DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

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Figure 1. *VA Illiana Health Care System in Danville, Illinois*
(Source: https://vaww.va.gov/directory/guide/, accessed on
January 28, 2020)

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Illiana Health Care System, which includes the Danville VA Medical Center and multiple outpatient clinics in Illinois. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

1. Quality, safety, and value

2. Medical staff privileging

3. Environment of care

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

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

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

7. Women's health (examining comprehensive care)

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

The unannounced visit was conducted during the week of January 13, 2020, at the VA Illiana Health Care System and Bob Michel VA Outpatient Clinic. The OIG held interviews and reviewed processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this healthcare system'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 healthcare system and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

Leadership and Organizational Risks

At the time of the OIG's visit, the healthcare system's leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and the Associate Director. Organizational communications and accountability were managed through a committee reporting structure with the Leadership Council overseeing several working groups. The leaders monitored patient safety and care through the Quality Executive Board which was responsible for tracking and trending quality of care and patient outcomes.

When the OIG conducted this inspection, the executive team had been working together as a group for over seven months. The Associate Director was the most tenured leader, having been permanently assigned in February 2006. The Director, assigned in May 2019, was the newest member of the leadership team. The Chief of Staff and ADPCS had served in their positions since December 2017 and March 2016, respectively.

The OIG noted that selected employee satisfaction survey results for the health system were generally lower than average scores, and the executive leaders' scores, with the exception of the Associate Director, were generally higher than VHA and the healthcare system scores. Additionally, patient survey results generally reflected similar or higher care ratings than the VHA average. However, opportunities appear to exist for leaders to improve various patient experiences for female veterans.

The inspection team also reviewed accreditation agency findings and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[1]

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

The executive leaders were generally knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to specific poorly performing SAIL and

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

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

community living center measures.[3] In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

The OIG noted opportunities for improvement in five clinical areas reviewed and issued 13 recommendations that are directed to the System Director, Chief of Staff, ADPCS, and Associate Director. These are briefly described below.

Medical Staff Privileging

The OIG observed compliance with elements of focused professional practice evaluations. However, the OIG identified deficiencies with ongoing professional practice evaluations of solo providers and provider exit review processes.[4]

Medication Management

The OIG found compliance with many elements of expected performance, including completion of pain screenings and the use of a multidisciplinary pain management committee to oversee and monitor quality measures. However, the OIG found deficiencies with aberrant behavior risk assessments, documented rationale for concurrent therapy with benzodiazepines, urine drug testing, and informed consent.

Mental Health

The OIG found compliance with the requirements for a designated suicide prevention coordinator, suicide safety plans, and monthly outreach activities. However, the OIG found deficiencies with required patient follow-up appointments and suicide prevention training.

Women's Health

The healthcare system complied with many of the requirements for the provision of women's health care. However, the OIG found deficiencies with community-based outpatient clinic-designated women's health primary care providers and the Women Veterans Health Committee.

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

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

High-Risk Processes

The healthcare system met many of the requirements for operations and management of reprocessing reusable medical equipment. However, the OIG identified deficiencies with manufacturers' instructions for use, standard operating procedures, and the annual risk analysis.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued 13 recommendations for improvement to the System Director, Chief of Staff, and ADPCS. The number of recommendations should not be used as a gauge for the overall quality provided at this system. The intent is for system leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and System Director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, 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.

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

Contents

Purpose and Scope

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

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[1] Investments in a culture of safety and continuous quality improvement, in concert with robust leadership and communication, significantly contribute to positive patient outcomes.[2] Figure 2 illustrates the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

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

1. Leadership and organizational risks

2. Quality, safety, and value (QSV)

3. Medical staff privileging

4. Environment of care

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

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

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

8. Women's health (examining comprehensive care)

9. High-risk processes (emphasizing reusable medical equipment)[3]

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

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

[3] See Figure 2. CHIP inspections address these processes during FY 2020 (October 1, 2019, through September 30, 2020); they may differ from prior years' focus areas.

Figure 2. Fiscal Year (FY) 2020 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

Methodology

The VA Illiana Health Care System includes multiple outpatient clinics in Illinois. Additional details about the types of care provided by the healthcare system can be found in Appendixes B and C.

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports.[4]

The OIG team also selected and physically inspected the Bob Michel VA Outpatient Clinic and the following areas of the healthcare system:

- o Acute psychiatric unit
- o Community living centers (CLC)[5]
- o Dental clinic
- o Medical/surgical/telemetry inpatient unit
- o Outpatient clinics
- o Post-anesthesia care unit
- o Sterile processing services areas
- o Urgent care
- o Veterans villages

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

The inspection period examined operations from December 9, 2017, through January 17, 2020, the last day of the unannounced multiday site visit.[6] While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended

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

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

[6] The range represents the time period from the prior CHIP inspection to the completion of the unannounced, multiday CHIP site visit in January 2020.

(codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leadership, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can impact the healthcare system's ability to provide care in the clinical focus areas.[7] To assess the healthcare system's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement

2. Employee satisfaction

3. Patient experience

4. Accreditation surveys and oversight inspections

5. Identified factors related to possible lapses in care and healthcare system response

6. VHA performance data (healthcare system)

7. VHA performance data (CLCs)

Executive Leadership Position Stability and Engagement

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

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[7] L. Botwinick, M. Bisognano, and C. Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare Improvement, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on November 6, 2019.)
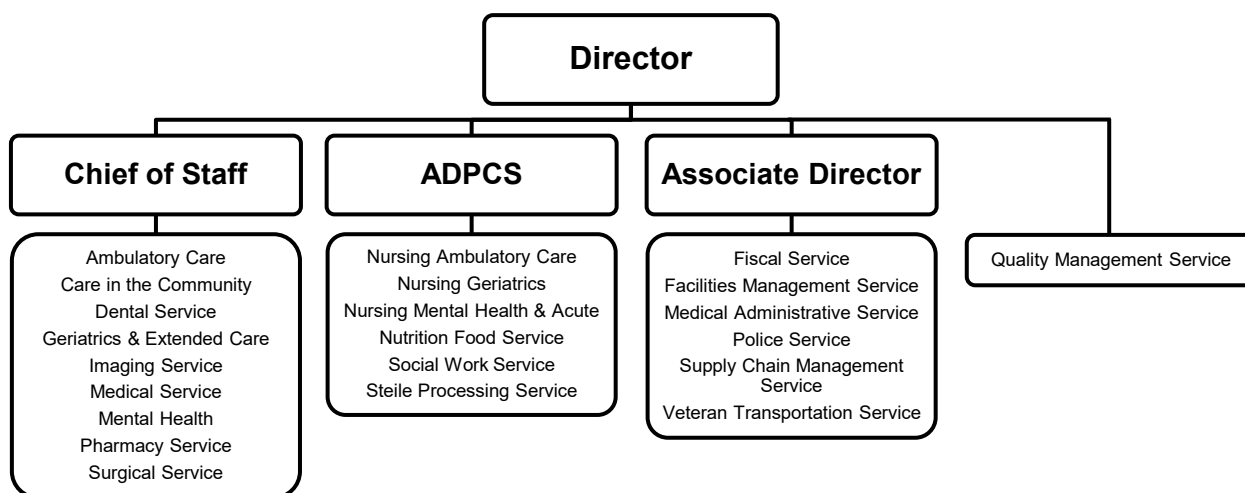
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Chief of Staff	ADPCS	Associate Director
Ambulatory Care Care in the Community Dental Service Geriatrics & Extended Care Imaging Service Medical Service Mental Health Pharmacy Service Surgical Service	Nursing Ambulatory Care Nursing Geriatrics Nursing Mental Health & Acute Nutrition Food Service Social Work Service Steile Processing Service	Fiscal Service Facilities Management Service Medical Administrative Service Police Service Supply Chain Management Service Veteran Transportation Service

Figure 3. *Healthcare System Organizational Chart*
Source: VA Illiana Health Care System (received January 13, 2020)

At the time of the OIG site visit, the executive team had been working together as a group for over seven months. The Associate Director was the most tenured leader, having been permanently assigned in February 2006. The Director, assigned in May 2019, was the newest member of the leadership team. The Chief of Staff and ADPCS had served in their positions since December 2017 and March 2016, respectively. (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	May 26, 2019
Chief of Staff	December 10, 2017
Associate Director for Patient Care Services	March 20, 2016
Associate Director	February 5, 2006

Source: VA Illiana Health Care System Supervisory Human Resources Specialist (received January 13, 2020)

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

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

The Director serves as the chairperson of the Leadership Council, which has the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Leadership Council oversees various working groups, such as the Clinical Executive, Administrative Executive, and Nurse Executive Boards.

