within 30 days of the completed VISN-led RME inspection and the VISN SPS Lead tracks action items until closure.[81] The OIG found that the Ann Arbor, Aleda E. Lutz, and Cleveland VAMCs did not have action plans developed within 30 days of inspection. Lack of timely action plan development could delay corrective measures to prevent untoward events. The Supply Management Specialist did not have an explanation for the noncompliance.

Recommendation 7

7. The Network Director determines the reasons for noncompliance and ensures that the Veterans Integrated Service Network Sterile Processing Services Lead oversees facility development of corrective action plans within the required time frame and tracks action items until closure.

[81] DUSHOM Memorandum, *Information and Instructions for Fiscal Year 2019 Sterile Processing Services Inspections.*

VISN concurred.

Target date for completion: September 30, 2021

VISN response: The Network Director and Chief Nursing Officer reviewed and determined that there were opportunities to improve redundancy in this process to ensure the development of facility corrective action plans with the required time frame. Timely development and submission of facility corrective action plans is now being monitored and tracked through the VISN-led Inspection Report tracker. VISN-led RME inspections for fiscal year 2021 resumed January 25, 2021, and have been completed at eight of eleven VISN 10 facilities to date. Action items are discussed in the VISN 10 SPS Management Community of Practice and tracked until closure. VISN 10 will request closure of this recommendation when 90% compliance has been achieved and maintained for two consecutive quarters.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The intent is for facility 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.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Access to care • Clinical vacancies • VISN efforts to reduce veteran suicide • Oversight inspections • VHA performance data • Observed trends in noncompliance	Seven OIG recommendations that can lead to patient and staff safety issues or adverse events are attributable to the Network Director and Chief Medical Officer. See details below.
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback	The results of the OIG's evaluation of the COVID-19 pandemic readiness and response were compiled and reported with other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Written utilization management plan • Annual utilization management program summary reviews • Collection, analysis, and action, as appropriate, in response to VISN peer review data • Quarterly VISN peer review data analysis reports submitted • Institutional disclosures for each facility reported quarterly	• None	• None
Medical Staff Credentialing	• Chief of Human Resources Management Service or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements • Regional Counsel or designee's documented review to determine the physician meets appointment requirements • VISN CMO concurrence and approval of the Regional Counsel or designee's review	• The VISN CMO ensures credentials files of physicians who had a potentially disqualifying licensure action are reviewed with Regional Counsel, or a designee, and submitted for approval of VA appointment.	• None
Environment of Care	• Establishment of VISN policy that maintains a comprehensive environment of care program at the VISN level • Establishment of a VISN Emergency Management Committee • Assessment of inventory management programs through a quality control review once per FY	• None	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	• Pain management point of contact appointed • Pain Management Strategy implementation progress reported • Pain committee established • Tertiary interdisciplinary pain care program available	• None	• None
Women's Health: Comprehensive Care	• Lead WVPM appointed • Multidisciplinary team established • Interdisciplinary comprehensive strategic planning at the VISN level • Quarterly program updates provided to executive leaders • Monthly calls held with facility WVPMs and women's health medical directors • Annual site visits completed • Staff education gaps assessed • Support staff available • Women veterans access and satisfaction data analyzed	• None	• The Network Director appoints a VISN lead WVPM. • The VISN lead WVPM provides quarterly program updates to executive leaders. • The VISN lead WVPM completes annual site visits at each facility.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Reusable Medical Equipment	• VISN SPS Management Board established • VISN-led facility inspection conducted	• None	• The VISN SPS Lead provides VISN-led facility RME inspection results to executive leaders. • VISN staff post inspection results to the RME SharePoint site within the required time frame. • The VISN SPS Lead oversees facility development of corrective action plans within the required time frame and tracks action items until closure.

Appendix B: VISN 10 Profile

The table below provides general background information for VISN 10.

