DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center

Chicago, Illinois

CHIP REPORT | REPORT #18-04673-138 | JUNE 18, 2019

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***Figure 1.** Jesse Brown VA Medical Center, Chicago, Illinois (Source: https://vaww.va.gov/directory/guide/, accessed on January 9, 2019)*

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
FPPE	focused professional practice evaluation
LIP	licensed independent practitioner
MST	military sexual trauma
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UCC	urgent care center
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

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

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

The OIG team looks at leadership and organizational risks as well as areas affecting quality patient care. At the time of the review, the clinical areas of focus were

1. Quality, safety, and value;
2. Medical staff privileging;
3. Environment of care;
4. Medication management (specifically the controlled substances inspection program);
5. Mental health (focusing on military sexual trauma follow-up and staff training);
6. Geriatric care (spotlighting antidepressant use for elderly veterans);
7. Women's health (particularly abnormal cervical pathology result notification and follow-up); and
8. High-risk processes (specifically the emergency department and urgent care center operations and management).

This unannounced visit was conducted during the week of November 5, 2018. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

The facility leadership team consists of the director, interim chief of staff, associate director for Patient Care Services (ADPCS), deputy director, and assistant director. Organizational communications and accountability are managed through a committee reporting structure, with the Governing Board having oversight for several working groups. The director and chief of Quality, Safety & Value Service are co-chairs of the Quality Leadership Council, which is responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.

The director, ADPCS, deputy director, and assistant director have been in their positions since November 2016, April 2018, August 2018, and January 2017, respectively. The chief of staff has served in an interim capacity since September 2018.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders were engaged and were working to improve employee satisfaction scores. The selected patient experience survey scores for facility leaders were lower than the VHA average, and facility leaders had implemented processes and plans to maintain positive patient experiences.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[1] disclosures of adverse patient events, and patient safety indicator data and identified organizational risk factors that may contribute to future issues of lapses in patient safety unless corrective processes are implemented and continuously monitored.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[2] Although the leadership team members were knowledgeable within their areas of responsibility about selected SAIL metrics and SAIL community living center (CLC) measures, the leaders should continue to take

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

[2] VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star rating" system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 6, 2019, but is not accessible by the public.)

actions to sustain and improve performance of the Quality of Care metrics and measures likely contributing to the facility's SAIL "3-star" and SAIL CLC "4-star" quality ratings.[3]

The OIG noted findings in seven of the eight clinical areas reviewed and issued 11 recommendations that are attributable to the director and chief of staff. These are briefly described below.

Quality, Safety, and Value

The OIG found general compliance with requirements for protected peer review and patient safety. However, the OIG identified noncompliance with the review of utilization management data and with the facility's committee review of resuscitation episodes.[4]

Medical Staff Privileging

The facility generally complied with requirements for privileging and ongoing professional practice evaluations. However, the OIG identified a concern with the focused professional practice evaluation process.[5]

Medication Management

Overall, the facility complied with requirements for most of the performance indicators evaluated for medication management, including the controlled substances coordinator reports, pharmacy operations, and requirements for controlled substances inspectors. However, the OIG identified noncompliance with the reconciliation of one random day's return of stock to pharmacy from every automated dispensing unit and with the verification of two signatures for waste of partial doses of controlled substances.

[3] Based on fiscal year 2018, quarter 3 ratings at the time of the site visit.

[4] The definition of utilization management can be found within VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the "forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria."

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

Mental Health

The OIG team also found the facility complied with many of the mental health performance indicators, including the designation of a military sexual trauma (MST) coordinator, tracking of MST-related data, and referral for MST-related care. There was a concern noted, however, with the completion of the MST mandatory training requirement for mental health and primary care providers.

Geriatric Care

For geriatric patients, clinicians documented reasons for prescribing medications and completed medication reconciliation to minimize duplicative medications and adverse interactions. However, the OIG identified a deficiency with patient/caregiver education in electronic health records.

Women's Health

The OIG also noted the facility generally complied with many of the performance indicators related to women's health, including requirements for clinical oversight of the women's health program and follow-up care when indicated. However, the OIG noted concerns with tracking data related to cervical cancer screenings and communicating abnormal results to patients that warranted recommendations for improvement.

High-Risk Processes

Generally, the OIG inspection revealed that the facility generally complied with many of the performance indicators for the operations and management of the emergency department. However, the OIG identified a deficiency whereby facility managers designated an urgent care center when an emergency department was also in operation at the same campus.

Summary

In reviewing key healthcare processes, the OIG issued 11 recommendations for improvement directed to the facility director and chief of staff. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. 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 eventually interfere with the delivery of quality health care.

Comments

The Acting Veterans Integrated Service Network director and facility director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 68–69, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to provide oversight of healthcare services to veterans. This focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Jesse Brown VA Medical Center (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.[6] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[7] Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility:

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (specifically the controlled substances inspection program)
6. Mental health (focusing on military sexual trauma follow-up and staff training)
7. Geriatric care (spotlighting antidepressant use for elderly veterans)
8. Women's health (particularly abnormal cervical pathology results notification and follow-up)

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[6] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (The website was accessed on January 24, 2019.)

[7] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (The website was accessed on January 24, 2019.)

9. High-risk processes (specifically the emergency department and urgent care center operations and management).[8]

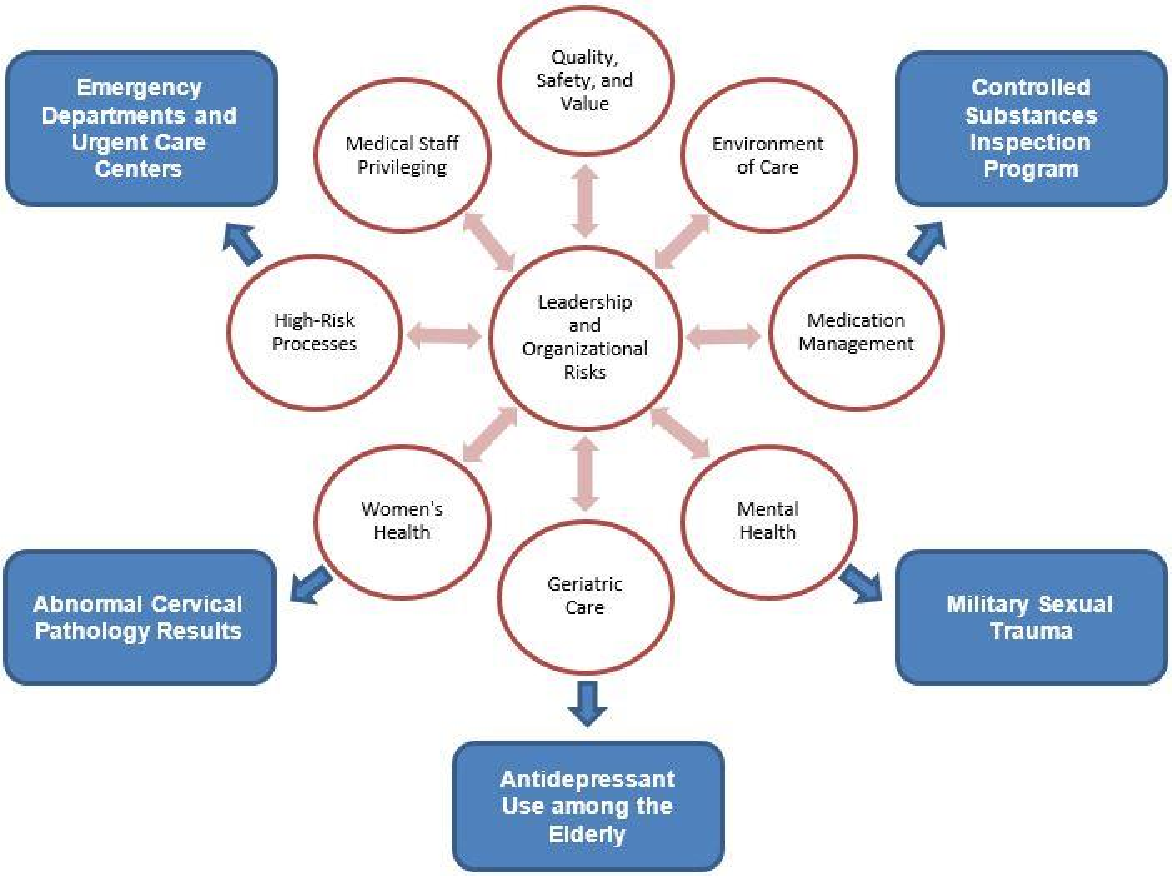

Figure 2. *FY 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

[8] See Figure 2. CHIP inspections address these processes during fiscal year (FY) 2019 (October 1, 2018, through September 30, 2019); they may differ from prior years' focus areas.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;[9] physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from April 2, 2016,[10] through November 9, 2018, the last day of the unannounced week-long site visit.[11]

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The facility director's comments submitted in response to the report recommendations appear within each topic area.

While on site, the OIG did not receive any complaints beyond the scope of the CHIP review. The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reports and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

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

[10] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient Clinic reviews.

[11] The range represents the time period from the last Clinical Assessment Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.[12] To assess the facility's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation and/or for-cause surveys and oversight inspections
5. Factors related to possible lapses in care
6. VHA performance data

Executive Leadership Position Stability and Engagement

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

[12] L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. www.IHI.org (The website was accessed on February 2, 2017.)