These leaders monitor patient safety and care through the Quality Executive Board. The Quality Executive Board is responsible for tracking, trending, and monitoring quality of care and patient outcomes and reports to the Leadership Council. See Figure 4.
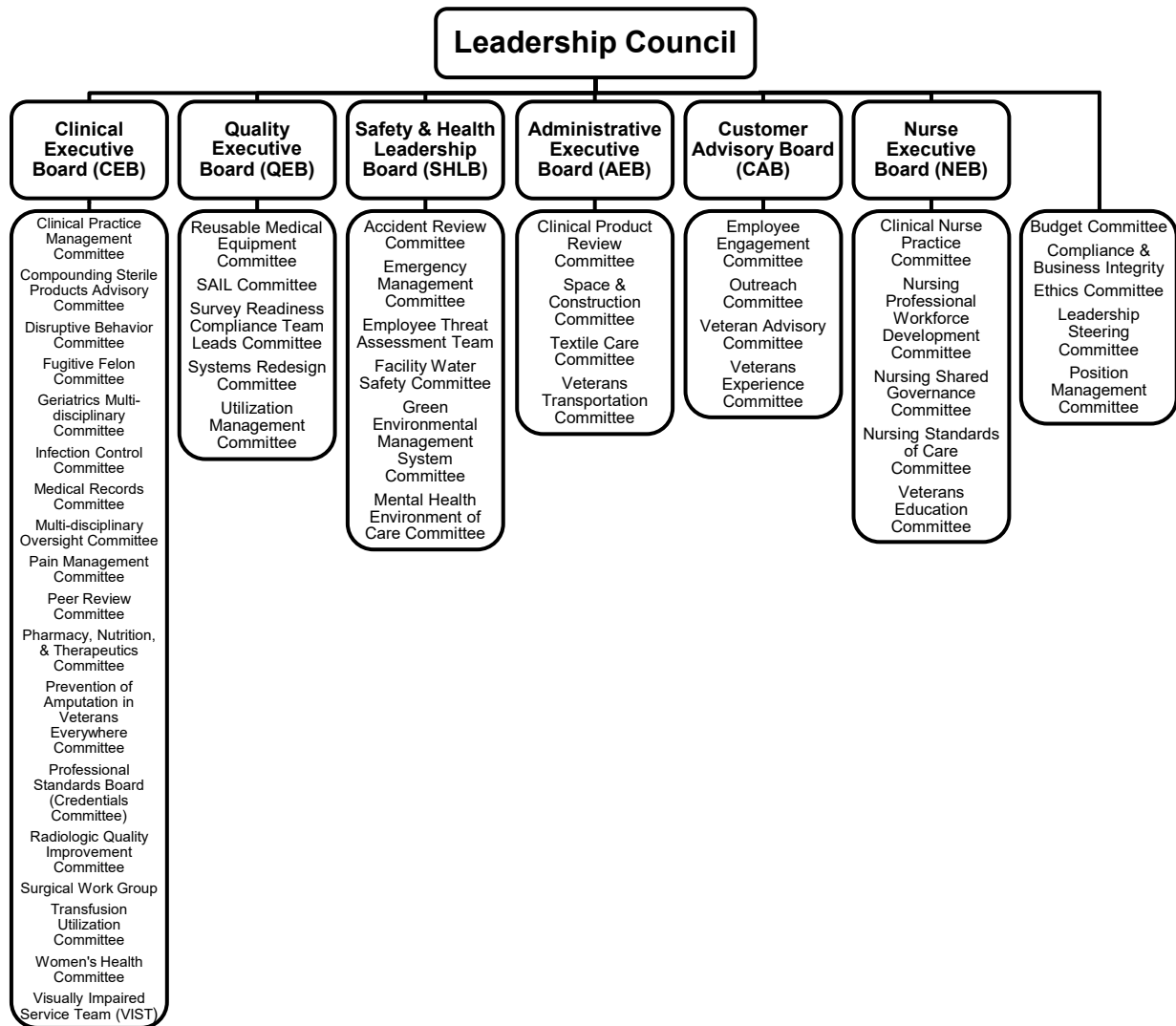
Leadership Council

Clinical Executive Board (CEB)	**Quality Executive Board (QEB)**	**Safety & Health Leadership Board (SHLB)**	**Administrative Executive Board (AEB)**	**Customer Advisory Board (CAB)**	**Nurse Executive Board (NEB)**	
Clinical Practice Management Committee	Reusable Medical Equipment Committee	Accident Review Committee	Clinical Product Review Committee	Employee Engagement Committee	Clinical Nurse Practice Committee	Budget Committee
Compounding Sterile Products Advisory Committee	SAIL Committee	Emergency Management Committee	Space & Construction Committee	Outreach Committee	Nursing Professional Workforce Development Committee	Compliance & Business Integrity
Disruptive Behavior Committee	Survey Readiness Compliance Team Leads Committee	Employee Threat Assessment Team	Textile Care Committee	Veteran Advisory Committee		Ethics Committee
Fugitive Felon Committee	Systems Redesign Committee	Facility Water Safety Committee	Veterans Transportation Committee	Veterans Experience Committee	Nursing Shared Governance Committee	Leadership Steering Committee
Geriatrics Multi-disciplinary Committee	Utilization Management Committee	Green Environmental Management System Committee			Nursing Standards of Care Committee	Position Management Committee
Infection Control Committee		Mental Health Environment of Care Committee			Veterans Education Committee	
Medical Records Committee						
Multi-disciplinary Oversight Committee						
Pain Management Committee						
Peer Review Committee						
Pharmacy, Nutrition, & Therapeutics Committee						
Prevention of Amputation in Veterans Everywhere Committee						
Professional Standards Board (Credentials Committee)						
Radiologic Quality Improvement Committee						
Surgical Work Group						
Transfusion Utilization Committee						
Women's Health Committee						
Visually Impaired Service Team (VIST)						

Figure 4. *Healthcare System Committee Reporting Structure*
Source: VA Illiana Health Care System (received January 13, 2020)

Employee Satisfaction

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

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2018, through September 30, 2019.[8] Table 2 provides relevant survey results for VHA, the healthcare system, and executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the healthcare system average for the selected survey leadership questions was lower than the VHA average.[9] The same trend was noted for the Associate Director; however, scores related to the Director, Chief of Staff, and ADPCS were generally higher than those for VHA and the healthcare system.

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[10]	0–100 where higher scores are more favorable	72.6	71.3	85.7	73.3	81.6	70.0

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

[9] 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.

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.4	3.2	3.8	3.8	3.5	3.2
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.3	3.7	3.7	3.7	3.4
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.4	4.0	3.5	3.7	3.4

Source: VA All Employee Survey (accessed November 18, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[11] Note that the healthcare system average for the selected survey questions was similar to the VHA average. Scores for the facility leaders were generally similar to or better than those for VHA and the healthcare system. However, opportunities appear to exist for the Chief of Staff and ADPCS to reduce employee feelings of moral distress at work.

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

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.7	4.5	3.8	3.8	4.1
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	4.1	3.4	4.0	3.7
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.4	1.5	1.4	1.9	2.2	1.3

Source: VA All Employee Survey (accessed November 18, 2019)

Patient Experience

To assess patient experiences with the healthcare system, which directly reflect on its leaders, the OIG team reviewed patient experience survey results that relate to the period of October 1, 2018, through July 31, 2019. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its

performance against the private sector. Table 4 provides relevant survey results for VHA and the healthcare system.[12]

VHA also collects SHEP survey data from Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward their healthcare experiences (see Table 4). For this system, the patient survey results generally reflected similar or higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

**Table 4. Survey Results on Patient Experience
(October 1, 2018, through July 31, 2019)**

Questions	Scoring	VHA Average	Health Care System Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.1	70.3
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	89.2
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	77.3	82.6
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	78.0	76.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 18, 2019)

In 2015, women represented 9.4 percent of the total veteran population in the United States, and it is projected that women will represent 16.3 percent of living veterans by 2043. Further, from 2005 to 2015, the number of women veterans using VA health care increased by 46.4 percent, from almost 240,000 to 455,875.[13] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

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[12] Ratings are based on responses by patients who received care at this healthcare system.

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

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients' experiences by gender (see Tables 5–7), including those for Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG noted that the results for both male and female respondents were mixed, with the majority of male response averages above the VHA average. System leaders reported active engagement with male and female patients. However, opportunities appear to exist for leaders to improve centered medical home and specialty care patient experiences for female veterans.

Table 5. Inpatient Survey Results on Experiences by Gender (October 1, 2018, through July 31, 2019)

Questions	Scoring	VHA[14]		Healthcare System[15]	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.3	83.8	82.1	82.4
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.6	83.4	89.1	96.1
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	68.4	62.2	68.7	84.8

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 18, 2019)

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[14] The VHA averages are based on 38,790–39,236 male and 1,858–1,866 female respondents, depending on the question.

[15] The healthcare system averages are based on 197–199 male and 11 female respondents, depending on the question.

Table 6. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2018, through July 31, 2019)

Questions	Scoring	VHA[16]		Healthcare System[17]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.6	43.1	43.6	7.4
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.9	49.7	62.4	26.2
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.5	65.8	67.7	36.2

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed March 16, 2020)

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[16] The VHA averages are based on 66,977–203,592 male and 4,905–10,953 female respondents, depending on the question.

[17] The healthcare system averages are based on 374–1,135 male and 24–49 female respondents, depending on the question.

Table 7. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2018, through July 31, 2019)

Questions	Scoring	VHA[18]		Healthcare System[19]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.0	46.0	50.4	0.0
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	55.4	54.7	23.0
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	70.4	70.8	75.2	40.0

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed March 16, 2020)

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.[20] Table 8 summarizes the relevant system inspections most recently performed by the OIG and The Joint

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[18] The VHA averages are based on 55,910–175,665 male and 2,905–9,304 female respondents, depending on the question.

[19] The healthcare system averages are based on 284–846 male and 17–41 female respondents, depending on the question.

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

Commission (TJC).[21] Of note, at the time of the OIG visit, the system had closed all but the most recently issued recommendations for improvement since the previous comprehensive healthcare inspection conducted in December 2017.

At the time of the site visit, the OIG also noted the system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[22]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the VA Illiana Health Care System, Danville, Illinois,* Report No. 17-05424-142, March 28, 2018)	December 2017	7	0
OIG (*Concerns Related to the Management of a Patient's Medication at Three VA Medical Centers and Inaccurate Response to a Congressional Inquiry at the VA Illiana Health Care System, Orlando, Florida, Indianapolis, Indiana, Danville, Illinois,* Report No. 18-02056-54, January 16, 2019)	February 2018	4	0
OIG (*Radiology Concerns at the VA Illiana Health Care System, Danville, Illinois,* Report No. 18-05350-135, May 5, 2020)	April 2019	4[23]	4

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[21] 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."

[22] 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.

[23] Although the OIG issued a total of six recommendations, only recommendations 3–6 were directed to VA Illiana Health Care System.

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
TJC Hospital Accreditation	January 2018	35	0
TJC Behavioral Health Care Accreditation		1	0
TJC Home Care Accreditation		3	0

Source: OIG and TJC (inspection/survey results verified with the Quality Management Program Analyst on January 15, 2020)

Identified Factors Related to Possible Lapses in Care and Healthcare System Response

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

The Risk Manager provided information on the nature of events that led to nine institutional disclosures. Though not reported as sentinel events, the facility Risk Manager also provided details regarding the reviews performed and administrative controls implemented to mitigate future risks to the facility, such as changes to system policies and revocation of provider privileges.

Table 9 lists the reported patient safety events from December 9, 2017 (the prior OIG comprehensive healthcare inspection), through January 13, 2020.[24]

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[24] 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 VA Illiana Health Care System is a low complexity (3) system as described in Appendix B.)

