DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

CHIP REPORT | REPORT #20-00069-222 | AUGUST 25, 2020

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Figure 1. *Edward Hines, Jr. VA Hospital in Hines, 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 Edward Hines, Jr. VA Hospital 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 27, 2020, at the Edward Hines, Jr. VA Hospital and Aurora VA Clinic. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this medical center's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this medical center and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

Leadership and Organizational Risks

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

When the team conducted this inspection, the permanently assigned executive team members had been working as a group for five months. The director position had been vacant for five months, and the Associate Director had served as acting Director since October 2019. The Chief of Staff was the most tenured member and had been in the position for over three years. The ADPCS and Assistant Director were permanently assigned in April and August 2019, respectively.

The OIG noted that specific survey results related to employees' satisfaction with the medical center executive leaders were generally similar to or higher than the VHA averages. Selected patient experience survey scores for medical center leaders generally reflected similar or higher care ratings than the VHA average; however, in some instances, female veterans reported less positive specialty care experiences than female patients nationally.

The inspection team also reviewed accreditation agency findings and sentinel events and did not identify any substantial organizational risk factors.[1] However, the OIG noted an opportunity for improvement with disclosures of adverse events. The OIG team also considered the vacant director position a vulnerability for the medical center.

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]

[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*, http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=9428. (The website was accessed on March 6, 2020, but is not accessible by the public.)

The executive leaders seemed generally knowledgeable within their scopes of responsibility about VHA data and/or medical center-level factors contributing to specific poorly performing SAIL measures; however, only the ADPCS could consistently express full understanding of Community Living Center (CLC) SAIL measures, despite the medical center's generally positive results.[3] In individual interviews, the executive leadership team members were somewhat able to discuss 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 six clinical areas reviewed and issued 23 recommendations that are directed to the Director, Chief of Staff, ADPCS, and Associate Director. These are briefly described below.

Quality, Safety, and Value

The medical center complied with requirements for establishment of a committee responsible for quality, safety, and value (QSV) oversight functions and the committee's review of aggregated data as well as most patient safety elements reviewed. However, the OIG expressed concerns with the QSV committee's monitoring and implementation of improvement actions, peer review of all applicable deaths within 24 hours of admission, the Medical Executive Board's quarterly review of the Peer Review Committee's summary analysis, and interdisciplinary review of utilization management data.

Medical Staff Privileging

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

Environment of Care

The medical center largely met general safety, privacy, and selected mental health requirements reviewed. However, the OIG identified opportunities within the medical center to remove expired supplies and improve environmental cleanliness in clinical areas. During a subsequent

[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."

review of *VHA's COVID-19 Screening Processes and Pandemic Readiness*, medical center leaders reported a need for additional surgical masks and face shields.[5]

Medication Management

The medical center complied with many elements of expected performance, including documented justification for concurrent therapy with benzodiazepines and establishment of a multidisciplinary pain management committee. However, the OIG found deficiencies with pain screenings, aberrant behavior risk assessments, urine drug testing, informed consent, and patient follow-up after therapy initiation.

Mental Health

The medical center complied with requirements associated with a designated suicide prevention coordinator, completion of mental health appointments, suicide safety plans, and patient follow-up for missed appointments. However, the OIG noted a concern with suicide prevention refresher training.

High-Risk Processes

The medical center met many of the requirements for the proper operations and management of reprocessing reusable medical equipment; however, the OIG identified noncompliance with quality assurance monitoring; reprocessing and storage area physical inspections; and staff training, competency and ongoing education.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued 23 recommendations for improvement to the Medical Center Director, Chief of Staff, ADPCS, and Associate Director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this medical center. The intent is for medical center leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 81–82, and the responses within the body of the report for the full

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

text of the directors' comments.) The OIG has received evidence of compliance and considers recommendations 19 and 21 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to 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 Edward Hines, Jr. VA Hospital (medical center) examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so that informed decisions can be made to improve care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[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]

[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.