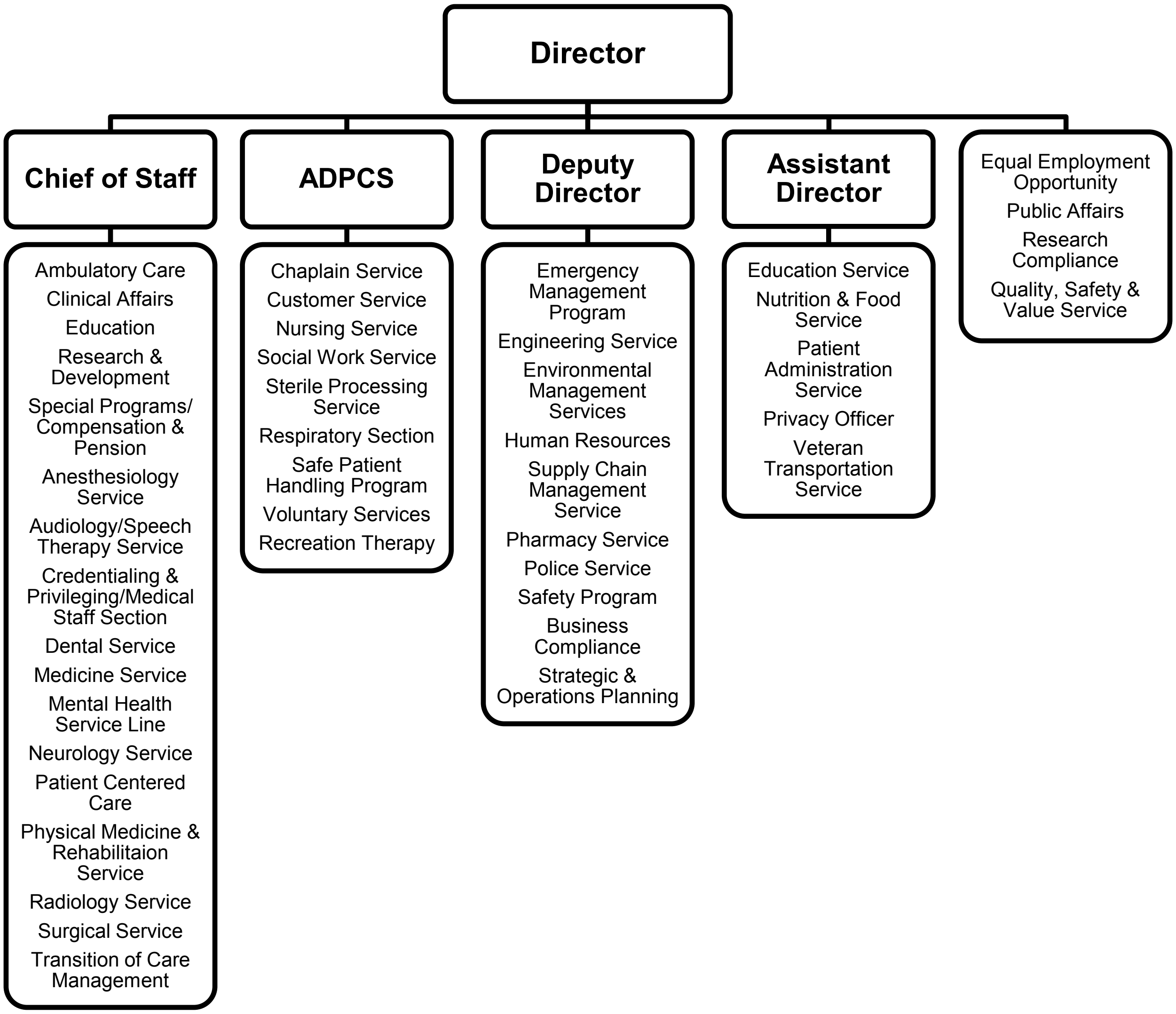

Figure 3. *Facility Organizational Chart*
Source: Jesse Brown VA Medical Center (received November 7, 2018)

At the time of the site visit, the OIG noted that three of the five members of the executive leadership team had been newly appointed within the past seven months. As a result, the leaders had been working together as a team for only two months (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	November 27, 2016
Interim chief of staff	September 10, 2018
Associate director for Patient Care Services	April 29, 2018
Deputy director	August 5, 2018
Assistant director	January 22, 2017

Source: Jesse Brown VA Medical Center Acting human resources officer (received November 5, 2018)

To help assess facility executive leaders' engagement, the OIG interviewed the director, interim chief of staff, ADPCS, and deputy director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL community living center (CLC) measures. These are discussed in greater detail below.

These leaders are also engaged in monitoring patient safety and care through the Governing Board, which has oversight of various working groups such as the Medical Executive Council, Quality Leadership Council, Operations Council, and Nursing Executive Council. The Quality Leadership Council is responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes and reports to the Governing Board. The director and chief of Quality, Safety & Value Service serve as the co-chairpersons of the Quality Leadership Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Quality Leadership Council oversees various committees, such as the Controlled Substance Committee, Cardiopulmonary Resuscitation Committee, Infection Control Committee, Patient Flow Committee, Patient Safety Committee, and Utilization Management (UM) Committee. See Figure 4.

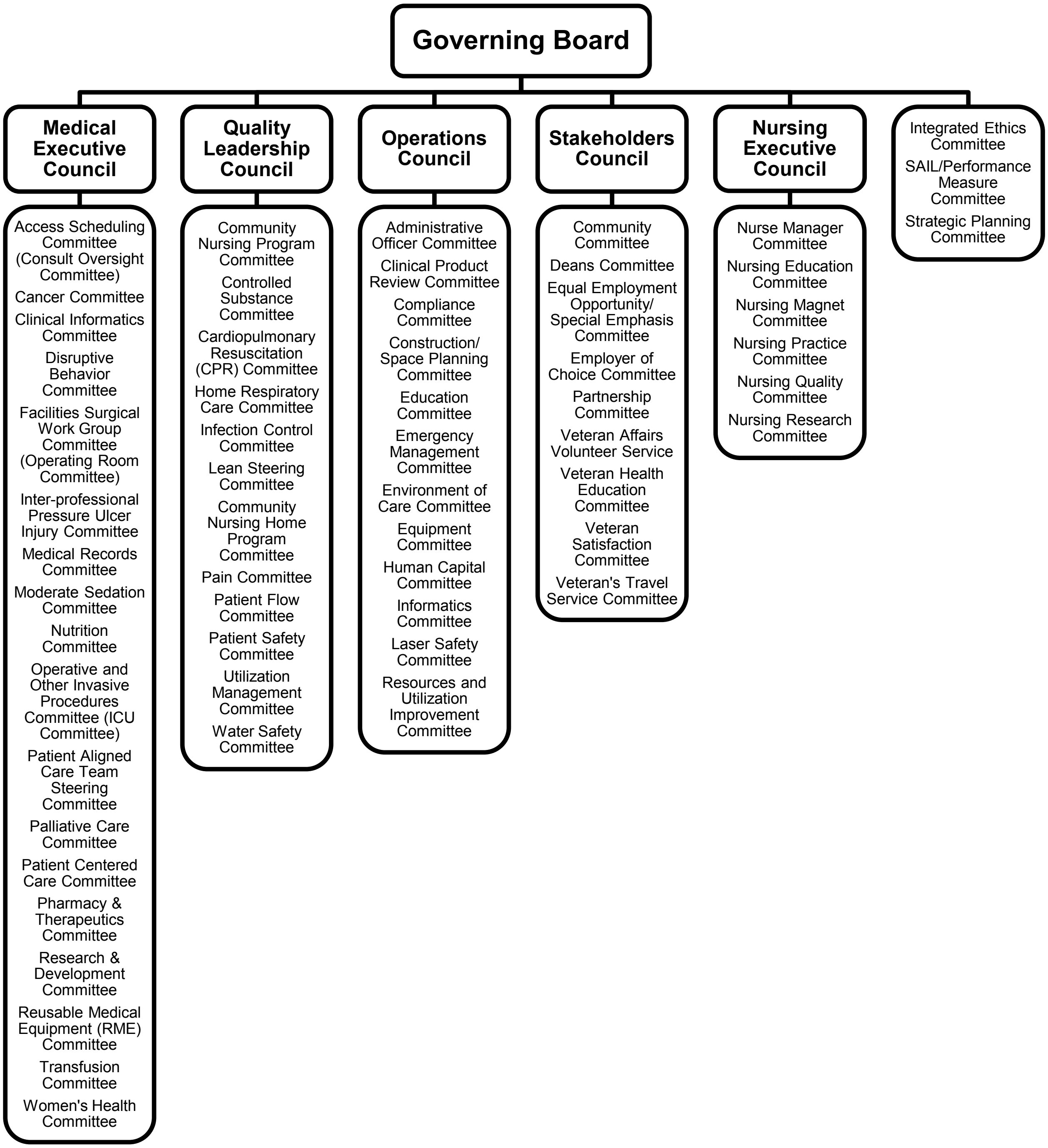

Figure 4. *Facility Committee Reporting Structure*
Source: Jesse Brown VA Medical Center (November 7, 2018)

Employee Satisfaction

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

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2017, through September 30, 2018.[13] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for several selected survey leadership questions was similar to or higher than the VHA average.[14] The director and chief of staff scores were lower than the facility and VHA averages, and the director shared details regarding initiatives to improve employee satisfaction, including Servant Leader training initiatives. Employees appear generally satisfied with the ADPCS, deputy director, and assistant director.

Table 2. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Deputy Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite*[15]	0–100 where HIGHER scores are more favorable	71.7	71.6	55.8	69.3	82.9	57.5	86.0
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.5	3.0	2.9	4.1	4.0	4.4

[13] Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, and associate director.

[14] 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.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Deputy Director Average	Asst. Director Average
commitment in the workforce.								
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.6	2.9	3.3	4.0	4.2	4.6
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.7	3.2	3.5	4.0	4.2	4.6

Source: VA All Employee Survey (accessed October 10, 2018)

Table 3 summarizes employee attitudes toward the workplace, also as expressed in VHA's All Employee Survey. Note that the facility averages for the selected survey questions were similar to the VHA average. Results for the director were worse than the VHA averages. Opportunities appear to exist for the director to provide a safe workplace environment where employees feel comfortable with bringing forth issues or ethical concerns. Facility leaders verbalized ongoing efforts to improve the culture of the organization.

Table 3. Survey Results on Employee Attitudes toward Workplace (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Deputy Director Average	Asst. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.8	3.1	3.9	4.3	3.8	4.8

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Deputy Director Average	Asst. Director Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.6	3.3	3.9	4.4	4.2	—[16]
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.5	1.5	2.3	1.5	0.7	0.3	1.8

Source: VA All Employee Survey (accessed October 10, 2018)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through June 30, 2018. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.[17]

[16] To preserve AES survey respondent anonymity, response averages are only provided for groups of five or more respondents.