**Table 9. Summary of Selected Organizational
Risk Factors
(December 9, 2017, through January 13, 2020)**

Factor	Number of Occurrences
Sentinel Events[25]	0
Institutional Disclosures[26]	9
Large-Scale Disclosures[27]	0

*Source: VA Illiana Health Care System's Risk Manager
(received January 14. 2020)*

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[28]

Figure 5 illustrates the system's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2019. Of note, Figure 5 uses green data points to indicate high performance for the system (for example, in the areas of health care (HC) associated (assoc) infections, adjusted length of stay (LOS), and care transition). Metrics that need improvement are denoted in orange and red (for example, rating (of) primary care (PC) provider, best place to work, and rating (of) specialty care (SC) provider).[29]
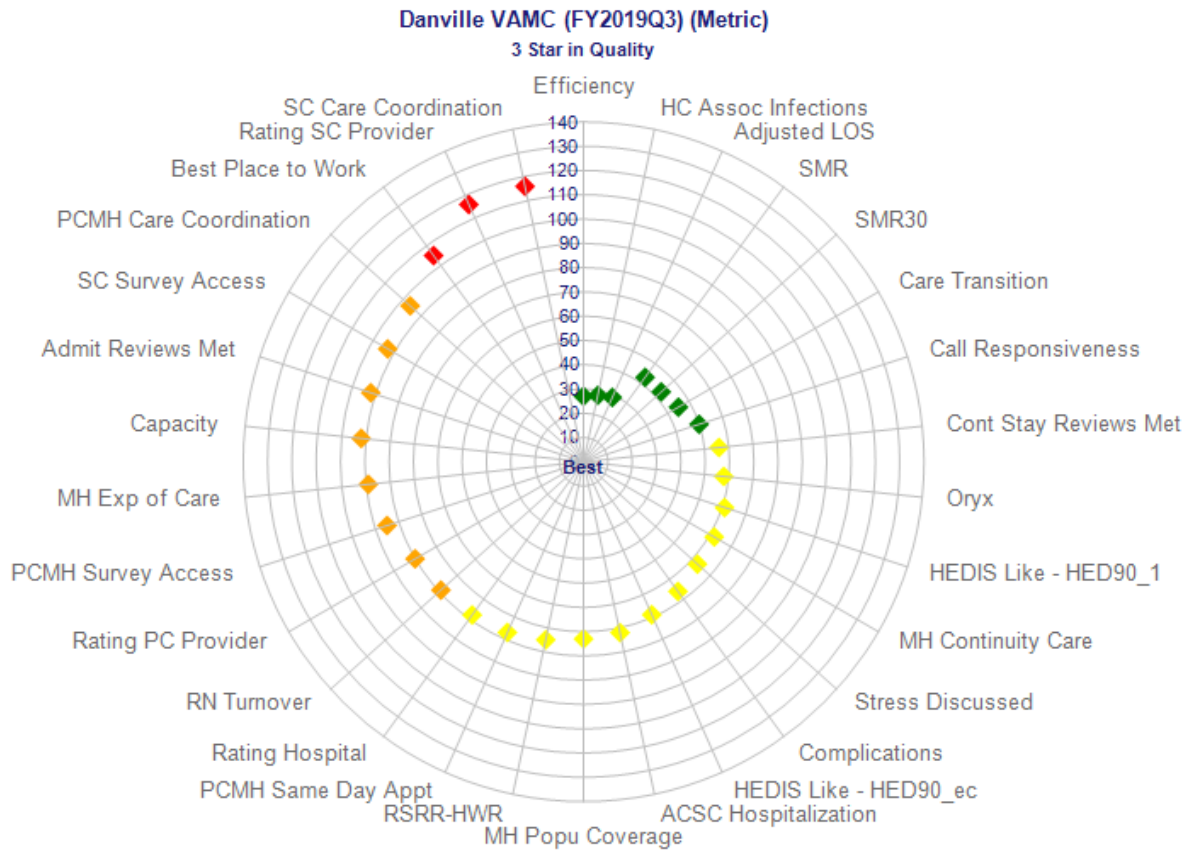
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[25] The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

[26] 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."

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

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

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

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

Veterans Health Administration Performance Data for Community Living Centers

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

Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource to review quality measures and health inspection results.[30]

Figure 6 illustrates the system's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2019. Figure 6 uses blue data points to indicate high performance for the system's CLC (for example, in the areas of catheter in bladder–long stay (LS), physical restraints (LS), and high risk pressure ulcer (PU) (LS). Metrics that need improvement are denoted in orange and red (for example, moderate-severe pain–short stay (SS), falls with major injury (LS), and new or worse PU (SS)).[31]

Red - 5th Quintile; Orange - 4th; Yellow - 3rd; Green - 2nd; Blue - 1st Quintile
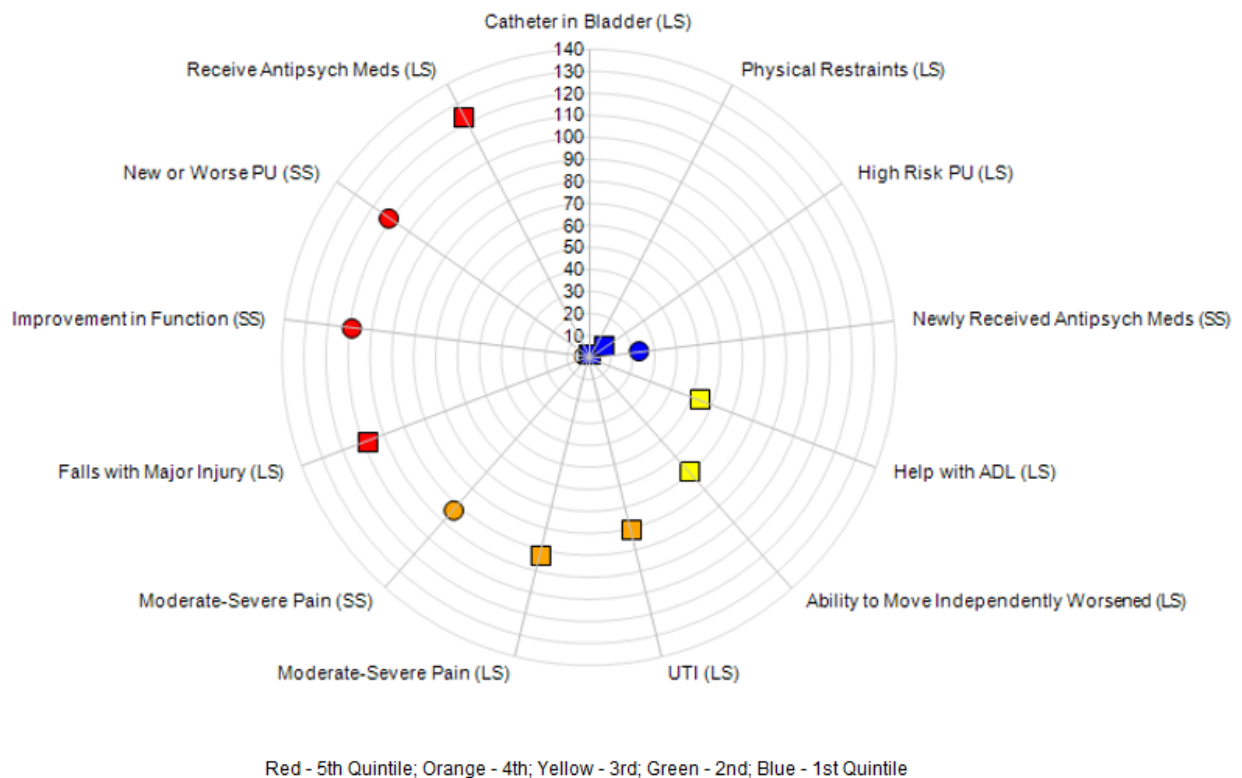
Figure 6. VA Illiana Health Care System CLC Quality Measure Rankings (as of June 30, 2019)
LS = Long-Stay Measure   SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

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

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

Leadership and Organizational Risks Conclusion

The system's executive leadership team appeared relatively stable, with all positions permanently filled more than six months prior to the OIG's site visit. Selected survey scores related to employees' satisfaction with the system's executive leaders were generally positive, and patient survey results largely reflected similar or higher care ratings than the VHA average. However, opportunities appear to exist for the leaders to improve various patient experiences for female veterans. The OIG's review of the system's accreditation findings did not identify any substantial organizational risk factors. In individual interviews, the leaders were able to speak in depth about actions taken during the previous 12 months to maintain or improve employee satisfaction and patient experiences. In addition, the executive leaders were generally knowledgeable within their scope of responsibilities about selected SAIL and CLC data and should continue to take action to sustain and improve performance.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.[32] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and to maintain Joint Commission accreditation.[33] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[34]

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

- Review of aggregated QSV data

- Recommendation and implementation of improvement actions

- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the healthcare system's processes for conducting protected peer reviews of clinical care.[35] Protected peer reviews, when conducted systematically and credibly, reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[36] The OIG team examined the completion of the following elements:

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[32] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellenc*e, September 2014.

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

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

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

[36] VHA Directive 1190.

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

- 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[37]

- Completion of final reviews within 120 calendar days

- Implementation of improvement actions recommended by the Peer Review Committee

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

Next, the inspection team assessed the healthcare system's utilization management (UM) program, a key component of VHA's framework for quality, safety, and value, which provides vital tools for managing the quality and the efficient use of resources.[38] 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.[39] Inspectors reviewed several aspects of the UM program:

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

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

- Interdisciplinary review of UM data

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

Finally, the OIG reviewers assessed the healthcare system's reports of patient safety incidents with related root cause analyses.[40] 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

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[37] VHA Directive 1190.

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

[39] VHA Directive 1117(2).

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

address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the healthcare system.[41] The healthcare system was assessed for its performance on several dimensions:

- Annual completion of a minimum of eight root cause analyses[42]

- Inclusion of required content in root cause analyses

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

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

- Submission of annual patient safety report to healthcare system leaders

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents.[43]

Quality, Safety, and Value Findings and Recommendations

The OIG determined that the healthcare system met the above requirements and made no recommendations.

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[41] VHA Handbook 1050.01.

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

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

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).[44]

Clinical privileges need to be specific and based on the individual practitioner's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[45]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance." The FPPE process occurs when a provider is hired at the facility and granted initial privileges and before any new clinical privileges are granted. Additionally, VA facilities must continuously monitor the performance of their providers. VHA requirements state that "the on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered."[46] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[47]
  - Clear documentation of the results and time frames
  - Evaluation by another provider with similar training and privileges
- OPPEs
  - Application of criteria specific to the service or section
  - Use of minimum criteria for selected specialty LIPs[48]
  - Evaluation by another provider with similar training and privileges

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

[45] VHA Handbook 1100.19.