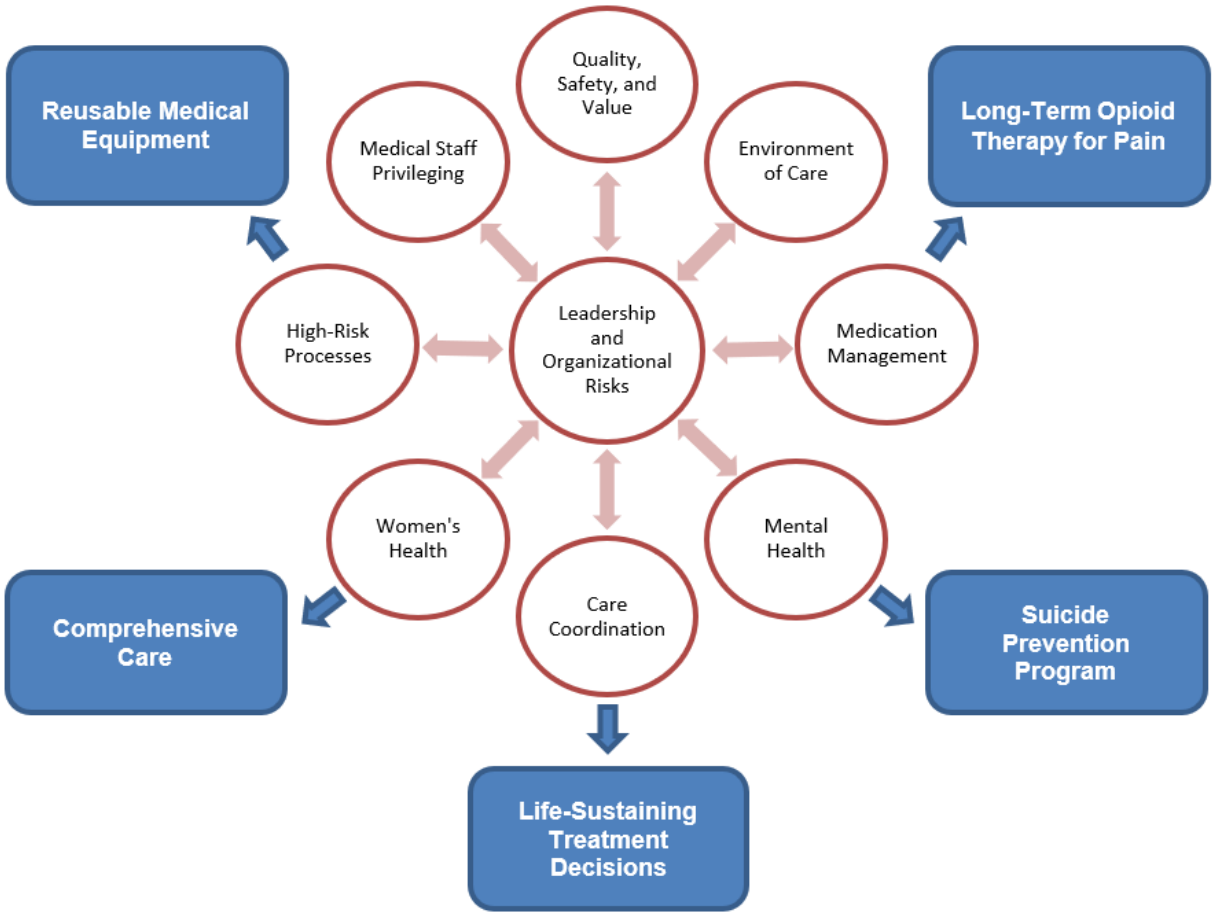

Figure 2. *Fiscal Year (FY) 2020 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

Methodology

The Edward Hines, Jr. VA Hospital includes multiple outpatient clinics in Illinois. Additional details about the types of care provided by the medical center can be found in Appendixes B and C.

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

The OIG team also selected and physically inspected the Aurora VA Clinic and the following areas of the medical center:

- Acute mental health unit
- Community living center (CLC)[5]
- Dental clinic
- Emergency Department
- Intensive care units
- Medical/surgical inpatient units
- Outpatient clinic
- Post-anesthesia care unit
- Sterile processing services areas
- Women's health clinic

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

The inspection examined operations from November 10, 2018, through January 31, 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.

[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.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leadership, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

Results and Recommendations

Leadership and Organizational Risks

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

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation surveys and oversight inspections
5. Identified factors related to possible lapses in care and medical center response
6. VHA performance data (medical center)
7. VHA performance data (CLC)

Executive Leadership Position Stability and Engagement

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

[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.)