Table B. Profile for VISN 10
(October 1, 2016, through September 30, 2019)

Profile Element	VISN Data FY 2017*	VISN Data FY 2018†	VISN Data FY 2019‡
Total medical care budget	$4,618,386,647	$4,841,576,828	$5,049,975,272
Number of:			
• Unique patients	506,058	510,700	514,856
• Outpatient visits	6,851,855	6,816,525	6,917,366
• Unique employees	20,934	21,094	21,644
Type and number of operating beds:			
• Community living center	1,124	1,124	1,124
• Domiciliary	686	686	686
• Hospital	1,090	1,089	1,081
• Residential rehabilitation	34	34	34
Average daily census:			
• Community living center	740	729	723
• Domiciliary	548	530	513
• Hospital	708	660	645
• Residential rehabilitation	23	28	29

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

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

**October 1, 2016, through September 30, 2017.*
†*October 1, 2017, through September 30, 2018.*
‡*October 1, 2018, through September 30, 2019.*

Appendix C: Survey Results

Table C. Survey Results on Patient Attitudes within VISN 10 (October 1, 2018, through September 30, 2019)

Questions	Scoring	Facility	Average Score
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.	VHA	68.3
		VISN 10	68.3
		Ann Arbor, Michigan	78.5
		Battle Creek, Michigan	50.9
		Chillicothe, Ohio	70.2
		Cincinnati, Ohio	62.9
		Cleveland, Ohio	67.1
		Dayton Ohio	71.2
		Detroit, Michigan	58.7
		Indianapolis, Indiana	71.6
		Marion, Indiana	64.3
		Saginaw, Michigan	76.1
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.	VHA	84.9
		VISN 10	84.9
		Ann Arbor, Michigan	90.7
		Battle Creek, Michigan	78.0
		Chillicothe, Ohio	88.8
		Cincinnati, Ohio	86.7
		Cleveland, Ohio	82.9
		Dayton Ohio	82.3
		Detroit, Michigan	80.2
		Indianapolis, Indiana	84.7
		Marion, Indiana	87.6
		Saginaw, Michigan	88.2

Questions	Scoring	Facility	Average Score
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.	VHA	77.3
		VISN 10	79.8
		Ann Arbor, Michigan	84.5
		Battle Creek, Michigan	80.1
		Chillicothe, Ohio	82.7
		Cincinnati, Ohio	81.9
		Cleveland, Ohio	87.5
		Columbus, Ohio	70.3
		Dayton Ohio	80.0
		Detroit, Michigan	65.5
		Indianapolis, Indiana	79.2
		Marion, Indiana	78.1
		Saginaw, Michigan	78.7
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.	VHA	78.0
		VISN 10	79.5
		Ann Arbor, Michigan	77.3
		Battle Creek, Michigan	69.9
		Chillicothe, Ohio	82.8
		Cincinnati, Ohio	75.0
		Cleveland, Ohio	87.0
		Columbus, Ohio	77.5
		Dayton, Ohio	82.5
		Detroit, Michigan	72.5
		Indianapolis, Indiana	77.3
		Marion, Indiana	81.4
		Saginaw, Michigan	84.1