[46] VHA Handbook 1100.19.

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

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

The OIG also determined whether service chiefs recommended continuing the LIPs' current privileges based in part on the results of OPPE activities and if the healthcare system's Executive Committee of the Medical Staff (referred to as the Clinical Executive Board at this system) decided to recommend continuing privileges based on FPPE and OPPE results.

Further, VA must put processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former licensed practitioner's clinical practice, VA has an obligation to notify state licensing boards (SLBs) and to subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[49] Further, "VA medical facility Directors must designate an individual, and backup, to be responsible for the SLB reporting process. This individual will be the subject matter expert (SME) for the facility…and ensure oversight of the exit review process, including receipt, review, and maintenance of the Provider Exit Review Forms."[50] The OIG reviewers assessed whether the healthcare system's staff

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

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

- Reported results to SLBs when indicated.

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

- Ten solo/few practitioners who underwent initial or reprivileging during the previous 12 months[51]

- Seven LIPs hired within 18 months before the site visit

- Twenty-one LIPs privileged within 12 months before the visit

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

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

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

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

Medical Staff Privileging Findings and Recommendations

The healthcare system complied with elements of focused professional practice evaluations. However, the OIG identified deficiencies with OPPE and provider exit review processes.

VHA requires that reprivileging decisions are based on OPPE information that is service- and practitioner-specific.[52] For one of six solo/few practitioner profiles with OPPE activities, the OIG found that the Chief of Staff could not demonstrate that reprivileging decisions were based upon service-specific OPPE data. VHA also requires that LIPs are evaluated on an ongoing basis by providers with similar training and privileges.[53] The OIG found that in one of six solo/few OPPE practitioner profiles, there was no evidence that a provider with similar training and privileges completed the evaluation. This resulted in LIPs providing care without a thorough evaluation of their competencies, which could impact the quality of care and patient safety. The Chief of Staff did not offer a reason for noncompliance but reported awareness of this deficiency and that new processes were under development to ensure providers with similar training and privileges complete ongoing professional practice evaluations of licensed independent practitioners.

Recommendation 1

1. The Chief of Staff determines reasons for noncompliance and makes certain that ongoing professional practice evaluations include service-specific criteria and are completed by providers with similar training and privileges.

Healthcare system concurred.

Target date for completion: September 30, 2020

Healthcare system response: The Chief of Staff attests the reason for noncompliance was considered in developing the action plan. Ongoing Professional Practice Evaluations (OPPE) compliance is presented at each Credentialing Committee meeting. This recommendation will be considered compliant when review identifies a ninety percent or greater and two consecutive quarters of compliance in completed OPPE including both service-specific criteria and like provider (numerator) when compared to the to the number of completed OPPE (denominator) during the review period. This will be tracked monthly and documented in the Credentialing Committee minutes which is chaired by the Chief of Staff.

VHA requires provider exit review forms, which documents the review of a provider's clinical practice, to be "completed within 7-calendar days of the departure of a licensed health care professional from a VA facility."[54] Of the 20 providers that departed the healthcare system

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[52] VHA Handbook 1100.19.

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

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

between January 13, 2019, and January 13, 2020, the OIG found that 13 provider exit forms were not completed within seven calendar days. This could have resulted in delayed reporting of potential substandard care to state licensing boards. The Chief of Staff indicated that the timeline stipulated in the directive was misinterpreted, which resulted in not completing the forms within the expected time frame.

Recommendation 2

2. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that provider exit review forms are completed within seven calendar days of licensed healthcare professionals departing the healthcare system.

Healthcare system concurred.

Target date for completion: September 30, 2020

Healthcare system response: The System Director attests the reason for noncompliance was considered in developing the action plan. Completed exit evaluations are presented and documented in Credentialing Committee, which meets at a minimum of every quarter and minutes are signed by the System Director. This recommendation will be considered compliant when review identifies a ninety percent or greater and two consecutive quarters of compliance in completed exit review forms (numerator) within seven days of departure when compared to the to the number of departed healthcare providers (denominator) during the review period. This will be tracked monthly and documented in the Credentialing Committee minutes which is chaired by the Chief of Staff.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct Comprehensive Environment of Care Inspection Rounds and to resolve issues in a timely manner. The goal of the Comprehensive Environment of Care Program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[55]

The purpose of this facet of the OIG inspection was to determine whether the healthcare system maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the healthcare system met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the inpatient mental health unit where patients with active suicidal ideation or attempts are treated. Inspectors reviewed several aspects of the healthcare system's environment:

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

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

o Environmental cleanliness and infection prevention

o Privacy

o Privacy for women veterans

o Logistics

During its review of the environment of care, the OIG team inspected the Bob Michel VA Outpatient Clinic and the following patient care areas of the Danville VA Medical Center:

- Acute psychiatric unit

- Community living center (Abe Lincoln, Victory, Unity, and Stars and Stripes units)

- Dental clinic

- Medical/surgical/telemetry inpatient unit

- Outpatient clinics (Yellow and Urology clinics)

- Post-anesthesia care unit

- Urgent care

- Veterans villages (Honor and Valor units)

Environment of Care Findings and Recommendations

The inspection team observed compliance with the requirements listed above and did not note issues with the availability of medical equipment and supplies. The OIG made no recommendations.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[56] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[57] Long-term opioid use is of particular concern in the veteran population where there is a high incidence of posttraumatic stress disorder, major depressive disorder, alcohol use, substance abuse, and suicide attempts.[58] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[59]

VHA requires routine assessments of pain and the completion of an opioid risk assessment before initiating patients on long-term opioid therapy and recommends against the therapy for patients with untreated substance use disorders. VHA also recommends avoiding drugs capable of inducing fatal interactions, such as opioids with benzodiazepines.[60] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[61] To achieve VHA's vision of providing patient-driven healthcare, providers are also required to obtain informed consent from patients and to provide education about the risks, benefits, and alternatives prior to initiating long-term opioid therapy.[62] VHA recommends evaluating patients receiving continued opioid therapy for improvement of pain and opioid-related adverse events at least every three months and more frequently as doses increase.[63]

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

- Completion of initial screening for pain

- Assessment of aberrant behavior risk

- Avoidance of concurrent therapy with benzodiazepines

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

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

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

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

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

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

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

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

- Completion of urine drug testing with intervention, when indicated

- Documentation of informed consent

- Timely follow-up with patients included required elements

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures include, but are not limited to, adherence to published clinical practice guidelines, timeliness of treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment, patient satisfaction, and quality of life.[64] The OIG examined the following indicators for program oversight and evaluation:

- Performance of pain management committee activities

- Monitoring of quality measures

- Following the quality improvement process

The OIG interviewed key employees and managers and reviewed relevant documents and the electronic health records of 49 randomly selected outpatients who had newly-dispensed (no VA dispensing in previous six months) long-term opioids for pain, daily or intermittently for 90 or more calendar days through VA from July 1, 2018, through June 30, 2019. The team considered whether providers acted in accordance with guidelines for the provision of pain management and the healthcare system's oversight process for evaluating pain management outcomes and quality.

Medication Management Findings and Recommendations

The OIG found that the system complied with indicators of expected performance, including completion of pain screenings, timely follow-up with patients, and the use of a multidisciplinary pain management committee to oversee and monitor required quality measures. However, the OIG found deficiencies with aberrant behavior risk assessments, documented justification for concurrent therapy with benzodiazepines, urine drug testing, and informed consent.

VA/DoD clinical practice guidelines recommend completion of an aberrant behavior risk assessment that includes a history of substance abuse, psychological disease, and aberrant drug-related behaviors,[65] prior to initiating long-term opioid therapy.[66] The OIG estimated that

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

[65] Examples of aberrant drug related behaviors include "lost prescriptions, multiple requests for early refills, unauthorized dose escalation, apparent intoxication, and frequent accidents." *Pain Management, Opioid Safety, VA Educational Guide* (2014), July 2014. https://www.va.gov/PAINMANAGEMENT/docs/OSI_1_Tookit_Provider_AD_Educational_Guide_7_17.pdf. (The website was accessed on September 17, 2019.)

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

providers completed aberrant behavior risk assessments for 43 percent of the patients at the healthcare system, based on electronic health records reviewed.[67] This may have resulted in providers prescribing opioids for patients at high risk for misuse. The Chief of Ambulatory Care reported that long-term opioid therapy program oversight ceased due to other priorities. The Chief of Quality Management shared that staffing vacancies impeded administrative oversight.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that providers complete an aberrant behavior risk assessment on all patients prior to initiating long-term opioid therapy.

Healthcare system concurred.

Target date for completion: March 31, 2021

Healthcare system response: The Chief of Staff attests the reason for noncompliance was considered in developing the action plan. Thirty records will be reviewed monthly by the Chief of Pharmacy to ensure that providers complete an aberrant behavior risk assessment on patients prior to initiating long-term opioid therapy. If less than thirty records are available, a one hundred percent review will be completed. This recommendation will be considered compliant when review identifies a ninety percent or greater and two consecutive quarters of compliance in completion of an aberrant risk assessment prior to initiation of long-term opioid therapy (numerator) when compared to the patients initiated on long-term opioid therapy (denominator) during the review period. Compliance will be reported to the Clinical Executive Board which is chaired by the Chief of Staff.

VA/DoD clinical practice guidelines recommend avoiding coadministration of drugs, such as an opioid and benzodiazepine, that could induce fatal drug-drug interactions.[68] The OIG determined that providers concurrently prescribed opioids and benzodiazepines for 6 of 49 patients, based on electronic health records reviewed.[69] For two of the six records, there was no documented justification for concurrent use.[70] This may have resulted in an increased risk of harm to patients and potentially fatal drug interactions. The Chief of Ambulatory Care reported that the long-term opioid therapy program ceased due to other priorities. The Chief of Quality Management also shared that pharmacy staffing vacancies had impeded program oversight.

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[67] The OIG is 95 percent confident that the true compliance rate is somewhere between 29.2 and 57.1 percent, which is statistically significantly below the 90 percent benchmark.

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

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

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

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers document justification for prescribing opioids and benzodiazepines concurrently.

Healthcare system concurred.