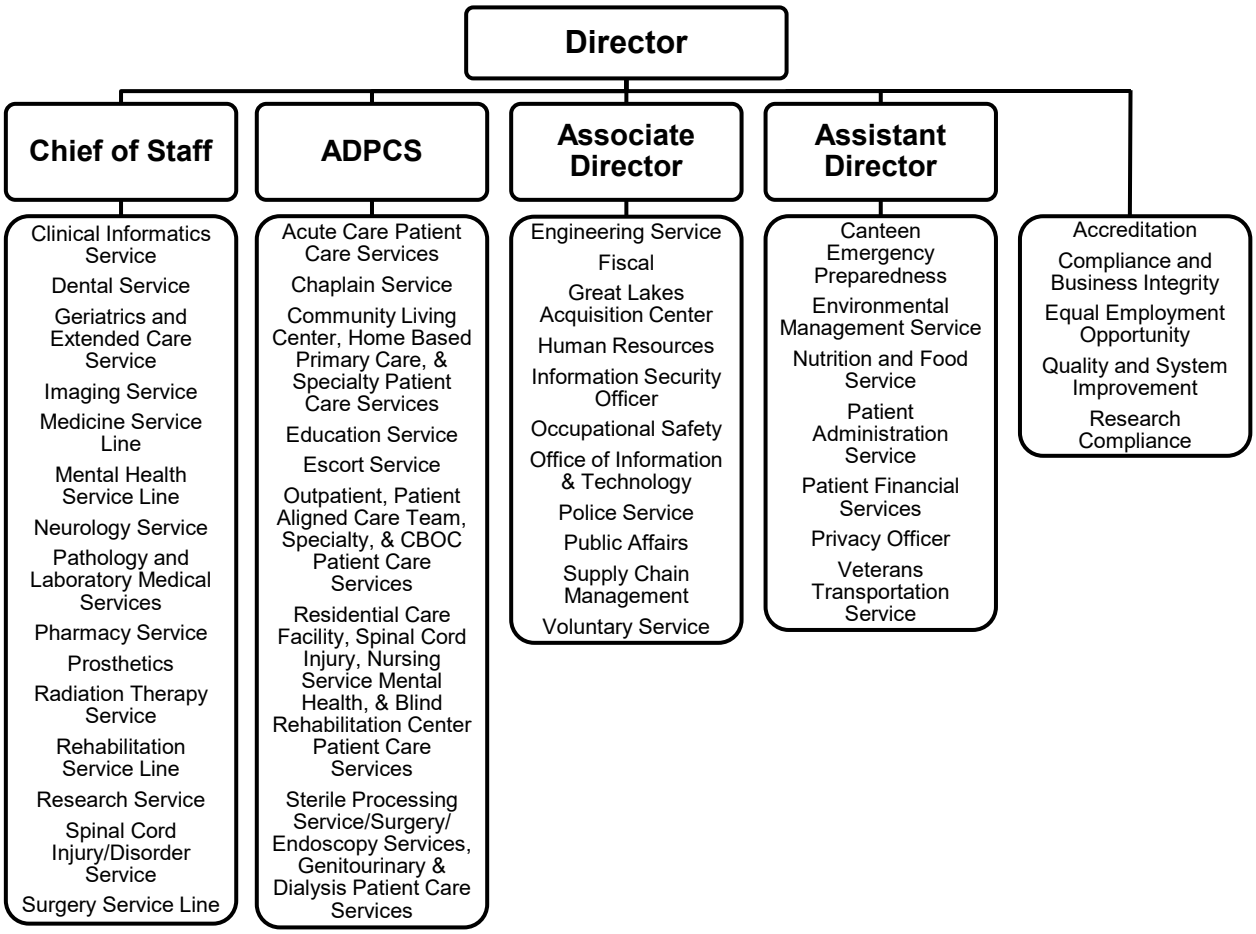

Figure 3. *Medical Center Organizational Chart*
Source: Edward Hines, Jr. VA Hospital (received January 27, 2020)

At the time of the OIG site visit, the permanently assigned executive team members had been working together as a group for five months. The medical center director position had been vacant for five months, and the Associate Director—in the position for one year—had served as acting Director since October 2019. Two VISN staff (from VISNs 6 and 12) served in the acting Associate Director role during that time. The Chief of Staff was the most tenured leader and had been in the position for over three years. The ADPCS and Assistant Director were permanently assigned in April and August 2019, respectively (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	October 20, 2019 (acting)
Chief of Staff	October 16, 2016
Associate Director for Patient Care Services	April 29, 2019
Associate Director	January 5, 2020 (acting)
Assistant Director	August 18, 2019

Source: Edward Hines, Jr. VA Hospital Supervisory Human Resources Specialist (received January 28, 2020)

To help assess the medical center executive leaders' engagement, the OIG interviewed the acting Director, Chief of Staff, ADPCS, acting Associate Director, and Assistant 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 scopes of responsibility about VHA data and/or system-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. However, except for the ADPCS, leaders did not consistently express full understanding of CLC SAIL measures, despite the positive results for the medical center. In individual interviews, the executive leadership members were somewhat knowledgeable about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and/or patient experiences. These are discussed in greater detail below.

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

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

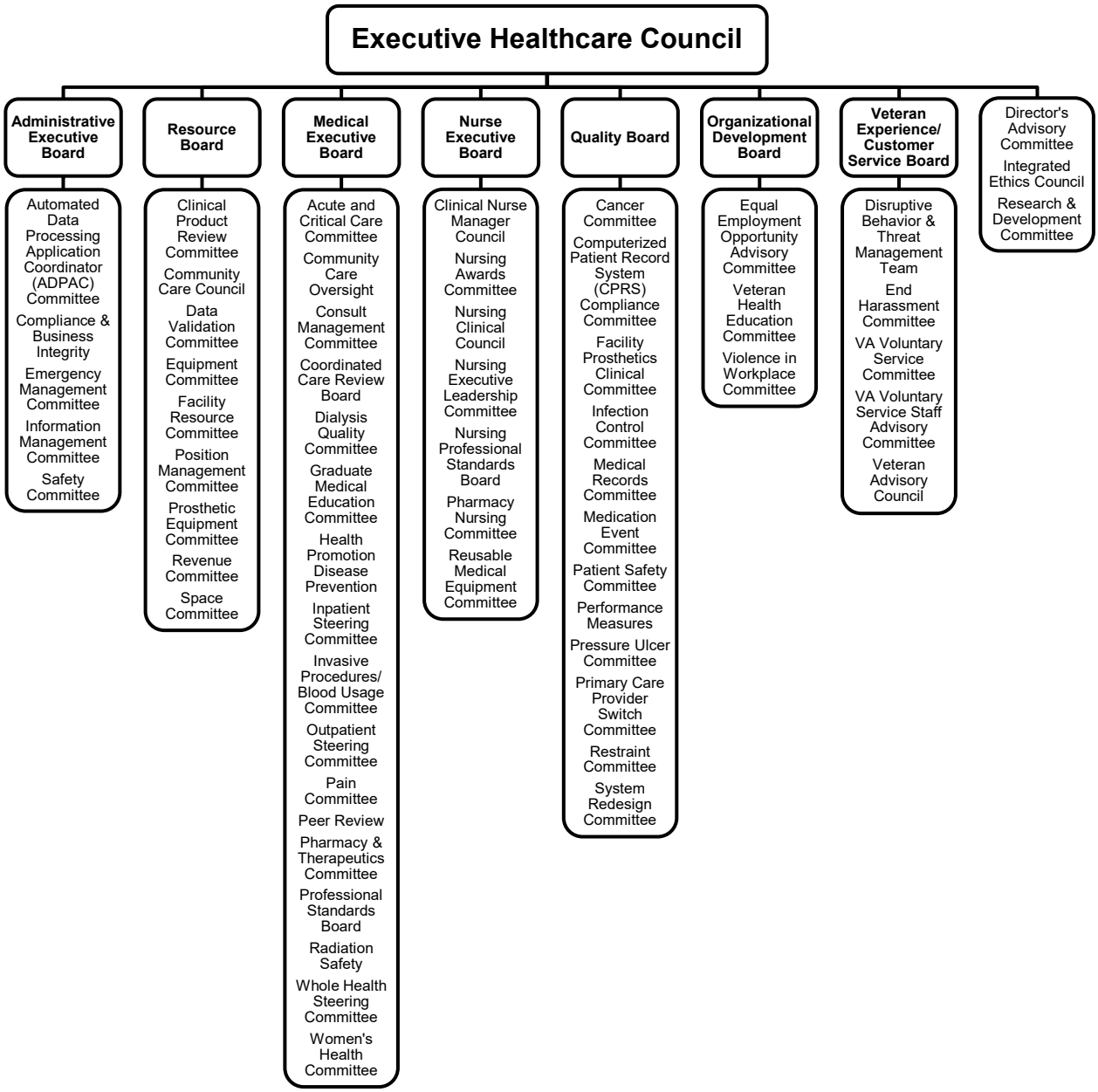

Figure 4. *Medical Center Committee Reporting Structure*
Source: Edward Hines, Jr. VA Hospital (received January 27, 2020)