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

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes towards facility leaders (see Table 4). For this facility, the inpatient and Specialty Care outpatient survey results reflected lower ratings than the VHA average. Opportunities appear to exist to improve patient satisfaction with care provided in those settings. The outpatient Patient-Centered Medical Home survey results reflected higher ratings than the VHA average. Facility leaders verbalized initiatives designed to address patient concerns.

Table 4. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2017, through June 30, 2018)

Questions	Scoring	VHA Average	Facility 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.	66.8	61.5
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.	84.3	81.5
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.	76.2	81.0
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.3	75.9

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 10, 2018)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[18] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[19] Indicative of effective leadership, the facility has closed all recommendations for improvement (see Table 5).[20]

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and College of American Pathologists.[21] Additional results included the Long Term Care Institute's inspection of the facility's CLC.[22]

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

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

[20] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

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

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

Table 5. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the Jesse Brown VA Medical Center, Chicago, Illinois, Report No. 16-00121-320, June 9, 2016*)	March 2016	15	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Jesse Brown VA Medical Center, Chicago, Illinois, Report No. 16-00029-322, June 9, 2016*)	March 2016	5	0
TJC			
• Regular	May 2018		
○ Hospital Accreditation		36	0
○ Behavioral Health Care Accreditation		11	0
○ Home Care Accreditation		7	0
• Behavioral Health Accreditation	March 2018	4	0

Sources: OIG and TJC (Inspection/survey results verified with the QSV manager on November 8, 2018)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from April 2, 2016 (the prior comprehensive OIG inspection), through November 9, 2018.[23]

Table 6. Summary of Selected Organizational Risk Factors (April 2, 2016, through November 9, 2018)

Factor	Number of Occurrences
Sentinel Events[24]	2
Institutional Disclosures[25]	8
Large-Scale Disclosures[26]	1

Source: Jesse Brown VA Medical Center's QSV manager (received November 7, 2018)

The OIG also reviewed patient safety indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[27] The rates presented are specifically applicable for this facility, and lower rates

[23] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Jesse Brown VA Medical Center is a high complexity (1b) facility as described in Appendix B.)

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

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

[26] According to VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

[27] Agency for Healthcare Research and Quality. https://www.qualityindicators.ahrq.gov/. (The website was accessed on December 11, 2017.)

indicate lower risks. Table 7 summarizes patient safety indicator data from July 1, 2016, through June 30, 2018.

Table 7. Patient Safety Indicator Data (July 1, 2016, through June 30, 2018)

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 12	Facility
Pressure ulcer	0.76	0.92	0.30
Death among surgical inpatients with serious treatable conditions	114.89	100.00	37.04
Iatrogenic pneumothorax[28]	0.15	0.16	0.00
Central venous catheter-related bloodstream infection	0.16	0.07	0.17
In-hospital fall with hip fracture	0.09	0.02	0.00
Perioperative hemorrhage or hematoma	2.59	3.64	2.16
Postoperative acute kidney injury requiring dialysis	0.96	1.88	0.00
Postoperative respiratory failure	4.88	5.44	2.12
Perioperative pulmonary embolism or deep vein thrombosis	3.05	3.60	2.58
Postoperative sepsis	3.70	2.47	1.79
Postoperative wound dehiscence (rupture along incision)	0.93	1.39	0.00
Unrecognized abdominopelvic accidental puncture or laceration	1.07	0.96	0.00

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

The patient safety indicator measure for central venous catheter[29] related bloodstream infections shows a higher reported rate than VHA and VISN 12. Facility staff reported that a patient developed a central venous catheter-related bloodstream infection after admission to the facility for treatment of a foot infection. The facility staff conducted a chart review, and no trends were

[28] According to Northwestern Memorial Hospital, "A Pneumothorax is a type of lung injury that allows air to leak into the area between the lungs and the chest wall, which causes mild to severe chest pain and shortness of breath. An Iatrogenic Pneumothorax is caused by medical treatment, often as an incidental event during a procedure such as a pacemaker insertion." Northwestern Medicine. http://www.nmh.org/nm/quality-lung-injury-due-to-medical-care. (The website was accessed on March 6, 2019.)

[29] A central venous catheter is a long, soft plastic tube (usually made of silicone) that is placed via a small cut in the neck, chest, or groin into a large vein in the chest to allow IV fluids and medications to be given over an extended period of time. https://medlineplus.gov/ency/imagepages/19861.htm (The website was accessed on February 5, 2019.)

identified. The 11 remaining patient safety indicator measures show a lower reported rate than VHA and VISN 12.

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[30]

VA also uses a star-rating system where facilities with a "5-star" rating are performing within the top 10 percent of facilities and "1-star" facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.[31] As of June 30, 2018, the facility was rated as "3-star" for overall quality.

[30] VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

[31] According to the methods established by the SAIL Model, this is based on normal distribution ranking of the quality domain for 130 VA Medical Centers.

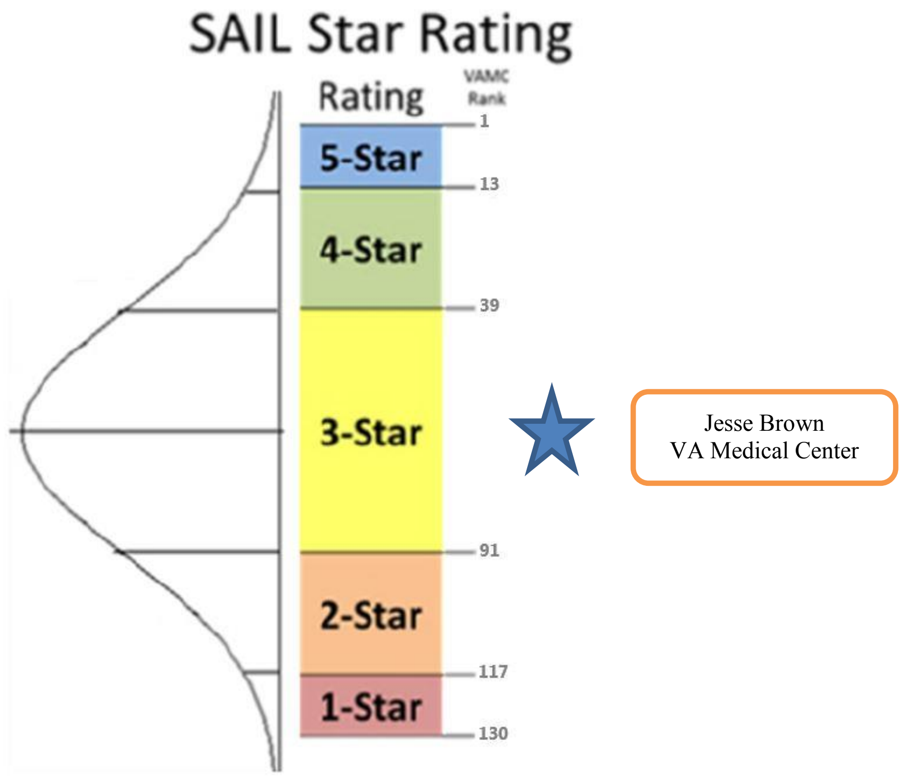

Figure 5. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed October 10, 2018)

Figure 6 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of June 30, 2018. Of note, Figure 6 uses blue and green data points to indicate high performance (for example, in the areas of registered nurse (RN) turnover, mental health (MH) population (Popu) coverage, and rating (of) primary care (PC) provider). Metrics that need improvement are denoted in orange and red (for example, complications, healthcare (HC) associated (Assoc) infections, continued (Cont) stay reviews met, and ambulatory care sensitive condition (ACSC) hospitalization).[32]

[32] For information on the acronyms in the SAIL metrics, please see Appendix D.

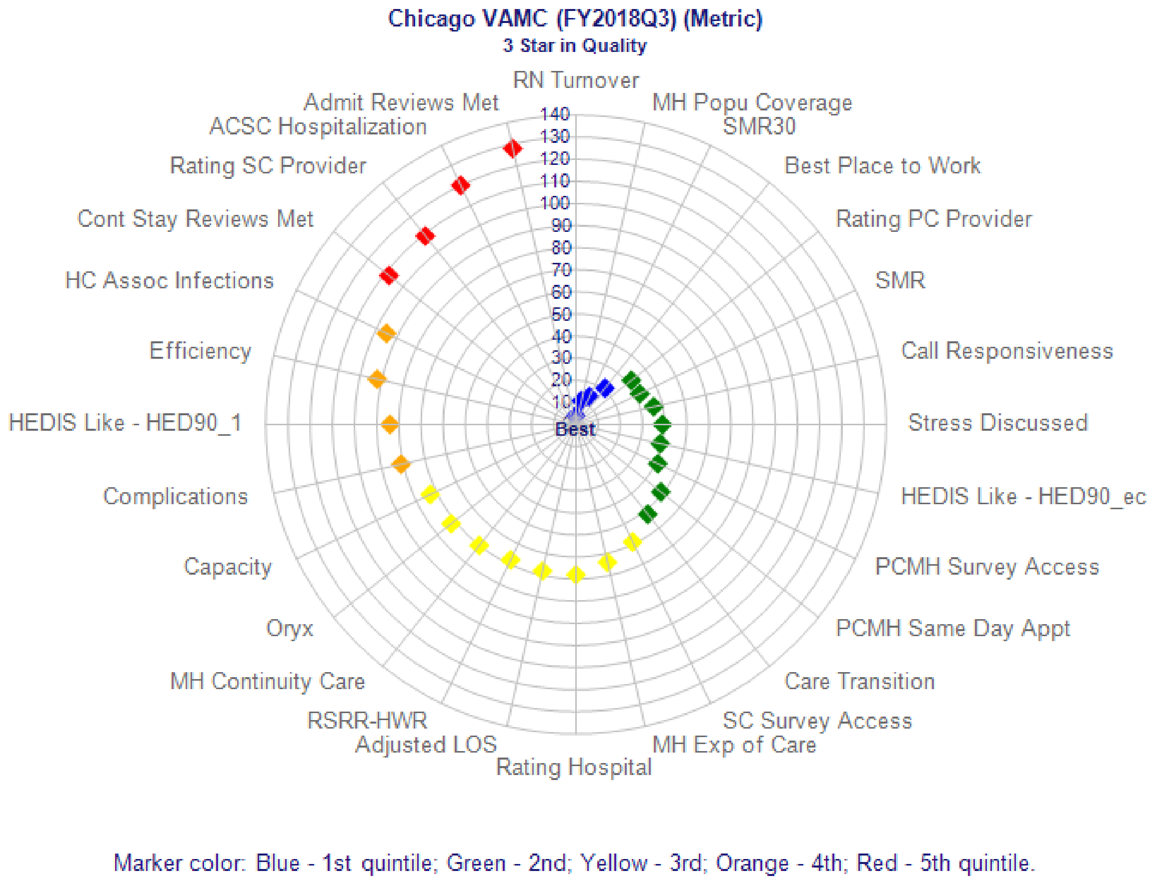

Figure 6. *Facility Quality of Care and Efficiency Metric Rankings (as of June 30, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