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

Appendix D: Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Healthcare Inspection - Administrative Summary –Opioid Purchases, VA Northern Indiana Health Care System, Marion, Indiana, Report No. 16-02160-344, August 17, 2017	April, 2016	0	0	–	–
Clinical Assessment Program Review of the Aleda E. Lutz VA Medical Center, Saginaw, Michigan, Report No. 16-00549-302, July 17, 2017	January 2017	0	16	–	0
Clinical Assessment Program Review of the VA Northern Indiana Health Care System, Fort Wayne, Indiana, Report No. 16-00577-335, August 15, 2017	March 2017	0	19	–	0
Comprehensive Healthcare Inspection Program Review of the John D. Dingell VA Medical Center, Detroit, Michigan, Report No. 17-01849-42, December 21, 2017	April 2017	0	10	–	0
Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center, Ohio, Report No. 17-04569-262, September 12, 2018	September 2017	0	4	–	0
Comprehensive Healthcare Inspection of the Cincinnati VA Medical Center, Cincinnati, Ohio, Report No. 17-05398-172, May 23, 2018	October 2017	0	7	–	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Administrative Summary–Follow-up to Clinical and Administrative Concerns at the Cincinnati VA Medical Center, Ohio, Report No.17-05398-177, May 23, 2018	October 2017	0	0	–	–
Quality of Care Concerns Regarding a Patient Who Had Cardiac Surgery at the VA Ann Arbor Healthcare System, Michigan, Report No.17-04875-308, September 27, 2018	October 2017	1	1	0	0
Alleged Inadequate Mental Health Treatment at the Dayton VA Medical Center, Ohio, Report No.17-03382-294, September 20, 2018	February 2018	0	3	–	0
Comprehensive Healthcare Inspection Program Review of the Dayton VA Medical Center, *Ohio,* Report No. 18-00619-242, August 14, 2018	March 2018	0	10	–	0
Comprehensive Healthcare Inspection Program Review of the VA Ann Arbor Healthcare System, Michigan, Report No.18-00621-245, August 14, 2018	March 2018	0	3	–	0
Comprehensive Healthcare Inspection Program Review of the Chillicothe VA Medical Center, Ohio, Report No. 18-01012-228, August 9, 2018	April 2018	0	2	–	0
Patient and Radiation Safety Concerns at the John D. Dingell VA Medical Center, Detroit, Michigan, Report No. 18-02210-19, November 27, 2018	April 2018	0	6	–	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Comprehensive Healthcare Inspection Program Review of the Battle Creek VA Medical Center, Michigan, Report No.18-01139-267, September 12, 2018	May 2018	0	3	–	0
Alleged Interference and Failure to Comply with the Pain Management Directive and the Opioid Safety Initiative at the VA Northern Indiana Health Care System, Fort Wayne, Indiana, Report No.17-05835-165, July 16, 2019	June 2018	1	11	0	0
Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center, Ohio, Report No. 18-01275-89, February 20, 2020	October 2018	0	13	–	1*

Source: Inspection/survey results verified with the Deputy Quality Management Officer on July 27, 2020.

**As of June 2021, 1 of the 13 recommendations issued to the medical center remained open.*

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES Data Use	Composite measure based on three individual All Employee Survey (AES) data use and sharing questions	A higher value is better than a lower value
Care transition	Care transition (Inpatient)	A higher value is better than a lower value
ED Throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like – HED90_1	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
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx – GM90_1	ORYX inpatient composite of global measures	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value

Measure	Definition	Desired Direction
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center.

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

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

Measure	Definition
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
Rehospitalized after NH Admission (SS)	Short-stay measure: percent of residents who were re-hospitalized after a nursing home admission.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: May 20, 2021

From: Network Director, Veterans Integrated Service Network 10 (10N10)

Subj: Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 10: VA Healthcare System Serving Ohio, Indiana and Michigan in Cincinnati

To: Director, Office of Healthcare Inspections (54CH04)

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

1. I have reviewed and concur with the response for the draft report of our Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 10: VA Healthcare System Serving Ohio, Indiana and Michigan in Cincinnati.

2. I concur with the responses and action plans submitted by my office.

3. Thank you for the opportunity to respond to this report.

(Original signed by:)

RimaAnn O. Nelson

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Randall Snow, JD, Team Leader Tishanna McCutchen, DNP, MSPH
Other Contributors	Elizabeth Bullock Kaitlyn Delgadillo, BSPH Ashley Fahle Gonzalez, MPH, BS Justin Hanlon, BAS LaFonda Henry, MSN, RN-BC Cynthia Hickel, MSN, CRNA Scott McGrath, BS Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH, BS Yurong Tan, Ph.D.

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