Employee Satisfaction

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

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2018, through September 30, 2019.[8] Table 2 provides relevant survey results for VHA, the medical center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. Results for the medical center were similar to the VHA average.[9] Scores for the medical center executive leaders were generally similar to or higher than VHA averages.[10]

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite*[11]	0–100 where higher scores are more favorable	72.6	72.0	77.1	76.7	72.9	83.2	70.0
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	3.4	4.2	3.0	3.0	4.2	3.4

[8] Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director. It is important to note that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current Assistant 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] It is important to note AES survey scores are not reflective of current acting Director, acting Associate director, Assistant Director who was assigned in August 2019, and may not be fully reflective of the current ADPCS who was assigned in April 2019.

[11] According to the 2019 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." http://aes.vssc.med.va.gov/Documents/SL_Index_FieldGuide.pdf (The website was accessed on March 18, 2020, but is not accessible by the public.)

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.5	4.1	3.4	3.5	4.5	3.9
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.6	4.1	3.3	4.0	4.3	4.1

Source: VA All Employee Survey (accessed on December 19, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[12] Note that the medical center and executive leaders averages for the selected survey questions were generally similar to or better than VHA averages.[13]

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.8	4.3	4.3	3.6	4.8	3.5

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

[13] It is important to note AES survey scores are not reflective of the current acting Director, acting Associate Director, or Assistant Director who was assigned in August 2019, and may not be fully reflective of the current ADPCS who was assigned in April 2019.

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination)*.	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.6	3.8	3.6	3.6	4.1	4.6
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	1.0	1.3	2.0	1.4	1.8

Source: VA All Employee Survey (accessed on December 19, 2019)

Patient Experience

To assess patient experiences with the medical center, which directly reflect on its leaders, the OIG team reviewed patient experience survey results that relate to the period of October 1, 2018, through September 30, 2019. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for VHA and the medical center.[14]

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 medical

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

center, the patient survey results were generally similar to or higher than the VHA average. Patients appeared satisfied with the care provided.

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

Questions	Scoring	VHA Average	Hines Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.3	67.2
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	85.7
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	85.4
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	82.6

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed on December 23, 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.[15] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

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

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

survey results were generally similar to or better than corresponding VHA averages. The same trend was noted for the outpatient Patient-Centered Medical Home Survey. However, for the outpatient Specialty Care Survey, female respondents consistently reported less positive experiences than female patients nationally, indicating opportunities to improve patient satisfaction.

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

Questions	Scoring	VHA[16]		Medical Center[17]	
		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).	84.5	82.8	85.4	79.1
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).	84.8	83.1	83.0	100.0
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).	68.7	61.8	67.2	67.0

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed on December 19, 2019)

[16] The VHA averages are based on 48,259–48,798 male and 2,342–2,359 female respondents, depending on the question.

[17] The medical center averages are based on 448–454 male and 17 female respondents, depending on the question.

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

Questions	Scoring	VHA[18]		Medical Center[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).	51.2	43.3	55.5	39.5
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	63.5	46.9
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.6	65.7	80.8	76.8

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed on December 19, 2019)

[18] The VHA averages are based on 79,450–241,828 male and 5,762–13,041 female respondents, depending on the question.

[19] The medical center averages are based on 579–2,144 male and 25–64 female respondents, depending on the question.

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

Questions	Scoring	VHA[20]		Medical Center[21]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.5	44.7	43.7	33.7
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	55.0	54.6	45.1
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	70.1	71.1	56.5

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed on December 19, 2019)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[22] Table 8 summarizes the relevant medical center inspections most recently performed by the OIG. Of note, at the time of the OIG visit, the medical center had closed all but three recommendations for improvement issued during the previous comprehensive healthcare inspection conducted in November 2018. The acting Quality Manager reported continuing to work with medical center

[20] The VHA averages are based on 65,968–208,722 male and 3,460–11,072 female respondents, depending on the question.

[21] The medical center averages are based on 762–2,455 male and 21–67 female respondents, depending on the question.

[22] 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.

managers to address the open recommendations from the previous comprehensive healthcare inspection.[23]

At the time of the site visit, the OIG team also noted the medical center's recent results from the Long Term Care Institute's inspection of the medical center's CLC[24] and the Paralyzed Veterans of America's inspection of the medical center's spinal cord injury/disease unit and related services.[25]

Table 8. Office of Inspector General Inspections

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the Edward Hines, Jr. VA Hospital, IL*, Report No. 18-04676-142, June 18, 2019)	November 2018	10	3[26]
OIG (*Alleged Delay in Surgical Care, Lack of Resident Oversight, and Improper Physician Pay, Edward Hines, Jr. VA Hospital, IL*, Report No. 19-00004-187, August 8, 2019)	November 2018	2	0

Source: OIG (inspection/survey results verified with the acting Quality Manager on January 28, 2020)

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

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a medical center, 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. VHA believes that there is an unwavering ethical obligation to disclose to patients harmful adverse events that have been sustained while receiving VA care, including cases where the harm may not be obvious or where there is a

[23] OIG: *Comprehensive Healthcare Inspection Program Review of the Edward Hines, Jr. VA Hospital, IL*, Report No. 18-04676-142, June 18, 2019.