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' (CMS) *Nursing Home Compare*.[33] The SAIL CLC provides a single resource to review quality measures and health inspection results. It

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

includes star ratings for an unannounced survey, staffing, quality, and overall results.[34] Table 8 summarizes the rating results for the facility's CLC as of June 30, 2018. Although the facility has an overall "5-star" rating, its rating for quality is only a "4-star," which is determined by the performance indicators detailed in Table 8.

Table 8. Facility CLC Star Ratings (as of June 30, 2018)

Domain	Star Rating
Unannounced Survey	★★★★
Staffing	★★★★★
Quality	★★★★
Overall	★★★★★

Source: VHA Support Service Center

In exploring the reasons for the "4-star" quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 7 illustrates the facility's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2018. Figure 7 uses blue and green data points to indicate high performance (for example, in the areas of moderate-severe pain (long stay) and newly received antipsychotic medications (short stay)). A metric that need improvement and was likely the reason why the facility had a "4-star" for quality is denoted in orange (improvement in function (short-stay)).[35]

[34] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on March 6, 2019, but is not accessible by the public.)

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

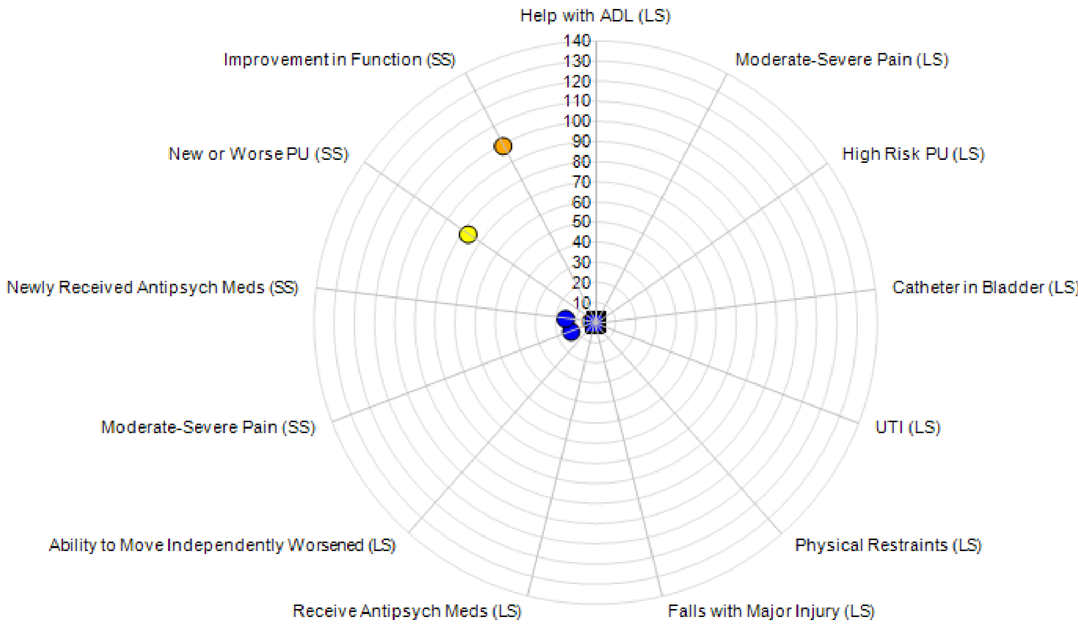

Figure 7. *Facility CLC Quality Measure Rankings (as of June 30, 2018)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team appeared relatively stable, with one of the positions permanently filled less than two months prior to the OIG's on-site visit. Selected survey scores related to employee satisfaction with the facility's executive leaders indicate opportunities for the director and chief of staff to improve employee satisfaction and for the director to provide a safe workplace environment where employees feel comfortable with bringing forth issues or ethical concerns. In the OIG's review of patient experience survey data, opportunities appeared to exist to improve inpatient and Specialty Care outpatient experiences. The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as implementing processes to improve quality care, supporting Servant Leader training initiatives, and initiating plans to maintain positive perceptions of the facility through active stakeholder engagement). However, the organizational risk factors detailed in this report, if uncorrected, can perpetuate noncompliance with requirements and/or lapses in quality care. Corrective processes must be fully implemented and continuously monitored. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and SAIL CLC metrics but should continue to take actions to sustain and improve performance of measures contributing to the SAIL "3-star" and CLC "4-star" quality ratings.

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 that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.[36] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[37] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[38]

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,[39] utilization management (UM) reviews,[40] patient safety incident reporting with related root cause analyses,[41] and cardiopulmonary resuscitation (CPR) episode reviews.[42]

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[43]

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[36] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 and has not been recertified.)

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

[38] VHA Directive 1026.

[39] The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a critical review of care, performed by a peer, to evaluate care provided by a clinician for a specific episode of care, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements.

[40] According to VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria."

[41] The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

[42] VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

[43] VHA Directive 1190.

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[44]

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.[45]

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.[46]

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[47]

- Protected peer reviews
    - Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
    - Implementation of improvement actions recommended by the Peer Review Committee
    - Completion of final reviews within 120 calendar days
    - Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee

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[44] VHA Directive 1117(1).

[45] VHA Handbook 1050.01.

[46] VHA Directive 1177, VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017.

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

- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[48]

- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Annual completion of a minimum of eight root cause analyses[49]
  - Inclusion of required content in root cause analyses (generally)
  - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report to facility leaders
- Resuscitation episode review
  - Evidence of a committee responsible for reviewing resuscitation episodes
  - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
  - Evidence of basic or advanced cardiac life support certification for code team responders
  - Evaluation of each resuscitation episode by the CPR Committee or equivalent

[48] VHA Directive 1190.

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

Quality, Safety, Value Conclusion

The OIG found general compliance with requirements for protected peer reviews and patient safety. However, the OIG identified concerns with the review of UM data and with the facility's committee review of resuscitation episodes that warrant recommendations for improvement.

Specifically, VHA requires that facility UM reviewers conduct a minimum of 75 percent of acute inpatient admission and continued stay reviews.[50] The OIG found during the timeframe of October 1, 2017, through September 30, 2018, that facility UM reviewers conducted 60 percent of required reviews, falling short of the 75 percent requirement. This resulted in insufficient evaluations of admission and continued stay appropriateness. Program managers and leaders cited position vacancies and systematic process challenges as the reasons for noncompliance.

Recommendation 1

1. The chief of staff ensures utilization management reviewers complete at least 75 percent of all inpatient stay reviews and monitors the reviewers' compliance.

Facility concurred.

Target date for completion: September 1, 2019

Facility response: Utilization management staffing has been increased in January and February 2019. This has facilitated the increase in inpatient utilization management review with compliance March 2019, 89.19% and April 2019, 87.53%. Monitoring of all inpatient utilization management review will continue to be conducted monthly by the Utilization Management Manager for 4 additional months with the expectation of compliance level being greater than 75%. This monthly inpatient stay reviews compliance will be reported in the Utilization Management Committee which reports to the Quality Leadership Council quarterly.

As to UM data, VHA requires that an interdisciplinary facility group review the data.[51] This group must include, but not be limited to, representatives from UM, medicine, nursing, social work, case management, mental health, and chief Business Office revenue utilization review (CBO R-UR). From October 1, 2017, through September 30, 2018, representatives from social work and CBO R-UR did not consistently attend meetings. As a result, the UM committee performed reviews and analyses of UM data without the perspectives of key social work and utilization review colleagues. Facility managers could not provide a reason why a designee did not attend committee meetings when the assigned social work representative was on extended leave, and managers were unaware of the CBO R-UR membership requirement.

[50] VHA Directive 1117(1).

[51] VHA Directive 1117(1).

Recommendation 2

2. The chief of staff makes certain that all required representatives consistently participate in interdisciplinary reviews of utilization management data and monitors the representatives' compliance.

Facility concurred.

Target date for completion: November 1, 2019

Facility response: The Utilization Management (UM) Committee charter was revised to include membership of the Chief Business Office Revenue Utilization Management Review member (CBO R-UR). The attendance matrix for the UM Committee has been revised to ensure monitoring of representation from all required members. All attendees are expected to attend every meeting or send a representative to the Utilization Management Committee monthly. The Utilization Management Committee will include in the old business of the agenda a review of the prior month's attendance matrix for purpose of monitoring compliance with attendance. The attendance expectation is 90% for the next 6 months. The Utilization Management Committee will report compliance quarterly to the Quality Leadership Council.

In accordance with TJC standards, VHA requires that the facility Cardiopulmonary Resuscitation (CPR) Committee reviews each resuscitative episode of care under the facility's responsibility.[52] There was no evidence that the CPR Committee reviewed 6 of 10 OIG-selected resuscitative episodes at the facility. This likely resulted in missed opportunities for the identification of errors or deficiencies in technique or procedures; availability or malfunction of equipment; and clinical issues or patient care issues, such as failure to rescue, that can contribute to the occurrence of a cardiopulmonary event. Facility managers were unaware of the CPR Committee's requirement to review each resuscitative episode of care.