Target date for completion: March 31, 2021

Healthcare system response: The Chief of Staff attests the reason for noncompliance was considered in developing the action plan. Thirty records will be reviewed monthly by the Chief of Pharmacy to ensure that providers document justification for prescribing opioids and benzodiazepines concurrently. If less than thirty records are available, a one hundred percent review will be completed. This recommendation will be considered compliant when ninety percent or greater of records reviewed identify compliance with documentation of justification for prescribing opioids and benzodiazepines concurrently (numerator) when compared to those records of concurrent opioids and benzodiazepines prescriptions (denominator) for six consecutive months. Compliance will be reported to the Clinical Executive Board which is chaired by the Chief of Staff.

VA/DoD clinical practice guidelines recommend that providers conduct "UDT [urine drug test] prior to initiating or continuing LOT [long-term opioid therapy] and periodically thereafter."[71] The OIG estimated that providers conducted initial urine drug testing in 76 percent of the patients, based on the electronic health records reviewed.[72] This resulted in providers' inability to identify patients who had substance use disorders, determine potential diversion, or ensure patients adhered to the prescribed medication regimen. Again, according to the Chief of Ambulatory Care, long-term opioid therapy program oversight ceased due to other priorities. Additionally, the Chief of Quality Management shared that staffing vacancies impeded administrative oversight.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers consistently conduct urine drug testing as required for patients on long-term opioid therapy.

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

[72] The OIG is 95 percent confident that the true compliance rate is somewhere between 62.5 and 87.0 percent, which is statistically significantly below the 90 percent benchmark.

Healthcare system concurred.

Target date for completion: March 31, 2021

Healthcare system response: The Chief of Staff attests the reason for noncompliance was considered in developing the action plan. Thirty records will be reviewed monthly by the Chief of Pharmacy to ensure that providers conduct urine drug testing on all patients prior to initiating long-term opioid therapy and periodically. If less than thirty records are available, a one hundred percent review will be completed. This recommendation will be considered compliant when ninety percent or greater of records reviewed identify compliance with urine drug testing as required for long term opioid therapy (numerator) when compared to records of those on long term opioid therapy (denominator) for six consecutive months. Compliance will be reported to the Clinical Executive Board in which the Chief of Staff is chair.

VHA requires providers to obtain and document informed consent prior to initiating long-term opioid therapy. VHA also recommends that informed consent conversations cover the risks and benefits of opioid therapy, as well as alternative therapies.[73] The OIG estimated that providers documented informed consent prior to initiating long-term opioid therapy in 71 percent of the patients at the healthcare system, based on electronic health records reviewed.[74] The remaining patients, therefore, may have received treatment without knowledge of the risks associated with long-term opioid therapy, including dependence, tolerance, addiction, and intentional or unintentional fatal overdose. The Chief of Ambulatory Care reported that long-term opioid therapy program oversight ceased due to competing priorities. Additionally, the Chief of Quality Management shared that staffing vacancies impeded administrative oversight.

Recommendation 6

6. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers obtain and document informed consent consistently for patients prior to initiating long-term opioid therapy.

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[73] VHA Directive 1005.

[74] The OIG is 95 percent confident that the true compliance rate is somewhere between 58.0 and 83.7 percent, which is statistically significantly below the 90 percent benchmark.

Healthcare system concurred.

Target date for completion: March 31, 2021

Healthcare system response: The Chief of Staff attests the reason for noncompliance was considered in developing the action plan. Thirty records will be reviewed monthly by the Chief of Pharmacy to ensure that providers obtain and document informed consent for patients prior to initiating long-term opioid therapy. If less than thirty records are available, a one hundred percent review will be completed. This recommendation will be considered compliant when ninety percent or greater of records reviewed include a documented informed consent prior to initiating long-term opioid therapy (numerator) when compared to records of patients on long-term opioid therapy(denominator) for six consecutive months. Compliance will be reported to the Clinical Executive Board in which the Chief of Staff is chair.

Mental Health: Suicide Prevention Program

In 2017, suicide was the 10th leading cause of death, with approximately 47,000 lives lost across the United States.[75] The suicide rate was 1.5 times greater for veterans than for non-veteran adults and estimated to represent approximately 22 percent of all suicide deaths in the United States.[76] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[77]

VHA has identified suicide prevention as a top priority and implemented various evidence-based approaches to reduce the veteran suicide rate. In addition to expanded mental health services and community outreach, VHA has developed comprehensive screening and assessment processes to identify at-risk patients.[78]

VHA requires that each medical center and very large CBOC have a full-time suicide prevention coordinator (SPC) to track and follow up with high-risk veterans, develop a process for responding to referrals from hotlines such as the Veteran Crisis Line, and conduct community outreach activities.[79] The OIG examined various requirements related to SPCs:

- Assignment of a full-time SPC

- Tracking and follow-up of high-risk veterans

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

  o Safety plan completion within the required time frame

  o Mental health teams' contacts with patients for missed appointments

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

- Completion of at least five outreach activities per month

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

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

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

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

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

VHA also requires that any patient determined to be at high risk for suicide be added to the facility high-risk list and have a High Risk for Suicide (HRS) Patient Record Flag (PRF) placed in his or her electronic health record "as soon as possible but no later than 1 business day after such determination by the SPC."[80] According to VHA, "Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death…The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions."[81] The HRS PRF is reviewed at least every 90 days and depending on changes to the suicide risk status, the HRS PRF will remain active or be removed.[82] Additionally, VHA requires designated high-risk patients to have a completed suicide safety plan and four face-to-face visits with an acceptable provider within the first 30 days of designation.[83]

The OIG noted that from July 1, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA required that "Any patient determined to be High Risk for Suicide [by the licensed independent provider] must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination."[84] However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management changed the requirement for the HRS PRF placement to be "as soon as possible but no later than 1 business day after determination by the SPC."[85] VHA further provided additional clarifying information:

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

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

- The SPC's determination process "may be beyond 24 hours after a referral, due to case consultation and review."[86]

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

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

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

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

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

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

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

The OIG is concerned that the updated requirement may result in delayed placement of HRS PRFs for at-risk patients. Without defined time frames for SPC determination that the HRS PRF is warranted, patients identified as at-risk for suicide could have flags placed in his or her chart several days after referral. For example, the current requirement would allow for a patient to be identified as high risk for suicide and referred to the SPC on Monday, the SPC to assess the patient for risk and determine the need for an HRS PRF on the following Friday, and the SPC to place an HRS PFR on the subsequent Monday (a week after referral).

On March 27, 2020, VHA also updated existing policy requirements to allow the review of HRS PRFs to "occur no earlier than 10 days before and no later than 10 days after the 90-day due date."[87]

Inspectors examined the completion of several requirements:

- Review of HRS PRFs within the required time frame

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

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

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

All VHA employees must complete suicide risk and intervention training within 90 days of entering their position. Clinical staff (including physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and Vet Center counselors) must complete Suicide Risk Management Training for Clinicians, and nonclinical staff must complete Operation S.A.V.E. training.[88] VHA also requires that all staff receive annual refresher training.[89] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[90]

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

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

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

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

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

- Relevant documents;

- The electronic health records of 47 outpatients whose electronic health records were flagged as high risk for suicide from July 1, 2018, to June 30, 2019; and

- Staff training records.

Mental Health Findings and Recommendations

The OIG found that the healthcare system complied with requirements associated with a designated suicide prevention coordinator, suicide safety plans, and community outreach activities.

However, the OIG found deficiencies. With VHA's original requirement that was in place when these patients received care—that "Any patient determined to be High Risk for Suicide must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"[91]—the OIG estimated that 47 percent of HRS PRFs were placed by the end of the next business day to the SPC.[92] But based on the current updated requirement that the SPC be responsible for determining placement of the HRS PRF (without a defined time frame for doing so), the OIG further calculated that the average time from referral to HRS PRF placement was 3 days (the observed range was 0–15 days).

Further, the OIG noted concerns with reviewing HRS PRFs within the required time frame. VHA required that all patients with an HRS PRF be reevaluated at least every 90 days and there is documented justification for continuing or discontinuing the flag.[93] The OIG estimated that 38 percent of patients with an HRS PRF were reevaluated at least every 90 days.[94] However, based upon the updated requirement that HRS PRFs be reviewed up to 10 days prior to or after the due date for reevaluation, the OIG found that one patient was not reviewed within the expected time frame (observed range was 50–97 days).

Additionally, the OIG noted concerns with the completion of four mental health visits within 30 days of HRS PRF placement and suicide prevention training.

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

[92] The OIG estimated that 95 percent of the time, the true compliance rate is between 32.6 and 60.9 percent, which is statistically significantly below the 90 percent benchmark.

[93] VHA Directive 2008-036; VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.

[94] The OIG estimated that 95 percent of the time, the true compliance rate is between 24.5 and 52.2 percent, which is statistically significantly below the 90 percent benchmark.

VHA requires veterans to have four follow-up visits with a qualified provider within 30 days of the HRS PRF placement. The follow-up visits should be face-to-face unless the veteran requests a telephonic visit, and there must be documentation identifying the patient's preference for a telephone call.[95] The OIG estimated that 74 percent of electronic health records reviewed did not have evidence of four face-to-face or telephonic follow-up visits with documented preference.[96] This resulted in insufficient follow-up on high-risk patients or fully documented patient preferences. The acting Suicide Prevention Coordinator stated that telephone visits were conducted with patients; however, due to geographic and economic limitations, as well as patient preferences, face-to-face encounters were a challenge to complete. The acting Suicide Prevention Coordinator, Chief of Mental Health, and Mental Health Case Manager were unaware of the requirement to document consent for a telephone encounter in lieu of a face-to-face visit.

Recommendation 7

7. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers conduct four follow-up visits, either face-to-face or telephonic with documented preference within the required time frame.

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

[96] The OIG estimated that 95 percent of the time, the true compliance rate is between 61.4 and 86.8 percent, which is statistically significantly below the 90 percent benchmark.

Healthcare system concurred.

Target date for completion: March 31, 2021

Healthcare system response: The Chief of Staff attests the reason for noncompliance was considered in developing the action plan.

Mental Health Service staff will conduct four follow-up visits either face-to-face or telephonic with documented preference within the required timeframe for Veterans with a High Risk for Suicide Patient Record Flag. Thirty records will be reviewed monthly by the Suicide Prevention Coordinator to ensure documentation of follow-up visits with documented preference for Veterans with a High Risk for Suicide Patient Record Flag. If less than thirty records are available, a one hundred percent review will be completed. This recommendation will be considered compliant when ninety percent or greater of records reviewed include documentation of follow-up visits within the required timeframe and preference for Veterans with a High Risk for Suicide Patient Record Flag (numerator) when compared to records of Veterans with a High Risk for Suicide Patient Record Flag (denominator) for six consecutive months. Compliance will be reported monthly to the Clinical Executive Board in which the Chief of Staff is chair.