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

[25] The Paralyzed Veterans of America inspection took place April 3–5, 2019. This veterans service organization review does not result in accreditation status.

[26] The OIG closed the open recommendations on July 17, 2020.

potential for harm to occur in the future.[27] During the onsite inspection, medical center staff reported three sentinel events for which the OIG did not find evidence of institutional disclosures. The Chief of Staff reported the nondisclosure of the events as a leadership decision. Therefore, an opportunity exists to improve the institutional disclosures process. The OIG also identified the lack of a permanent director as an area of vulnerability for the medical center.[28]

Table 9 lists the reported patient safety events from November 10, 2018 (the prior OIG comprehensive healthcare inspection), through January 28, 2020.[29]

Table 9. Summary of Selected Organizational Risk Factors (November 10, 2018, through January 28, 2020)

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

Source: Edward Hines, Jr. VA Hospital's Quality Management Supervisor (received January 28, 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

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

[28] On March 16, 2020, the VISN 12 Network Director announced the selection of a new Medical Center Director effective March 29, 2020.

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

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

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

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

limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[33]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2019. Of note, Figure 5 uses blue and green data points to indicate high performance for the medical center (for example, in the areas of rating (of) primary care (PC) provider, patient-centered medical home (PCMH) care coordination, mental health (MH) continuity (of) care, and registered nurse (RN) turnover). Metrics that need improvement are denoted in orange and red (for example, rating (of) hospital, complications, and health care (HC) associated (Assoc) infections).[34]

[33] 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.)

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

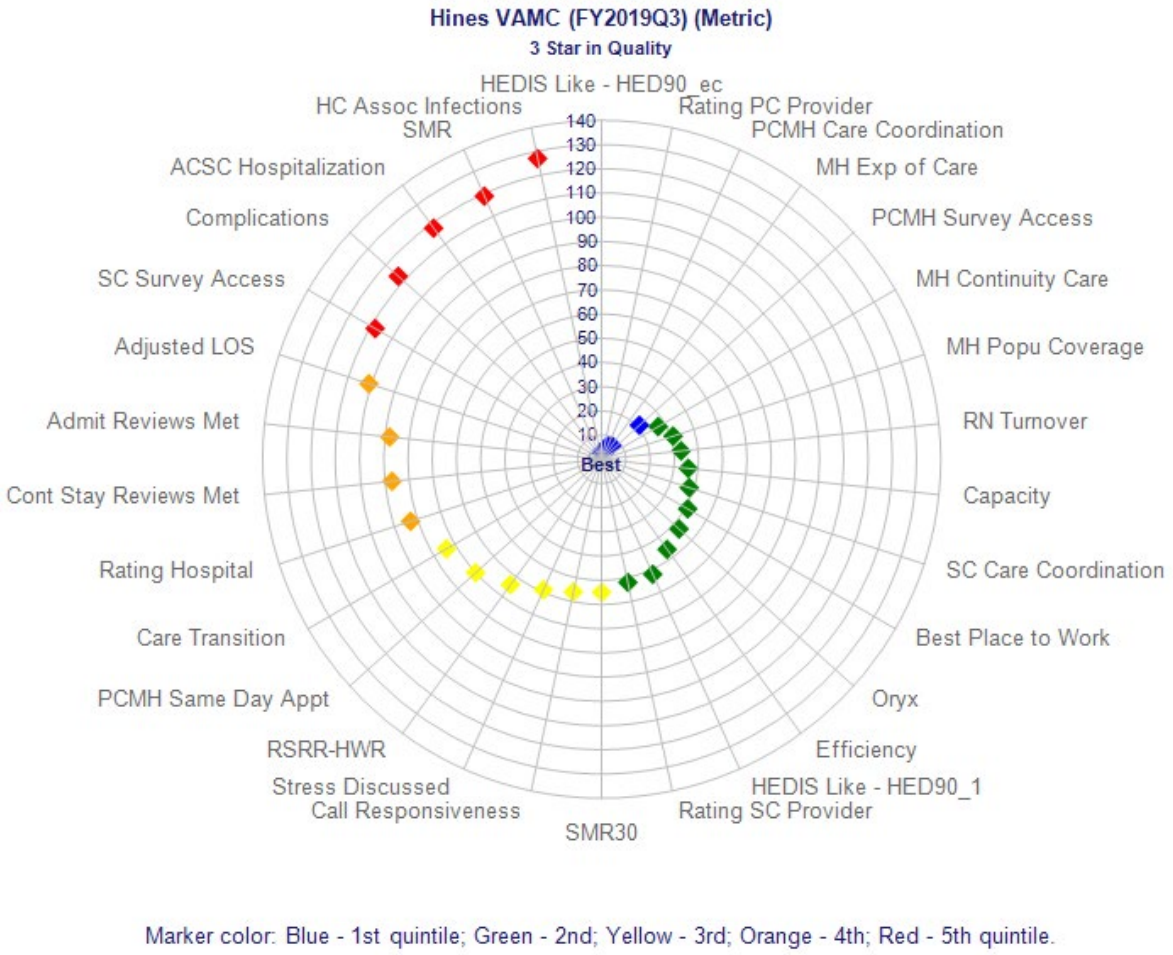

Figure 5. *Medical Center Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

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.[35]

Figure 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2019. Figure 6 uses blue and green data points to indicate high performance for the CLC (for example, in the areas of ability to move independently worsened–long-stay (LS), help with activities of daily living (ADL)–LS, catheter in bladder (LS), and moderate-severe pain–short-stay (SS)). Metrics that need improvement are denoted in orange and red (for example, newly received antipsychotic (Antipsych) medications (Meds)–SS and new or worse pressure ulcer (PU)–SS).[36]