Recommendation 3

3. The facility director ensures the Cardiopulmonary Resuscitation Committee reviews each resuscitative episode under the facility's responsibility and monitors the Cardiopulmonary Resuscitation Committee's compliance.

[52] VHA Directive 1177.

Facility concurred.

Target date for completion: October 31, 2019

Facility response: All code blue events are reviewed by the CPR Committee members in advance of the CPR meeting. Any complicated issues identified will be reviewed by multiple Subject Matter Experts for appropriateness and timeliness of care rendered. Each CPR meeting will review the information for each code blue event and the committee's discussion and any identified opportunities will be documented in the meeting minutes. Monitoring of CPR meeting minutes for inclusion of this information will be conducted for 6 months. The CPR Committee meets a minimum of quarterly and reports quarterly to the Quality Leadership Council.

Medical Staff Privileging

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

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

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluate and determines the practitioner's professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges." "The ongoing monitoring of privileged practitioners, Ongoing Professional Practice Evaluation[s] (OPPE), [are] essential to confirm the quality of care delivered."[55]

According to TJC, the "FPPE for Cause" should be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care. The "FPPE for Cause" is limited to a particular timeframe and customized to the specific provider and related clinical concerns.[56] Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.[57]

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

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[53] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA Handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

[54] VHA Handbook 1100.19.

[55] VHA Handbook 1100.19.

[56] Office of Quality and Performance, "*Provider Competency and Clinical Care Concerns*," July 2016 (Revision 2).

[57] VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. (This VHA Handbook was scheduled for recertification on or before the last working date of December 2014 and has not been recertified.)

- No solo/few practitioners[58] were hired within 18 months[59] before the site visit or were privileged within the prior 12 months[60]
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs re-privileged within 12 months before the visit
- Three providers who underwent a FPPE for cause within 12 months prior to the visit.

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[61]
  - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
  - Criteria defined in advance
  - Use of required criteria in FPPEs for selected specialty LIPs
  - Results and timeframes clearly documented
  - Evaluation by another provider with similar training and privileges
  - Medical Staff Executive Committee consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
  - Criteria specific to the service or section
  - Use of required criteria in OPPEs for selected specialty LIPs

[58] This refers to circumstances where there are two or less practitioners in a particular specialty.

[59] The 18-month period was from May 5, 2017, through November 5, 2018.

[60] The 12-month review period was from November 5, 2017, through November 5, 2018; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers few practitioners as being less than three providers in the facility that are privileged in a particular specialty.

[61] According to VHA Handbook 1100.19, facility-specific means that privileges are granted only for procedures and types of services performed at the facility; service-specific refers to privileges being granted in a specific clinical service, such as neurology; and provider-specific means that the privileges should be granted to the individual provider based on their clinical competence and capabilities.

  - Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities
  - Evaluation by another provider with similar training and privileges
  - Medical Staff Executive Committee's decision to recommend continuing privileges based on OPPE results
- Focused professional practice evaluations for cause
  - Clearly defined expectations/outcomes
  - Time limited
  - Provider's ability to practice independently not limited for more than 30 days
  - Shared with the provider in advance
- Reporting of privileging actions to National Practitioner Data Bank

Medical Staff Privileging Conclusion

The facility generally complied with requirements for privileging and OPPEs. However, the OIG identified a concern with the FPPE process that warranted a recommendation.

Specifically, VHA requires that all LIPs new to the facility have FPPEs completed, documented in the practitioner's provider profile, and reported to an appropriate committee of the medical staff.[62] The process involves the evaluation of privilege-specific competence of the practitioner who has not had documented evidence of competently performing the requested privileges. Evaluation methods may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.

VHA also requires that FPPEs be time limited.[63] Time limitations help to ensure an efficient process by preventing undefined or indefinite evaluation of providers. For 5 of 10 completed FPPEs, the OIG found that FPPE timeframes were not clearly delineated. This could have resulted in an inefficient process for evaluating these LIPs. Clinical managers believed that documenting a general date range met the timeframe requirement and were unaware of the requirement to clearly delineate timeframes.

[62] VHA Handbook 1100.19.

[63] VHA Handbook 1100.19.

Recommendation 4

4. The chief of staff ensures that clinical managers initiate focused professional practice evaluations that include clearly delineated timeframes and monitors clinical managers' compliance.

Facility concurred.

Target date for completion: October 15, 2019

Facility response: Focused Professional Practice Evaluations will have defined timeframes delineated (to include month, date, and year). If during that timeframe there is insufficient relevant cases, the FPPE will be continued with a new defined timeframe until a sufficient number of cases can be evaluated. Compliance will be monitored by the Chief of Staff for this practice with presentation to the Professional Standards Board (PSB) (a subcommittee of the Medical Executive Council) monthly. PSB monthly meeting minutes monitors will be conducted for 6 months with expectation of 100% compliance with documentation of the defined timeframes.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. 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. The physical environment of a healthcare organization must not only be functional, but should also promote healing.[64]

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.[65]

VHA requires its facilities to have the "capacity for [providing] mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting;" however, for facilities that do not have inpatient mental health services, that "capacity" could mean facilitating care at a nearby VA or non-VA facility.[66]

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities' efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.[67] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,

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

[65] Applicable requirements for high-risk areas and emergency management include those detailed in or by various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

[66] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA Handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

[67] VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

Occupational Safety and Health Administration,[68] and National Fire Protection Association standards.[69] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[70]

In all, the OIG team inspected seven inpatient units—intensive care, 6W-CLC, 5E-medical/surgical, 5W-medical/surgical, 6E telemetry, 7-inpatient mental health, and post-anesthesia care—in addition to selected outpatient areas, which included the same-day-surgery/pre- and post-operative care unit; the emergency department; and the primary care, women's health, and physical medicine and rehabilitation clinics. The team also reviewed the emergency management program and inspected the Adam Benjamin, Jr., VA Outpatient Clinic in Crown Point, Indiana. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Community based outpatient clinic
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Locked inpatient mental health unit

[68] The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA's Mission is to assure safe and healthy working conditions "by setting and enforcing standards and by providing training, outreach, education, and assistance." https://www.osha.gov/about.html (The website was accessed on June 28, 2018.)

[69] The National Fire Protection Association (NFPA) is a global nonprofit organization "devoted to eliminating death, injury, property, and economic loss due to fire, electrical, and related hazards." https://www.nfpa.org/About-NFPA (The website was accessed on June 28, 2018.)

[70] TJC. Environment of Care standard EC.02.05.07.

- Mental health environment of care rounds
- Nursing station security
- Public area and general unit safety
- Patient room safety
- Infection prevention
- Availability of medical equipment and supplies

- Emergency management
  - Hazard vulnerability analysis (HVA)
  - Emergency operations plan (EOP)
  - Emergency power testing and availability

Environment of Care Conclusion

Generally, the facility met requirements with the performance indicators. The OIG did not note any issues with the availability of medical equipment and supplies. The OIG made no recommendations.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.[71] Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.[72]

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.[73]

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the prior two completed quarters;[74] and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
    - Monthly summary of findings to the director
    - Quarterly trend reports to the director
    - Quality Management Committee's review of monthly and quarterly trend reports
    - Actions taken to resolve identified problems
- Pharmacy operations
    - Staff restrictions for monthly review of balance adjustments[75]
- Requirements for controlled substances inspectors

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[71] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (The website was accessed on March 7, 2019.)

[72] American Society of Health-System Pharmacists, "ASHP Guidelines on Preventing Diversion of Controlled Substances," *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

[73] VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

[74] The two quarters were from April 1, 2018, through September 30, 2018.

[75] Controlled substances balance adjustment reports list transactions in which the pharmacy vault inventory balance was manually adjusted.

- No conflicts of interest
- Appointed in writing by the director for a term not to exceed three years
- Hiatus of one year between any reappointment
- Completion of required annual competency assessment

- Controlled substances area inspections
    - Completion of monthly inspections
    - Rotations of controlled substances inspectors
    - Patterns of inspections
    - Completion of inspections on day initiated
    - Reconciliation of dispensing between pharmacy and each dispensing area
    - Verification of controlled substances orders
    - Performance of routine controlled substances inspections
- Pharmacy inspections
    - Monthly physical counts of the controlled substances in the pharmacy
    - Completion of inspections on day initiated
    - Security and verification of drugs held for destruction[76]
    - Accountability for all prescription pads in pharmacy
    - Verification of hard copy controlled substances prescriptions
    - Verification of 72-hour inventories of the main vault
    - Quarterly inspections of emergency drugs
    - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[77]

Medication Management Conclusion

The OIG found general compliance with requirements for most of the performance indicators evaluated, including the controlled substances coordinator reports, pharmacy operations, and

[76] According to VHA Directive 1108.02(1), The Destructions File Holding Report "lists all drugs awaiting local destruction or turn-over to a reverse distributor." Controlled substances inspectors "must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report."

[77] When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists' review of medications ordered by the providers.

requirements for controlled substances inspectors. However, the OIG identified noncompliance with the reconciliation of one random day's return of stock to pharmacy from every automated dispensing unit and with the verification of two signatures for waste of partial doses of controlled substances.

Specifically, VHA requires controlled substances inspection program staff to reconcile one random day's stocking/refilling from the pharmacy to every automated dispensing unit and one random day's return of stock to pharmacy from every automated dispensing unit during controlled substances area inspections.[78]

The OIG found that controlled substances program staff did not conduct reconciliations of one random day's return of stock to pharmacy from every automated dispensing unit in any of the 10 controlled substances areas for the five months of inspection reports reviewed.[79] This reconciliation provides the opportunity to identify potential drug diversion activities and any discrepancies with refilling or returning controlled substances. The controlled substances coordinator was not aware of the correct report to conduct the reconciliation process and stated the reason for noncompliance was lack of oversight for the requirement in the new directive.

Recommendation 5

5. The facility director makes certain that controlled substances program staff perform one random day's reconciliation of controlled substances returned to pharmacy from every automated dispensing unit during monthly inspections and monitors the program staff's compliance.

[78] VHA Directive 1108.02(1).

[79] April 2018 to August 2018.