VHA requires that all employees complete suicide risk and intervention training within 90 days of entering their position and annual refresher training thereafter.[97] The OIG found that of the 20 staff records reviewed, 4 staff did not complete the training within 90 days of entering their position, and 3 staff did not complete annual refresher training as required. Failure to complete annual refresher training may prevent employees from providing optimal treatment to veterans who are at risk for suicide. The Chief of Mental Health indicated that each service chief oversees staff completion of required suicide prevention training and this is not monitored by the SPC. The Chief of Quality Management acknowledged the requirement and shared that the SPC and Mental Health team would be working to develop and implement new monitoring processes.

Recommendation 8

8. The System Director evaluates and determines any additional reasons for noncompliance and makes certain staff complete suicide risk and intervention training within 90 days of entering their position and annual suicide prevention refresher training thereafter.

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[97] VHA Directive 1071.

Healthcare system concurred.

Target date for completion: December 1, 2020

Healthcare system response: The System Director attests the reason for noncompliance was considered in developing the action plan. Completion of the annual suicide refresher training by employees will be monitored by the Suicide Prevention Coordinator to determine compliance with employee completion of the suicide risk and intervention training within ninety days of entering their position and annual suicide prevention refresher training thereafter. This recommendation will be considered compliant when ninety percent or greater of employees reviewed have completed suicide risk intervention training within ninety days of entering their position and annually thereafter (numerator), compared to employees required to have completed suicide risk intervention training within ninety days of entering their position and annually thereafter (denominator) for six consecutive months. Compliance will be reported at a minimum of quarterly to the Clinical Executive Board which is chaired by the Chief of Staff.

Care Coordination: Life-Sustaining Treatment Decisions

Life-sustaining treatments (LSTs) are intended to extend the life of a patient expected to die soon without medical intervention. Life-sustaining treatments may include artificial nutrition, hydration, and mechanical ventilation. VHA issued the life-sustaining treatment decisions (LSTD) handbook to standardize practices related to discussing and documenting goals of care and LSTD. Per VHA, the goal is to encourage personalized, proactive, patient-driven treatment plans for veterans with serious illness by "…eliciting, documenting, and honoring patients' values, goals, and preferences."[98]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.[99] Implementation requirements included initiating conversations about the goals of care. A goals of care conversation is a discussion between a healthcare provider and a patient or surrogate to help define the patient's values, goals, and preferences for care and, based on the discussion, make choices about starting, limiting, or ceasing LSTs.[100] VHA requires practitioners to initiate goals of care conversations with high-risk patients—including hospice patients or their surrogates—within a time frame that meets the medical needs of the patient or at the time of a triggering event.[101]

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

- Decision-making capacity,

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

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

- Goals of care,

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

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

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

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

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

- Informed consent for the LST plan.

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

- Decision-making capacity,

- Goal(s) of care,

- Plan of care for the use of LST, and

- Informed consent for the LST plan.

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

The healthcare system was assessed for its adherence to requirements for goals of care conversations:

- Completion of LSTD notes

- Timely documentation of LSTD

- Inclusion of required elements in LSTD documentation

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

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[102] Inspectors examined if the healthcare system established an LSTD committee that was comprised of a multidisciplinary membership, which included representation from Ethics Consultation Service, and reviewed proposed LST plans.

To determine whether the healthcare system complied with the OIG-selected requirements related to LSTD for hospice patients, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 49 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

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[102] VHA Handbook 1004.03(1).

Care Coordination Findings and Recommendations

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

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[103] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans are anticipated to increase.[104] To help the VA better understand the needs of the growing women's veteran population, efforts have been made by VHA to identify and address the urgent needs "by examining health care use, preferences, and the barriers Women Veterans face in access to VA care."[105] Additionally, a VA report in 2016 on suicide among veterans pointed out concerning trends in suicide among women veterans and discussed "the importance of understanding suicide risk among women veterans and developing gender-tailored suicide prevention strategies."[106]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment. Facilities must, therefore, ensure availability of appropriate resources, services, and staffing ratios.[107] VHA also requires delivery of quality care to all women veterans accessing VA emergency services. In addition, VHA requires facilities to establish a multidisciplinary women veteran health committee "that develops and implements a Women's Health Program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans."[108]

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

- Provision of care requirements

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

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

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

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

[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).

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

- o Primary Care Mental Health Integration services available

- o Gynecologic care coverage available 24/7

- o Gynecology care accessible

- o Facility women health primary care providers designated

- o CBOC women's health primary care providers designated

- o Emergency contraception accessible

- Oversight of program and monitoring of performance improvement data

  - o Women Veterans Health Committee established

    - Quarterly meetings held

    - Core members attend

    - Quality assurance data collected and tracked

    - Reports made to clinical executive leaders

- Assignment of required staff

  - o Women Veterans Program Manager position filled

  - o Women's Health Medical Director or clinical champion on staff

  - o Maternity Care Coordinator position filled

  - o Women's health clinical liaison is assigned at each CBOC

Women's Health Findings and Recommendations

The system complied with requirements for most of the provision of care indicators and some of the selected staffing elements reviewed. VHA requires the facility to have a designated Maternity Care Coordinator.[109] Although the OIG found no evidence of a formal Maternity Care Coordinator, the system provided documentation that an employee monitored and coordinated the delivery of maternity care and tracked outcomes of services that had been furnished through purchased care.[110,111] The OIG made no recommendations.

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[109] VHA Directive 1330.01(2).

[110] VHA Handbook 1330.03, *Maternity Health Care and Coordination,* October 5, 2012.

[111] Purchased care is provided by non-VA clinicians. VHA Directive 1330.03 defines purchased care as services delivered by non-VA provider authorizations at VA expense, or by sharing agreements.

The OIG identified weaknesses with the CBOC-designated women's health primary care providers and the Women Veterans Health Committee.

VHA requires that each facility have designated women's health primary care providers (WH-PCPs).[112] The OIG found that the two CBOCs did not have designated WH-PCPs, and one CBOC lacked coverage for the sole designated WH-PCP. The lack of coverage could have negatively impacted patients' ability to receive services from primary care providers who are specifically trained and experienced in women's health. The Chief of Ambulatory Care reported that staffing shortages impacted the availability of WH-PCPs at the CBOCs but anticipated that a new women's health provider would be privileged within 30 days.

Recommendation 9

9. The System Director evaluates and determines any additional reasons for noncompliance and ensures that each community-based outpatient clinic has at least two designated women's health primary care providers or arrangements for leave coverage when there is only one designated provider.

Healthcare system concurred.

Target date for completion: December 1, 2020

Healthcare system response: The System Director attests the reason for noncompliance was considered in developing the action plan. Initial WH-PCP designation and annual continued education requirements are monitored monthly until compliant and tracked by the Women's Health Program Manager. Compliance will be measured by the number of WH-PCPs at each CBOC (numerator) as compared to the number WH-PCPs required for each CBOC (denominator). The recommendation will be considered compliant when each CBOC has 2 WH-PCPs. Compliance will be reported quarterly to the Clinical Executive Board in which the System Director is a member.

VHA requires that the Women Veterans Health Committee meets quarterly, reports to executive leaders, and has a core membership. The required members include a women veterans program manager; a women's health medical director; "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED, radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership."[113]

The OIG requested to review the Women Veterans Health Committee meeting minutes for FY 2019, quarters 3 and 4; however, the healthcare system staff only provided June 18, 2019

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[112] VHA Directive 1330.01(2).
[113] VHA Directive 1330.01(2).

meeting minutes for review. The OIG noted the committee did not meet quarterly or report to executive leaders and lacked core membership representation from all of the required members. The attendees included the Women Veterans Health program support assistant and the imaging service representative Furthermore, the committee charter dated March 10, 2014, did not include all core representatives. This resulted in a lack of expertise and oversight in the review and analysis of data as the committee plans and carries out improvements for quality and equitable care for women veterans.[114] The Chief of Ambulatory Care indicated difficulty with recruiting qualified candidates for the women veterans program manager position as the reason for noncompliance.

Recommendation 10

10. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that the Women Veterans Health Committee holds quarterly meetings with required representatives, and report to executive leaders.

Healthcare system concurred.

Target date for completion: October 30, 2020

Healthcare system response: The System Director attests the reason for noncompliance was considered in developing the action plan. All mandatory members of the Women Veterans Health Committee have been added to the Women Veterans Health Committee attendance sheets and attendance compliance will be monitored by the Women Veterans Health Coordinator. This recommendation will be considered compliant when ninety percent or above of the required members, or representatives are in attendance (numerator) when compared to required members at the Women Veterans Health Committee (denominator) for two consecutive quarters. Compliance will be reported quarterly by the Women's Health Coordinator to the Clinical Executive Board in which the System Director is a member.

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[114] VHA Directive 1330.01(2).

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have a Sterile Processing Services (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment…"[115] The goal of SPS is to "...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[116] To ensure this, VHA requires facilities to conduct the following activities:

- Maintain a current inventory list of all RME

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

- Use CensiTrac® Instrument Tracking System for tracking reprocessed instruments[117]

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

- Monitor data for reprocessing and storing RME

- Conduct annual airflow/ventilation system inspections[118]

VHA requires strict controls that closely monitor climate, storage, and sterilization parameters and additionally requires that quality assurance documentation of this monitoring be maintained for a minimum of three years.[119] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[120]

In addition, RME reprocessing areas must be clean, restricted, and airflow-controlled. All areas where RME reprocessing occurs must have safety data sheets, an unobstructed eyewash station,

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

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

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

[118] VHA Directive 1116(2).

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

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

personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[121]

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued annual and essential staff competency assessments, and monthly continuing education. This ensures that staff have the sufficient aptitude, knowledge, and skills to effectively and safely reprocess and sterilize RME.[122]

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

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

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[121] VHA Directive 1116(2).
[122] VHA Directive 1116(2).