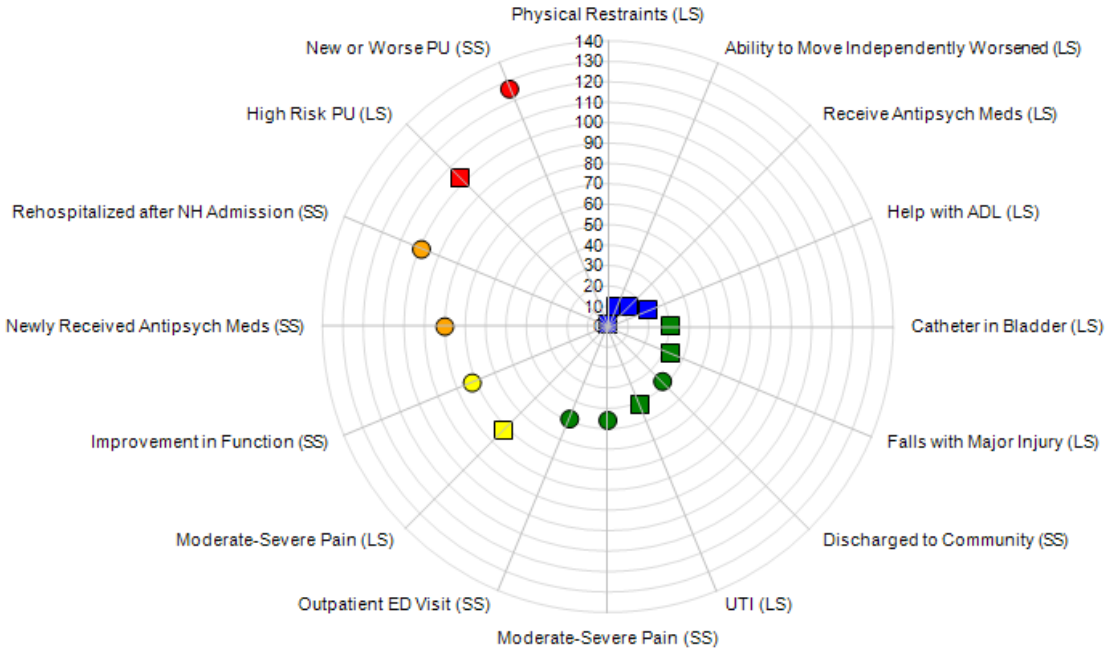

Figure 6. *Edward Hines, Jr. VA Hospital CLC Quality Measure Rankings (as of September 30, 2019)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

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

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

Leadership and Organizational Risks Conclusion

At the time of the OIG site visit, the permanently assigned executive team members had been working as a group for five months. The director position had been vacant for five months, and the Associate Director had served as acting Director since October 2019. Survey results related to employees' satisfaction with the medical center executive leaders were generally similar to or better than VHA averages. Patient survey results indicated satisfaction with care provided; however, female veterans reported less positive specialty care experiences than female patients nationally, illustrating opportunities for improvement. The OIG's review of the medical center's accreditation findings and sentinel events did not identify any substantial organizational risk factors. However, an opportunity exists to improve the institutional disclosure process. The OIG also identified the lack of a permanent director as a vulnerability for the medical center. Of note, a new medical center director was permanently appointed in March 2020. In individual interviews, the executive leaders were somewhat able to discuss actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. Although the leaders were generally knowledgeable within their scopes of responsibility about selected VHA data used by the SAIL model, only the ADPCS could consistently express full understanding of CLC SAIL measures, despite the positive results for the medical center.

Quality, Safety, and Value

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

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

- Review of aggregated QSV data
- Recommendation and implementation of improvement actions
- Monitoring of fully implemented improvement actions

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

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

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

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

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

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

[41] VHA Directive 1190.

- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[42]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee
- Quarterly review of Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

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

- Completion of at least 80 percent of all required inpatient reviews
- Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
- Interdisciplinary review of UM data
- Implementation and monitoring of improvement actions recommended by the interdisciplinary UM group

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

[42] VHA Directive 1190.

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

[44] VHA Directive 1117(2).

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

[46] VHA Handbook 1050.01.

- Annual completion of a minimum of eight root cause analyses[47]
- Inclusion of required content in root cause analyses
- Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
- Provision of feedback about root cause analysis actions to reporting employees
- Submission of annual patient safety report to medical center leaders

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

Quality, Safety, and Value Findings and Recommendations

The OIG determined that the medical center met applicable patient safety requirements. However, the OIG identified concerns with QSV committee, peer review, and UM processes.

The Joint Commission (TJC) requires the medical center to establish a standing governing body committee responsible for quality, safety, and value functions and practices.[49] The role of the committee includes reviewing relevant data and information and ensuring that recommended actions are fully implemented and that any resulting changes are monitored.[50] Of the four quarters—January 2019 through November 2019—of Quality Board meeting minutes reviewed, the OIG noted that two quarters lacked evidence of full implementation of recommended actions and monitoring of changes. This may have prevented quality of care and patient safety process improvements at the medical center. The acting Medical Center Director stated that the Quality Board identified deficits with the medical center's process for capturing meeting discussions and tracking action items, and had already begun implementing changes for improvement.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures specific action items are monitored and documented in the Quality Board minutes when problems or opportunities are identified.

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

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

[49] TJC. Rationale for Leadership standard LD.01.03.01, LD.03.02.01, and 03.05.01, Leadership Introduction to Operations standards LD.03.07.01 through LD.04.03.11, and Performance Improvement standard PI.03.01.01.

[50] TJC. Rationale for Performance Improvement standard PI.01.01.

Medical center concurred.

Target date for completion: November 30, 2020.