Facility concurred.

Target date for completion: October 31, 2019

Facility response: The Controlled Substance Coordinator (CSC) has incorporated the random one day's reconciliation of controlled substances returned to pharmacy from every automated dispensing unit into the monthly inpatient pharmacy-controlled substance inspection checklist. This inspection checklist will ensure the controlled substance inspection program inspectors perform one random day's reconciliation of controlled substances returned to pharmacy from every automated dispensing unit. The CSC reviews every inspector's monthly checklist to ensure compliance. All monthly findings are reported to the facility director or designee. The CSC will monitor completion for one random day's reconciliation of controlled substances returned to pharmacy from 10 random automated dispensing units. This will be conducted for 6 consecutive months with expectation of 90% compliance starting on May 1, 2019. The CSC meets monthly and reports to the Quality Leadership Council quarterly.

VHA requires that controlled substances inspectors verify during controlled substances inspections that there is evidence of documentation of two signatures for any waste of partial doses for five randomly selected dispensing activities.[80] The OIG reviewed six months of documentation for controlled substances inspections for 10 areas.[81] For all 10 areas, the controlled substances inspectors did not verify documentation of two signatures for waste when partial doses were administered. This may result in the inability to account for all controlled substances. The controlled substances coordinator acknowledged the lack of oversight as the reason for noncompliance.

Recommendation 6

6. The facility director ensures that the controlled substances inspectors verify documentation for two signatures for any waste of partial doses and monitors controlled substances inspectors' compliance.

[80] VHA Directive 1108.02(1).

[81] April 2018 through September 2018.

Facility concurred.

Target date for completion: October 31, 2019

Facility response: Although the automated dispensing system requires two signatures of documentation for wastage, the Controlled Substance Coordinator (CSC) will further incorporate controlled substance inspector verification of documentation of two signatures for any waste when partial doses are administered. This verification of two signatures by the inspectors will be added to the monthly controlled substance checklist. The CSC reviews every inspector's monthly checklist to ensure compliance. All monthly findings are reported to the facility director or designee and the CSC. The CSC will monitor completion of the verification of two waste signatures by reviewing the waste actions from 10 different automated dispensing units (total of 10 waste actions) for each month. This will be conducted for 6 consecutive months with expectation of 90% compliance starting on May 1, 2019. This will be reported to the CSC which reports to the Quality Leadership Council quarterly.

Mental Health: Military Sexual Trauma Follow-Up and Staff Training

The Department of Veterans Affairs uses the term "military sexual trauma" (MST) to refer to a "psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training."[82] MST is an experience, not a diagnosis or a mental health condition. Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.[83]

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership. [84] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[85]

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system (CPRS).[86] Those who screen positive must have access to appropriate MST-related care.[87] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.[88]

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.[89] All mental health and primary care providers must complete MST mandatory

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[82]VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

[83]Military Sexual Trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on November 17, 2017.)

[84] VHA Directive 1115.

[85]VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008 (amended November 16, 2015). (This VHA Handbook was scheduled for recertification on or before the last working date of September 2013 and has not been recertified.)

[86]VHA Directive 1115 states that "MST-related care is not subject to the minimum active duty service requirement set forth in 38 U.S.C. 5303A; Veterans may therefore be able to receive MST-related care even if they are not eligible for VA health care under other treatment authorities."

[87]VHA Directive 1115.

[88] VHA Handbook 1160.01.

[89] VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[90]

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 50 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Designated facility MST coordinator
  - Establishes and monitors MST-related staff training
  - Establishes and monitors informational outreach
  - Communicates MST-related issues, services, and initiatives with local leadership
- Evidence of tracking MST-related data
- Provision of clinical care
  - Referral for MST-related care to patients with positive MST screens
  - Initial evaluation within 24 hours of referral for mental health services
  - Comprehensive diagnostic and treatment planning evaluation within 30 days of referral for mental health services
- Completion of MST mandatory training requirement for mental health and primary care providers

Mental Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including the designation of an MST coordinator, tracking of MST-related data, and referral for MST-related care. There was a concern noted, however, with the completion of the MST mandatory training requirement for mental health and primary care providers that warranted a recommendation for improvement.

Specifically, VHA requires that all primary care and mental health providers complete the MST mandatory training requirement no later than 90 days after entering their position.[91] The OIG

[90] VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017; Acting Deputy Under Secretary for Health for Operations and Management, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers,* February 2, 2016.

[91] VHA Directive 1115.01.

found that 8 of 10 providers hired after July 1, 2012, did not complete the required training within 90 days. This could potentially prevent clinicians from providing appropriate counseling, care, and service to veterans who experienced MST. The chief of QSV cited an ineffective monitoring process as the reason for noncompliance.

Recommendation 7

7. The facility director confirms that mental health and primary care providers complete military sexual trauma mandatory training requirements no later than 90 days after entering their position and monitors providers' compliance.

Facility concurred.

Target date for completion: October 31, 2019

Facility response: Each month the MST Coordinator will request from the TMS Coordinator the MST deficiency report to be submitted to the Chief of Medicine and Chief of Mental Health. The appropriate supervisors will then be notified of any deficiency and will ensure completion of the training or correction of the TMS listing. Monitoring of this process will be completed monthly by the TMS Coordinator with the MST coordinator for 6 months. The compliance will be reported to Associate Chief of Staff monthly. Expectation is 90% compliance or greater.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."[92] The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.[93]

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepression drugs, psychotherapy, or a combination of both."[94]

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.[95] The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."[96] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[97] Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.[98] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[92] Hans Peterson, "Late Life Depression," *U.S. Department of Veterans Affairs*, Mental Health Featured Article, March 1, 2011. https://www.mentalhealth.va.gov/featureArticle_Mar11LateLife.asp. (The website was accessed on March 8, 2019.)

[93] VA/DoD *Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf (The website was accessed November 20, 2018.)

[94] Centers for Disease Control and Prevention, "Depression is Not a Normal Part of Growing Older," January 31, 2017. https://www.cdc.gov/aging/mentalhealth/depression.htm. (The website was accessed on March 8, 2019.)

[95] American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." http://www.sigot.org/allegato_docs/1057_Beers-Criteria.pdf (The website was accessed on March 22, 2018.)

[96] TJC. Provision of Care, Treatment, and Services standard PC 02.03.01.

[97] VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

[98] TJC. National Patient Safety Goal standard NPSG.03.06.01.

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.[99]

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 45 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[100] The OIG evaluated the following performance indicators:

- Justification for medication initiation
- Evidence of patient and/or caregiver education specific to the medication prescribed
- Clinician evaluation of patient and/or caregiver understanding of the education provided
- Medication reconciliation

Geriatric Care Conclusion

Generally, the OIG found compliance with many of the performance indicators, including documenting justification for initiating the medication and performing medication reconciliation. Additionally, the OIG identified a deficiency with patient/caregiver education in electronic health records that warranted a recommendation for improvement.

TJC requires education for patients and families about any potential clinically significant adverse drug reactions or other concerns regarding administration of a new medication and that the clinician evaluates the patient's/caregiver's understanding of the education provided.[101] The OIG estimated that clinicians provided this education to 29 percent of the patients at the facility, based on electronic health records reviewed.[102] Providing medication education is critical to ensuring that patients or their caregivers have the information they need to successfully engage in their healthcare decisions. Program staff stated that not all prescribing providers were aware of the requirements, leading to inconsistency in providing patient education.

[99] VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.
[100] The seven selected antidepressant medications are Amitriptyline, Clomipramine, Desipramine, Doxepin (>6mg/day), Imipramine, Nortriptyline, and Paroxetine.
[101] TJC. Medication Management standard MM.06.01.01.
[102] The OIG is 95 percent confident that the true compliance rate is somewhere between 15.9 and 42.5 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 8

8. The chief of staff ensures clinicians provide and document patient/caregiver education and monitors clinicians' compliance.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: A consult will be required when providers order a new prescription for a tricyclic antidepressant and/or paroxetine. Modifications in the computerized medical record system (CPRS) for the medication template will ensure that the indication is documented, and patients and/or caregivers are counseled about potential side effects. Once the template is approved, monitoring will occur by Pharmacy Service with random sampling of 10 new prescriptions per month for a tricyclic antidepressant and/or paroxetine. This monitor will be conducted for 6 consecutive months with the expectation of 90% compliance. This monitor will be reported monthly to the Pharmacy and Therapeutics Committee which reports quarterly to the Medical Executive Council.

Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.[103] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[104] In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.[105] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[106]

VA is authorized to provide "gender-specific services, such as Papanicolaou tests (Pap smears)," to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.[107]

VHA requires that each facility have a "full-time women veterans program manager (WVPM) to execute comprehensive planning for women's health care." VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women's health program. Each facility must also have a "Women Veterans Health Committee (WVHC) comprised of appropriate facility leadership and program directors, which develops and implements a Women's Health Program strategic plan." The Women Veterans Health Committee must meet at least quarterly and report to the executive leadership. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.[108]

VHA has established timeframes for notifying patients of abnormal cervical pathology results. Abnormal cervical pathology results must be communicated to patients within seven calendar days from the date the results are available to the ordering provider. Communication of the

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[103] Centers for Disease Control and Prevention. "Cervical Cancer" *Inside Knowledge* fact sheet, December 2016. https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf. (The website was accessed on February 28, 2018.)

[104] Center for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

[105] Centers for Disease Control and Prevention. *What Are the Risk Factors for Cervical Cancer?* February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm. (The website was accessed on March 8, 2019.)

[106] Center for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

[107] VHA Directive 1330.01(2), *Health Care Services for Women Veterans,* February 15, 2017 (amended July 24, 2018).

[108] VHA Directive 1330.01(2).

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.[109]

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of 47 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Appointment of a women veterans program manager
- Appointment of a women's health medical director or clinical champion
- Facility Women Veterans Health Committee
    - Core membership
    - Quarterly meetings
    - Reports to clinical executive leadership
- Collection and tracking of cervical cancer screening data
    - Notification of patients due for screening
    - Completed screenings
    - Results reporting
    - Follow-up care
- Communication of abnormal results to patients within required timeframe
- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women's Health Conclusion

The facility generally complied with many of the performance indicators, including requirements for clinical oversight of the women's health program and follow-up care if indicated. However, the OIG identified concerns with tracking data related to cervical cancer screenings and communication of abnormal results to patients that warranted recommendations for improvement.