- o Eating or drinking in the area prohibited

- o Equipment properly stored

- o Required temperature and humidity maintained

- Completion of staff training, competency, and continuing education

  - o Required training completed in a timely manner

  - o Competency assessments performed

  - o Monthly continuing education received

High-Risk Processes Findings and Recommendations

The OIG found there was general compliance with many of the performance indicators evaluated, including physical inspections of reprocessing areas and staff training. However, the OIG identified deficiencies with administrative processes.

VHA requires that facilities "must have standard operating procedures (SOPs) based on [the] manufacturer's guidelines that establish a documented and systematic approach to critical and semi-critical RME processes."[123] VHA also requires that "all SOPs are kept up-to-date, reviewed at least every 3 years and updated when there is a change in process or a change in manufacturer's IFU [instructions for use]."[124] The OIG found that the SOPs for the colonoscope, core drill,[125] and autoclavable camera head[126] did not align with the manufacturers' instructions for use. This resulted in the potential for inadequate disinfection and reprocessing of RME. The SPS Chief indicated that some steps in the instructions for use were redundant and omitted in the SOPs to simplify verbiage.

Recommendation 11

11. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that standard operating procedures align with current manufacturers' guidelines and instructions for use.

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[123] VHA Directive 1116(2).

[124] VHA Directive 1116(2).

[125] A core drill is a "powered instrument used to cut, shape, fixate, and dissect bone as well as to fragment, emulsify and aspirate soft tissue in all types of procedures."

[126] The autoclavable camera head "provides high-resolution images for incredibly sharp, accurate imaging. The camera is tightly sealed, preventing lens fogging even after autoclave steam sterilization reprocessing."

Healthcare system concurred.

Target date for completion: September 30, 2020

Healthcare system response: The Associate Director for Patient Care Services attests the reason for noncompliance was considered in developing the action plan. Standing Operating Procedures are monitored and tracked to ensure they are reviewed and updated to match the "Instructions for Use" prior to their expiration date. This recommendation will be considered compliant when ninety percent or above of the Standard Operating Procedures match the manufactures "Instructions for Use" (numerator) when compared to manufactures "Instructions for Use" (denominator). Compliance will be monitored monthly and will be reported to Reusable Medical Equipment Committee which the Associate Director for Patient Care Services is a member of.

VHA requires the SPS Chief to perform an annual risk analysis and report the results to the VISN SPS Management Board.[127] The OIG found that the FY 2019 annual risk analysis was completed but not reported to the VISN SPS Management Board. This may potentially delay or prevent the identification and mitigation of problems or process failures. The SPS Chief expressed unawareness of the VISN SPS Management Board reporting requirement.

Recommendation 12

12. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that the Sterile Processing Services Chief reports the annual risk analysis to the Veterans Integrated Service Network Sterile Processing Services Management Board.

Healthcare system concurred.

Target date for completion: September 30, 2020

Healthcare system response: The Associate Director for Patient Care Services attests the reason for noncompliance was considered in developing the action plan. The Associate Director for Nursing and Patient Care Services ensured that the Chief of Sterile Processing Services sent the annual sterile processing risk analysis to Veterans Integrated Service Network 12 for reporting purposes at the Veterans Integrated Service Network 12 Sterile Processing Services Management Board. The risk analysis dated February 26, 2020, was forwarded to Veterans Integrated Service Network 12 on February 29, 2020. Compliance was reported to Quality Executive Board where the Associate Director for Patient Care Services is a member.

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[127] VHA Directive 1116(2).

VHA requires that competencies for RME staff are completed prior to performing reprocessing duties.[128] The OIG found that eight selected SPS staff had a competency assessment for colonoscope, core drill, and autoclavable camera head SOPs that did not align with manufacturer's instructions for use; therefore, the competencies were invalid. This could result in improper cleaning of the RME and compromise patient safety. The Chief of SPS indicated that some steps in the instructions for use were redundant and omitted in the SOPs to simplify verbiage.

Recommendation 13

13. The Associate Director for Patient Care Services evaluates and determines additional reasons for noncompliance and ensures that Sterile Processing Services staff receive properly completed competency assessments for reprocessing reusable medical equipment.

Healthcare system concurred.

Target date for completion: September 30, 2020

Healthcare system response: The Associate Director for Patient Care Services attests the reason for noncompliance was considered in developing the action plan. The Associate Director for Nursing and Patient Care Services ensured that the Chief of Sterile Processing Services reviewed the Sterile Processing Service staff employee competency assessment in question. Current Standard Operating Procedure training was performed, and on May 26, 2020, the competency assessment was reviewed and signed by the Sterile Processing staff member and their Supervisor. The recommendation will be compliant when one hundred percent of the SPS staff complete the required competencies as compared to the valid competencies (denominator). Compliance will be reported to Reusable Medical Equipment Committee which the Associate Director for Patient Care Services is a member of.

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[128] VHA Directive 1116(2).

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• None	• None
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• Professional practice evaluation criteria are service-specific and evaluations are completed by providers with similar training and privileges.	• Provider exit review forms are completed within seven calendar days of licensed health care professionals departing the system.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Medical center
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Accommodation and privacy for women veterans
	  ○ Logistics
	• Inpatient mental health unit
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Accommodation for women veterans
	  ○ Logistics
	• Community-based outpatient clinic
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Privacy for women veterans
	  ○ Logistics
		• None	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• Providers complete an aberrant behavior risk assessment on all patients prior to initiating long-term opioid therapy. • Providers document justification for prescribing opioids and benzodiazepines concurrently. • Providers conduct urine drug testing as required for patients on long-term opioid therapy. • Providers obtain and document informed consent consistently for patients when initiating long-term opioid therapy.	• None
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements	• Mental health providers conduct four follow-up appointments, either face-to-face or telephonic with documented consent, within the required time frame.	• All staff complete suicide risk and intervention training within 90 days of entering their position annual suicide prevention refresher training thereafter.
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• None	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• CBOCs have at least two designated women's health primary care providers and arrangements for leave coverage if CBOC only has one designated provider.	• The Women Veterans Health Committee holds quarterly meetings with required representatives and reports to executive leaders.
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Data monitoring • Physical inspection • Staff training	• SOPs align with manufacturers' guidelines and IFUs. • SPS staff receive properly completed competency assessments for processing reusable medical equipment	• The SPS Chief reports the annual risk analysis to the VISN SPS Management Board.

Appendix B: Healthcare System Profile

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

**Table B.1. Profile for VA Illiana Health Care System (550)
(October 1, 2016, through September 30, 2019)**

Profile Element	Healthcare System Data FY 2017[2]	Healthcare System Data FY 2018[3]	Healthcare System Data FY 2019[4]
Total medical care budget	$238,042,468	$236,946,625	$237,655,437
Number of:			
• Unique patients	33,502	31,254	30,375
• Outpatient visits	369,826	331,119	328,101
• Unique employees[5]	1,166	1,170	1,150
Type and number of operating beds:			
• Community living center	217	217	217
• Domiciliary	35	35	35
• Medicine	20	20	14
• Mental health	22	22	22
• Residential rehabilitation	6	6	6
Average daily census:			
• Community living center	86	90	83
• Domiciliary	28	29	26
• Medicine	9	7	5
• Mental health	15	13	12
• Residential rehabilitation	3	2	3

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

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[1] The VHA medical centers are classified according to a facility complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs."

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

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

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

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

Appendix C: VA Outpatient Clinic Profiles[1]

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Peoria, IL	550BY	18,775	11,951	Anesthesia Cardiology Dermatology Endocrinology Eye Gastroenterology General surgery Hematology/Oncology Infectious disease Nephrology Orthopedics Podiatry	Laboratory & Pathology Nuclear med Radiology	Nutrition Pharmacy Social work Weight management

[1] Includes all outpatient clinics in the community that were in operation as of August 27, 2019.

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

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

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

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

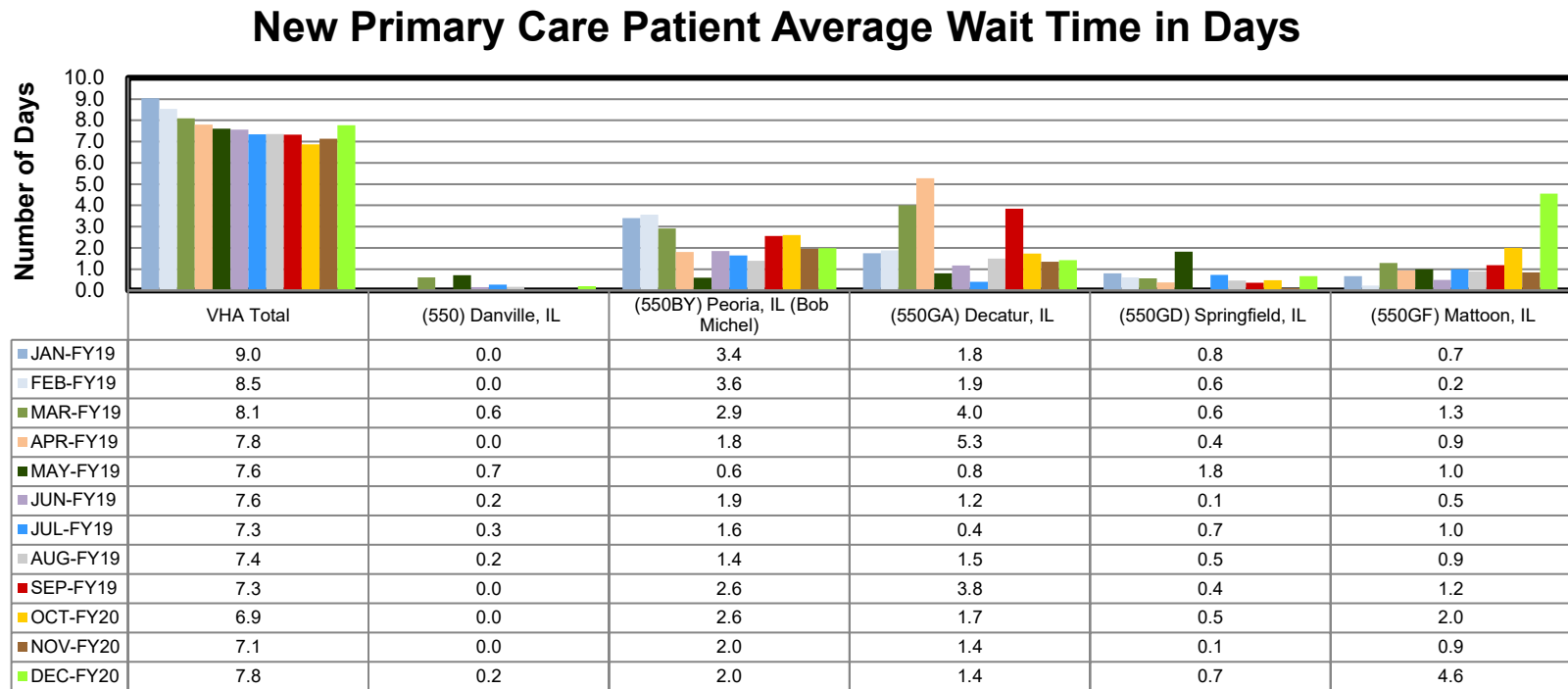| Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
				Poly-trauma Pulmonary/ Respiratory disease Rehab physician Spinal cord injury Urology Vascular		
Decatur, IL	550GA	8,742	2,483	Anesthesia Cardiology Dermatology Endocrinology Hematology/ Eye General surgery Infectious disease Oncology Orthopedics Nephrology Podiatry Urology Vascular	n/a	Nutrition Pharmacy Social work Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Springfield, IL	550GD	11,343	5,534	Anesthesia Cardiology Dermatology Endocrinology Gastroenterology Hematology/Oncology Infectious disease Nephrology General surgery Orthopedics Podiatry Urology Vascular	n/a	Nutrition Pharmacy Social work Weight management
Mattoon, IL	550GF	4,340	2,045	Anesthesia Cardiology Dermatology Endocrinology General surgery Hematology/Oncology Infectious disease Nephrology Orthopedics Podiatry Urology Vascular	n/a	Nutrition Pharmacy Social work Weight management