Medical center response: The Medical Center Director ensures that the improvement actions recommended in the Quality Board are fully implemented and monitored. In May 2020, the Quality Board modified the template for minutes to reflect an appended tracker for improvement actions and progress. All pending actions are now added to the tracker for next meeting minutes to assure monitoring and closure. The compliance will be monitored and reported by Chief of Quality to Quality Board monthly.

This recommendation will be considered compliant when ninety percent or greater of (Numerator) the number of Quality Board Meeting minutes reflect the monitoring of improvement actions; (Denominator) the number of minutes are audited for six consecutive months.

VHA requires peer review of all "deaths within 24 hours of admission (except in cases when death is anticipated and clearly documented, such as transfer from hospice care)."[51] From December 19, 2018, through December 19, 2019, the OIG found that only 5 of 10 applicable deaths within 24 hours of admission were peer reviewed. This may have prevented timely identification of issues in the practice of one or more healthcare providers at the medical center. The Deputy ADPCS—who also serves as the acting Quality Management Chief and acting Risk Manager—reported that one of the deaths did not warrant a peer review, and the remaining four deaths were not reviewed because a new employee was not adequately trained to identify cases requiring peer review.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that all applicable deaths within 24 hours of admission are peer reviewed.

[51] VHA Directive 1190.

Medical center concurred.

Target date for completion: October 30, 2020

Medical center response: The Chief of Staff will ensure that all applicable deaths within 24 hours are peer reviewed. In April 2020, a process was established by the Acting, Risk Manager to ensure all deaths are reviewed using the daily occurrence screen from Veterans Integrated System Technology Architecture (VISTA).

This recommendation will be considered compliant when ninety percent or greater of (Numerator) the number of applicable deaths within 24 hours of admission are peer reviewed; (Denominator) the number of applicable deaths within 24 hours of admission are audited for six consecutive months. Compliance will be reported at the Medical Executive Board quarterly.

VHA requires that summaries of the Peer Review Committee's analyses are reviewed quarterly by an executive-level medical committee.[52] For two of four quarters reviewed—October 1, 2018 through September 30, 2019—the OIG did not find evidence that the Medical Executive Board reviewed the Peer Review Committee summary reports. Inconsistent reviews of quarterly Peer Review Committee summary reports by the Medical Executive Board may result in missed opportunities to identify and address potential improvement needs for clinical practice and organizational performance. The Deputy ADPCS— who also serves as the acting Chief of Quality Management and acting Risk Manager—attributed the noncompliance to inconsistencies in the medical center's peer review process and failure to institute backup coverage when the Risk Manager was unavailable.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that a summary of the Peer Review Committee's analyses is reviewed quarterly by the Medical Executive Board.

[52] VHA Directive 1190.

Medical center concurred.

Target date for completion: October 30, 2020

Medical center response: The Chief of Staff ensures that the Peer Review Committees analyses is reviewed in the Medical Executive Board. In May 2020, the Medical Executive Board reviewed the quarter two analyses of the Peer Review Committee and implemented the review as a standing agenda item.

This recommendation will be considered compliant when ninety percent or greater of (Numerator) the number of minutes with the Peer Review analyses reported to the Medical Executive Board quarterly; (Denominator) the number of Medical Executive Board Minutes are audited for two consecutive quarters.

VHA requires that an interdisciplinary group review UM data to facilitate ongoing collaboration across services and departments.[53] This group of key stakeholders influence patient flow and must include, but not be limited to individual, "representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR [chief business office revenue-utilization review]."[54] From January 2019 through January 2020, the Inpatient Steering Committee—the medical center group that reviews UM data—lacked consistent representation from social work. As a result, the group performed UM data reviews and analyses without the perspectives of a key colleague. The chairperson of the Inpatient Steering Committee reportedly believed the Mental Health social worker could represent two disciplines—Mental Health and Social Work—during committee meetings.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures all required representatives consistently participate in interdisciplinary reviews of utilization management data.

[53] VHA Directive 1117(2).

[54] VHA Directive 1117(2).

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff will ensure that the Inpatient Steering Committee has all required representation for review of utilization management data. In October 2019, the membership was reviewed, and all required disciplines were added to the Inpatient Steering Committee attendance roster. The minutes of the Inpatient Steering Committee will reflect the attendance of all required disciplines for the utilization management data review. The compliance will be monitored by Chief of Staff.

This recommendation will be considered compliant when ninety percent or greater of (Numerator) the number of members present; (Denominator) the number of total required members per directive are audited for six consecutive months. Attendance Audits will be reported monthly to the Medical Executive Board.

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).[55]

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.[56]

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."[57] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
  - Establishment of criteria in advance
  - Use of required minimum criteria for selected specialty LIPs[58]
  - 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[59]
  - Evaluation by another provider with similar training and privileges

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

[56] VHA Handbook 1100.19.

[57] VHA Handbook 1100.19.

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

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

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

Further, VA must put processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former licensed practitioner's clinical practice, VA has an obligation to notify state licensing boards (SLBs) and to subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[60] 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."[61] The OIG reviewers assessed whether the medical center's staff

- Designated an individual and backup responsible for the SLB reporting process,
- Completed forms within the required time frame and with required oversight, and
- Reported results to SLBs when indicated.

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

- One solo/few practitioner who underwent initial or reprivileging during the previous 12 months[62]
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs privileged within 12 months before the visit
- Twenty LIPs who left the medical center in 12 months before the visit

Medical Staff Privileging Findings and Recommendations

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

VHA requires that all LIPs new to the medical center have FPPE results documented in the practitioner's profile and reported to an appropriate medical staff committee.[63] For 10 newly

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

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

[62] 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 specialty. The OIG considers few practitioners as being less than three providers in the facility that are privileged in a specialty. The 12-month review period was from November 4, 2018, through November 4, 2019.