[109] VHA Directive 1330.01(2).

Specifically, VHA requires that each facility have a process to track and follow-up on cervical cancer screenings.[110] The OIG found that the facility did not track cervical cancer screening data. Lack of a process for tracking cervical cancer screening data may cause delays in providing appropriate care.[111] Program managers were unaware of the requirement.

Recommendation 9

9. The chief of staff makes certain that program managers implement a process for tracking cervical cancer screening data and monitors program managers' compliance.

Facility concurred.

Target date for completion: January 15, 2020

Facility response: The SOP will be updated to ensure standardization throughout the medical center and CBOCs to confirm that the cervical cancer screening tracking practices are standardized throughout the medical center and CBOCs. A random audit of 30 screening records/month will be conducted by Women's Health Coordinator and Quality, Safety and Value for 6 months to ensure staff compliance with the SOP for tracking of cervical cancer screenings with a threshold compliance of 90%. Compliance will be tracked and reported at the Women Veteran's Health Committee which reports to the Medical Executive Council on a quarterly basis.

VHA requires the ordering provider to notify the patient of abnormal cervical pathology results within seven calendar days.[112] The OIG determined that ordering providers timely notified patients of abnormal results in 79 percent of the electronic health records reviewed.[113] Timely communication of abnormal results minimizes potential risks to patients.[114] Program managers reported that providers communicated to patients but failed to document the communication within seven days as the reason for noncompliance.

Recommendation 10

10. The chief of staff confirms that providers notify patients of abnormal cervical pathology results within the required timeframe and monitors providers' compliance.

[110] VHA Directive 1330.01(2).
[111] VHA Directive 1330.01(2).
[112] VHA Directive 1330.01(2).
[113] Confidence Intervals are not included because the data represents every patient in the study population.
[114] VHA Directive 1330.01(2).

Facility concurred.

Target date for completion: January 15, 2020

Facility response: Women's Health Coordinator will ensure standardization throughout the medical center and CBOCs with review of all areas providing this service. An audit of 30 records/month for 6 months will be conducted to ensure staff compliance with the communication of all abnormal cervical pathology results within the required timeframe of 7 calendar days with a threshold compliance of 90%. Compliance will be communicated at the Women Veteran's Health Committee which reports to the Medical Executive Council on a quarterly basis.

High-Risk Processes: Operations and Management of Emergency Departments and Urgent Care Centers

VHA defines an emergency department as a "unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations." An urgent care center (UCC) "provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries."[115] A variety of emergency services may exist, dependent on "capability, capacity, and function of the local VA medical facility;" however, emergency care must be uniformly available in all VHA emergency departments and UCCs.[116]

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide "unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week." VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that "evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care."[117]

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can "undermine the timeliness of care and, ultimately, patient safety." Effective management processes that "support patient flow [in the ED or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care."[118]

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement (EMI) initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software (EDIS) tracking program to document and manage the flow of patients.[119]

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[115] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016 (amended March 7, 2017).

[116] VHA Directive 1101.05(2).

[117] VHA Directive 1101.05(2).

[118] TJC. Leadership standard LD.04.03.11.

[119] VHA Directive 1101.05(2); The Emergency Medicine Management Tool (EMMT) uses data collected from EDIS to generate productivity metrics. The use of EDIS and EMMT are key tools in accomplishing EMI initiative goals.

VA EDs and UCCs must also be designed to promote a safe environment of care. Managers must ensure medications are securely stored,[120] a psychiatric intervention room is available,[121] and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also requires emergency departments to have communication systems available to accept requests by local emergency medical services for transporting medically and psychiatrically unstable patients to VA emergency departments.[122]

The OIG examined the clinical risks of the emergency department/UCC areas by evaluating the staffing; the provision of care, including selected aspects of mental health and women's health; and the reduction of patient safety risks to optimize quality care and outcomes in those areas. In addition to conducting manager and staff interviews, the OIG team reviewed emergency department staffing schedules, committee minutes, and other relevant documents. The OIG evaluated the following performance indicators:

- General
  - Presence of an emergency department or UCC
  - Availability of acute care medical and/or surgical inpatient beds in facilities with emergency departments
  - Emergency department/UCC operating hours
  - Workload capture process
- Staffing for emergency department/UCC
  - Dedicated medical director
  - At least one licensed physician privileged to staff at all times
  - Minimum of two registered nurses on duty during all hours of operation
  - Backup call schedules for providers
- Support services for emergency department/UCC
  - Access during regular hours, off hours, weekends, and holidays
  - On-call list for staff required to respond
  - Licensed independent mental health provider available as required for the facility's complexity level

[120] TJC. Medication Management standard MM.03.01.01.

[121] A psychiatric intervention room is where individuals experiencing a behavioral health crisis, including serious disturbances, agitation, or intoxication may be taken immediately on arrival.

[122] VHA Directive 1101.05(2).

   - Telephone message system during non-operational hours
   - Inpatient provider available for patients requiring admission
- Patient flow
   - EDIS tracking program
   - Emergency department patient flow evaluation
   - Diversion policy
   - Designated bed flow coordinator
- General safety
   - Directional signage to after-hours emergency care
   - Fast tracks[123]
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
   - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

Generally, the OIG noted compliance with many of the performance indicators for the operations and management of the emergency department. However, the OIG identified a deficiency with the presence of both an emergency department and an UCC that warranted a recommendation.

Specifically, VHA requires that UCCs not exist in VA medical facilities with an emergency department.[124] The OIG found that facility managers designated an area within the primary care clinic as the UCC when an emergency department was also in operation at the same campus. This could create confusion and force patients and significant others to self-triage and potentially present to the UCC when emergency care is needed. Facility managers reported the need to serve a significant volume of unscheduled patients who are presenting to the emergency department

[123] The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated.

[124] VHA Directive 1101.05(2).

during the clinic operational hours and do not require emergent care. Facility managers also stated that this patient volume could not be accommodated with a fast-track system within the confines of the emergency department and that was the rationale for establishing an UCC.[125]

Recommendation 11

11. The facility director ensures that the urgent care center is discontinued and patient needs and flow are more adequately addressed in the established emergency department and primary care clinic, and monitors compliance.

Facility concurred.

Target date for completion: November 30, 2019

Facility response: The current Urgent Care will transition to an Emergency Department Fast Track and re-aligned under the Emergency Department. The current Primary Care Staff will transition to Emergency Department Medical Staff. Stop Code 130 will be utilized for all Veterans presenting to the Emergency Department/Fast Track and will be entered into EDIS for tracking.

[125] An ED fast track is a designated care area within the domain of the ED that may be a section within or close to the ED where lower acuity ED patients can be seen and is operated under the supervision of Emergency Medicine.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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.

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation and/or for-cause surveys and oversight inspections • Factors related to possible lapses in care • VHA performance data	Eleven OIG recommendations, ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events, are attributable to the director and chief of staff. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• The Cardiopulmonary Resuscitative Committee reviews each resuscitative episode under the facility’s responsibility.	• UM reviewers complete at least 75 percent of all inpatient stay reviews. • All required members consistently participate in interdisciplinary reviews of UM data.
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• None	• Clinical managers initiate FPPEs that include clearly delineated timeframes.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	• Parent facility o General safety o Environmental cleanliness and infection prevention o General privacy o Women veterans program o Availability of medical equipment and supplies • Community based outpatient clinic o General safety o Environmental cleanliness and infection prevention o General privacy o Women veterans program o Availability of medical equipment and supplies • Locked inpatient mental health unit o Mental health environment of care rounds o Nursing station security o Public area and general unit safety o Patient room safety o Infection prevention o Availability of medical equipment and supplies • Emergency management o Hazard vulnerability analysis (HVA) o Emergency operations plan (EOP) o Emergency power testing and availability	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• None	• Controlled substances inspection program staff perform one random day's reconciliation of controlled substances returned to pharmacy from every automated dispensing unit during monthly inspections. • The controlled substances inspectors verify documentation for two signatures for any waste of partial doses.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers	• None	• Mental health and primary care providers complete MST mandatory training requirements no later than 90 days after entering their position.
Geriatric Care: Antidepressant Use among the Elderly	• Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation	• None	• Clinicians provide and document patient/caregiver education.
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion	• Program managers implement a process to track cervical cancer screening data. • Providers timely notify patients of abnormal cervical pathology results.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data • Communication of abnormal results to patients within required timeframe • Provision of follow-up care for abnormal cervical pathology results, if indicated		
High-Risk Processes: Operations and Management of Emergency Departments and UCCs	• General • Staffing for emergency department/UCC • Support services for emergency department/UCC • Patient flow • General safety • Medication security and labeling • Management of patients with mental health disorders • Emergency department participation in local/regional EMS system • Women veteran services • Life support equipment	• None.	• Facility director discontinues UCC and addresses patient needs and flow through the established emergency department and primary care clinic.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this high complexity (1b) affiliated[126] facility reporting to VISN 12.[127]

Table B.1. Facility Profile for Jesse Brown VAMC (537) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[128]	Facility Data FY 2017[129]	Facility Data FY 2018[130]
Total medical care budget dollars	$449,260,152	$480,570,412	$482,225,688
Number of: • Unique patients	51,566	48,914	49,091
• Outpatient visits	658,399	644,369	629,209
• Unique employees[131]	2,074	2,136	2,197
Type and number of operating beds: • Community living center	22	22	22
• Domiciliary	40	40	40
• Medicine	75	75	75
• Mental health	40	40	40
• Rehabilitation medicine	8	8	8
• Surgery	25	25	25
Average daily census: • Community living center	18	19	17
• Domiciliary	35	32	32
• Medicine	69	70	64

[126] Associated with a medical residency program.

[127] The VHA medical centers are classified according to a facility complexity model; 1b designation indicates a facility with medium-high volume, high risk patients, many complex clinical programs, and medium-large research and teaching programs.