Source: VHA Support Service Center and VA Corporate Data Warehouse

Note: The OIG did not assess VA's data for accuracy or completeness. n/a = not applicable

Appendix D: Patient Aligned Care Team Compass Metrics[1]

New Primary Care Patient Average Wait Time in Days

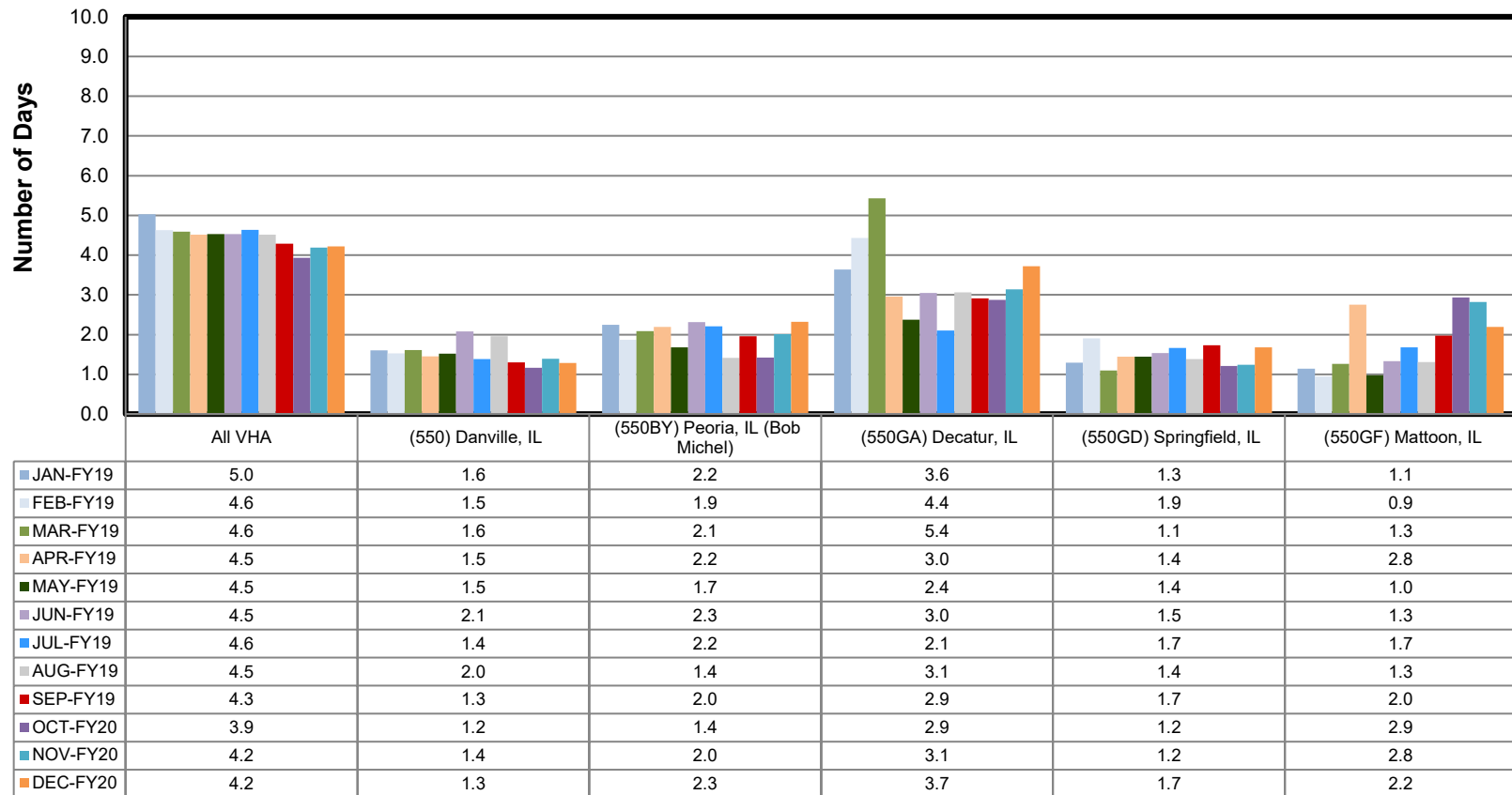|	VHA Total	(550) Danville, IL	(550BY) Peoria, IL (Bob Michel)	(550GA) Decatur, IL	(550GD) Springfield, IL	(550GF) Mattoon, IL
JAN-FY19	9.0	0.0	3.4	1.8	0.8	0.7
FEB-FY19	8.5	0.0	3.6	1.9	0.6	0.2
MAR-FY19	8.1	0.6	2.9	4.0	0.6	1.3
APR-FY19	7.8	0.0	1.8	5.3	0.4	0.9
MAY-FY19	7.6	0.7	0.6	0.8	1.8	1.0
JUN-FY19	7.6	0.2	1.9	1.2	0.1	0.5
JUL-FY19	7.3	0.3	1.6	0.4	0.7	1.0
AUG-FY19	7.4	0.2	1.4	1.5	0.5	0.9
SEP-FY19	7.3	0.0	2.6	3.8	0.4	1.2
OCT-FY20	6.9	0.0	2.6	1.7	0.5	2.0
NOV-FY20	7.1	0.0	2.0	1.4	0.1	0.9
DEC-FY20	7.8	0.2	2.0	1.4	0.7	4.6

Source: VHA Support Service Center

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

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. The absence of reported data is indicated by "n/a."

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

Established Primary Care Patient Average Wait Time in Days

	All VHA	(550) Danville, IL	(550BY) Peoria, IL (Bob Michel)	(550GA) Decatur, IL	(550GD) Springfield, IL	(550GF) Mattoon, IL
JAN-FY19	5.0	1.6	2.2	3.6	1.3	1.1
FEB-FY19	4.6	1.5	1.9	4.4	1.9	0.9
MAR-FY19	4.6	1.6	2.1	5.4	1.1	1.3
APR-FY19	4.5	1.5	2.2	3.0	1.4	2.8
MAY-FY19	4.5	1.5	1.7	2.4	1.4	1.0
JUN-FY19	4.5	2.1	2.3	3.0	1.5	1.3
JUL-FY19	4.6	1.4	2.2	2.1	1.7	1.7
AUG-FY19	4.5	2.0	1.4	3.1	1.4	1.3
SEP-FY19	4.3	1.3	2.0	2.9	1.7	2.0
OCT-FY20	3.9	1.2	1.4	2.9	1.2	2.9
NOV-FY20	4.2	1.4	2.0	3.1	1.2	2.8
DEC-FY20	4.2	1.3	2.3	3.7	1.7	2.2

Source: VHA Support Service Center

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

Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL)), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

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

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

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

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

Source: VHA Support Service Center

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

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

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

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 24, 2020

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

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

To: Director, Office of Healthcare Inspections (54CH02)
Director, GAO/OIG Accountability Liaison (VHA 10EG GOAL Action)

1. I have reviewed the Comprehensive Healthcare Inspection of the VA Illiana Health Care System, Danville, IL draft report.

2. I concur with the findings and recommendations proposed.

3. I concur with the submitted action plans from the facility.

4. I would like to thank the OIG Inspection team for a thorough review of the VA Illiana Health Care System, Danville, IL.

(Original signed by:)

Victoria P. Brahm, MSN, RN, VHA-CM
Director, VA Great Lakes Health Care System (10N12)

Appendix H: Health Care System Director Comments

Department of Veterans Affairs Memorandum

Date: June 18, 2020

From: Director, VA Illiana Health Care System (550/00)

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

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

Thank you for the opportunity to review the draft of the Inspector General report from the VA Illiana Health Care System CHIP Review. I have reviewed each recommendation and concur with the findings, recommendations and submitted action plans.

(Original signed by:)

Shawn P. Bransky
Director, VAIHCS (550)

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Rose Griggs, MSW, LCSW, Team Leader Jeffery Benoit, MSN, AGNP Barbara Miller, BSN, RN Renay Montalbano, MSN, RN Jennifer Reed, MSHI, RN
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Alicia Castillo-Flores, MBA, MPH Limin Clegg, PhD Sheila Cooley, MSN, GNP Jennifer Frisch, MSN, RN Justin Hanlon, BS LaFonda Henry, MSN, RN-BC Erin Johnson, BA Susan Lott, MSA, RN Scott McGrath, BS Larry Ross, Jr., MS Krista Stephenson, MSN, RN Robyn Stober, JD, MBA Marilyn Stones, BS Caitlin Sweany-Mendez, MPH, BS Robert Wallace, ScD, MPH

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    Adam Kinzinger, Darrin LaHood, Bobby L. Rush, John M. Shimkus
  Indiana – Jim Baird, Larry Bucshon, Pete Visclosky, Jackie Walorski

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