[128] October 1, 2015, through September 30, 2016.

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

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

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

Profile Element	Facility Data FY 2016[128]	Facility Data FY 2017[129]	Facility Data FY 2018[130]
• Mental health	31	32	27
• Rehabilitation medicine	4	4	4
• Surgery	10	10	10

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

VA Outpatient Clinic Profiles[132]

The VA outpatient clinics in communities within the catchment area of the facility provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table B.2. provides information relative to each of the clinics.

Table B.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)[133]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[134] Provided	Diagnostic Services[135] Provided	Ancillary Services[136] Provided
Auburn Gresham-Chicago, IL	537HA	4,688	3,003	Dermatology	n/a	Nutrition Pharmacy Social work Weight management
Chicago Heights, IL	537GA	4,112	2,987	Dermatology Anesthesia	n/a	Nutrition Pharmacy Weight management

[132] Includes all outpatient clinics in the community that were in operation as of August 15, 2018. The OIG omitted Chicago-California Avenue, IL (537QA), as no data was reported.

[133] The definition of an "encounter" can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015, and has not been updated.) An encounter is a "professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

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

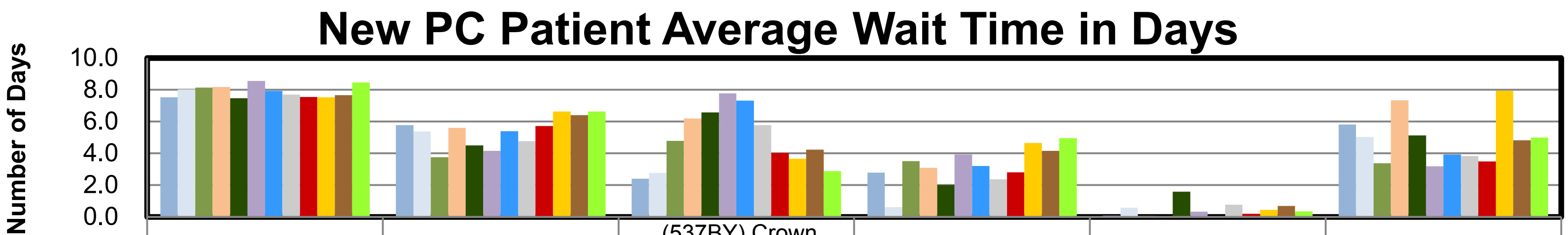
[135] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[134] Provided	Diagnostic Services[135] Provided	Ancillary Services[136] Provided
Crown Point, IN	537BY	20,409	18,137	Cardiology Dermatology Endocrinology Gastroenterology Infectious disease Anesthesia Eye Podiatry Urology	Laboratory & pathology Radiology	Nutrition Pharmacy Social work Weight management Dental
Lakeside-Chicago, IL	537GD	10,507	1,562	Dermatology	Laboratory & pathology	Pharmacy Social work

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

Appendix C: Patient Aligned Care Team Compass Metrics[137]

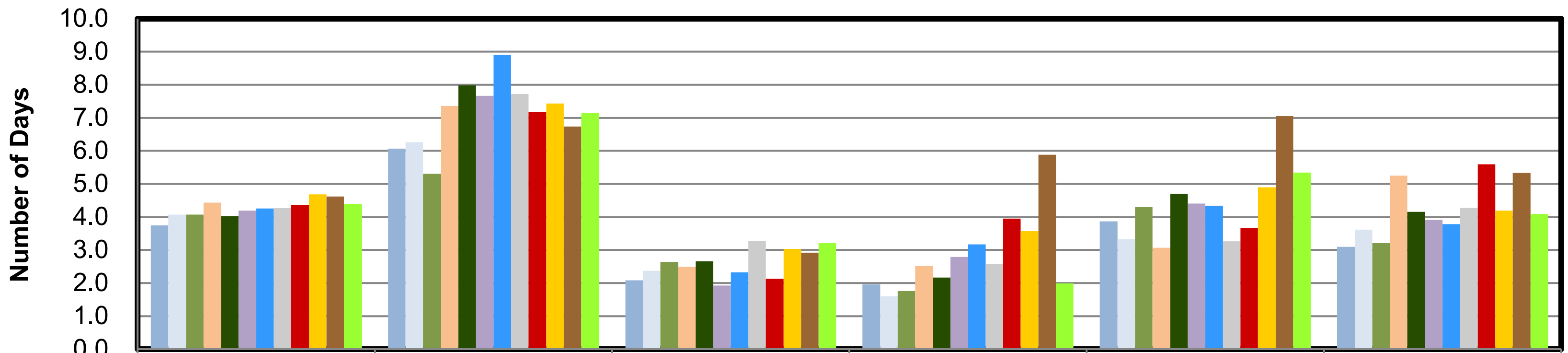


	VHA Total	(537) Chicago, IL (Jesse Brown)	(537BY) Crown Point, IN (Adam Benjamin Jr.)	(537GA) Chicago Heights, IL	(537GD) Lakeside, IL	(537HA) Auburn Gresham, IL
OCT-FY18	7.5	5.8	2.4	2.8	0.1	5.8
NOV-FY18	8.0	5.4	2.8	0.6	0.6	5.0
DEC-FY18	8.1	3.8	4.8	3.5	0.1	3.4
JAN-FY18	8.2	5.6	6.2	3.1	0.1	7.3
FEB-FY18	7.5	4.5	6.6	2.0	1.6	5.1
MAR-FY18	8.6	4.2	7.8	3.9	0.3	3.2
APR-FY18	7.9	5.4	7.3	3.2	0.1	3.9
MAY-FY18	7.7	4.8	5.8	2.4	0.8	3.8
JUN-FY18	7.6	5.7	4.0	2.8	0.2	3.5
JUL-FY18	7.5	6.6	3.7	4.7	0.4	8.0
AUG-FY18	7.7	6.4	4.2	4.2	0.7	4.8
SEP-FY18	8.5	6.6	2.9	5.0	0.4	5.0

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness The OIG omitted Chicago-California Avenue, IL (537QA), as no data was reported.
Data Definition: "The average number of calendar days between a new patient's primary care completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Note that prior to FY15, this metric was calculated using the earliest possible create date.

[137] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 13, 2018.

Established PC Patient Average Wait Time in Days



	VHA Total	(537) Chicago, IL (Jesse Brown)	(537BY) Crown Point, IN (Adam Benjamin Jr.)	(537GA) Chicago Heights, IL	(537GD) Lakeside, IL	(537HA) Auburn Gresham, IL
OCT-FY18	3.7	6.1	2.1	2.0	3.9	3.1
NOV-FY18	4.1	6.3	2.4	1.6	3.3	3.6
DEC-FY18	4.1	5.3	2.6	1.8	4.3	3.2
JAN-FY18	4.4	7.4	2.5	2.5	3.1	5.3
FEB-FY18	4.0	8.0	2.7	2.2	4.7	4.2
MAR-FY18	4.2	7.7	1.9	2.8	4.4	3.9
APR-FY18	4.3	8.9	2.3	3.2	4.3	3.8
MAY-FY18	4.3	7.7	3.3	2.6	3.3	4.3
JUN-FY18	4.4	7.2	2.1	4.0	3.7	5.6
JUL-FY18	4.7	7.4	3.0	3.6	4.9	4.2
AUG-FY18	4.6	6.7	2.9	5.9	7.1	5.3
SEP-FY18	4.4	7.1	3.2	2.0	5.3	4.1

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Chicago-California Avenue, IL (537QA), as no data was reported.
Data Definition: "The average number of calendar days between an established patient's primary care completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[138]

Measure	Definition	Desired Direction
ACSC hospitalization	Ambulatory care sensitive conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit reviews met	% Acute admission reviews that meet interqual criteria	A higher value is better than a lower value
APP capacity	Advanced practice provider capacity	A lower value is better than a higher value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Care transition	Care transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont stay reviews met	% Acute continued stay reviews that meet interqual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/capacity	Efficiency and physician capacity	A higher value is better than a lower value
Employee satisfaction	Overall satisfaction with job	A higher value is better than a lower value

[138] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

Measure	Definition	Desired Direction
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like	Outpatient performance measure (HEDIS)	A higher value is better than a lower 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 wait time	Mental health care wait time for new patient completed appointments within 30 days of preferred date	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	ORYX	A higher value is better than a lower value
PC routine care appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC urgent care appt	Timeliness in getting a PC urgent care appointment (PCMH)	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
Physician capacity	Physician capacity	A lower value is better than a higher value
PC wait time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value

Measure	Definition	Desired Direction
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value

Measure	Definition	Desired Direction
SC care coordination	SC care coordination	A higher value is better than a lower value
SC routine care appt	Timeliness in getting a SC routine care appointment (specialty care)	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
SC urgent care appt	Timeliness in getting a SC urgent care appointment (specialty care)	A higher value is better than a lower value
Seconds pick up calls	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty care wait time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value
Telephone abandonment rate	Telephone abandonment rate	A lower value is better than a higher value

Source: VHA Support Service Center

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions[139]

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

[139] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on March 6, 2019, but is not accessible by the public.)

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: May 7, 2019

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

Subj: Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center, Chicago, IL

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

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

1. I have reviewed the Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center, Chicago IL. I concur with the recommendations made by the inspection team.

2. I have reviewed the response from the Jesse Brown VA Medical Center, Chicago, IL. Evidence of the corrective action plan with quality improvements to address the recommendations are provided.

3. I would like to thank the OIG inspections team for a thorough Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center, Chicago, IL.

(Original signed by:)

Victoria P. Brahm, MSN, RN, VHA-CM
Acting Network Director, VISN 12

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: May 6, 2019

From: Director, Jesse Brown VA Medical Center (537/00)

Subj: Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center, Chicago, IL

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

1. We appreciate the opportunity to work with the Office of Inspector General as we continually strive to improve the quality of healthcare to America's Veterans.

2. I concur with the findings and recommendation of the OIG CHIP Survey Team. The importance of this review is acknowledged as we continually strive to provide the best possible care.

(Original signed by:)

Marc A. Magill
Medical Center Director

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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