[63] VHA Handbook 1100.19.

hired LIPs, the OIG found evidence of FPPE results in 7 practitioners' profiles. This resulted in inadequate data to support decisions to continue clinical privileges for the remaining LIPs. The Deputy Chief of Staff reported that some service chiefs were not storing or linking supporting data to the FPPE, resulting in incomplete data.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs initiate and complete focused professional practice evaluations on all newly hired licensed independent practitioners.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff will ensure that service chiefs initiate and complete focused professional practice evaluation on all newly hired licensed independent providers. The completed Focused Professional Practice Evaluations along with primary data will be presented to the Professional Standards Board for approval and the continuation of Privileges. All new Licensed Independent Practitioner charts will be audited monthly for compliance with target goal of ninety percent of applicable files.

This recommendation will be considered compliant when ninety percent or greater of (Numerator) the number of Focused Professional Practice Evaluations completed within ninety days; (Denominator) the number of newly Licensed Independent Practitioners are audited for six consecutive months. Compliance will be monitored by Supervisor, Credentialing and Privileging and reported monthly to Professional Standards Board chaired by the Chief of Staff.

VHA requires that service chiefs include the minimum specialty-specific criteria for OPPEs of Gastroenterology, Nuclear Medicine, Pathology, and Radiation Oncology practitioners.[64] The OIG found that the OPPEs of two practitioners from Pathology and Radiation Oncology lacked the minimum specialty-specific criteria. This resulted in the Pathology and Radiation Oncology practitioners practicing without a thorough evaluation of their practices. The Deputy Chief of Staff reportedly believed services were in compliance with the requirements and that pathology and radiation oncology LIP forms were revised concurrently with the gastroenterology form.

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

Recommendation 6

6. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that service chiefs include the minimum pathology and radiation oncology specific criteria for ongoing professional practice evaluations of licensed independent practitioners.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff will ensure that the Service Chiefs include the minimum pathology and radiation oncology specific criteria for ongoing professional practice evaluations of licensed independent practitioners. The Ongoing Professional Performance Evaluation forms with specialty specific criteria for Pathology and Radiation Oncology are now updated. Each specialty area now verifies quarterly that the correct specialty specific criteria for Ongoing Professional Performance Evaluations are implemented.

This recommendation will be considered compliant when ninety percent or greater of (Numerator) the number of minimum Pathology and Radiation Oncology Ongoing Professional Performance Evaluations with minimum criteria; (Denominator) the number of Pathology and Radiation Oncology providers Ongoing Professional Performance Evaluations due are audited for six consecutive months. Compliance will be monitored by Supervisor, Credentialing and Privileging and reported monthly to the Professional Standards Board chaired by the Chief of Staff.

Further, VHA requires that the service chiefs' determinations to continue current privileges are based, in part, on OPPE activities such as direct observation, clinical pertinence reviews, and clinical discussions.[65] For 11 LIPs who were reprivileged within the last 12 months, including the one solo/few LIP, service chiefs could not demonstrate that the determinations to continue privileges were based in part on OPPE activities. Ten LIP profiles lacked supporting data and one did not have evidence of an OPPE. This resulted in inadequate data to support decisions to continue clinical privileges for these LIPs. The Deputy Chief of Staff cited that some services were not storing or linking supporting data to OPPE, and the Credentialing Supervisor stated that service chiefs believed current practices met requirements.

Recommendation 7

7. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs collect, review, and use ongoing professional practice evaluation data in determinations to continue current privileges.

[65] VHA Handbook 1100.19.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff will ensure that the Service Chiefs collect, review, and use Ongoing Professional Practice Evaluation data in determinations to continue current privileges. Service Chiefs are providing Ongoing Professional Practice Evaluation data to the credentialing and privileging department at the time of re-appointment in support of continuing clinical privileges at the Professional Standards Board meeting. Thirty files or a hundred percent review if less than 30 files will be audited to assure compliance.

This recommendation will be considered compliant when ninety percent or greater of (Numerator) the number of Ongoing Professional Practice Evaluation data supports continued current privileges; (Denominator) the number of Ongoing Professional Practice Evaluation files are audited for six consecutive months. Compliance will be monitored by Supervisor, Credentialing and Privileging and reported monthly to the Professional Standards Board chaired by the Chief of Staff.

VHA also requires that the Executive Committee of the Medical Staff (referred to locally as the Medical Executive Board) recommend continuing privileges based on FPPE and OPPE results. Committee minutes must indicate which materials were reviewed and the rationale for the privileging recommendation. The committee's recommendation is then submitted to the Medical Center Director for approval.[66] For 14 LIPs—3 of whom had initial privileges continued and 11 whom were reprivileged within the last 12 months, including the 1 solo/few LIP—profiles lacked evidence that service chief determinations to continue privileges were based in part on FPPE and OPPE activities. Specifically, LIP profiles lacked supporting data, were missing OPPEs, OPPE forms were not reviewed and signed prior to the Medical Executive Board meeting, and recommendations for continuation of privileges were not reflected in Medical Executive Board minutes. Consequently, the Medical Executive Board's decisions to recommend continuation of privileges were not based on FPPE and OPPE activities. This resulted in inadequate data to support decisions to continue clinical privileges for these LIPs. The Deputy Chief of Staff and Credentialing Supervisor cited service chiefs' failure to store or link supporting data to FPPEs and OPPEs, belief that current practices met requirements, and a lack of oversight as reasons for noncompliance.

[66] VHA Handbook 1100.19.

Recommendation 8

8. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Medical Executive Board's decisions to recommend initial and continuation of privileges are based on focused and ongoing professional practice evaluation results.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff will ensure that the Service Chiefs are providing Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation with data to the credentialing and privileging department at the time of re-appointment in support of continuing clinical privileges. The completed Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation is taken to the Professional Standards Board for approval and the continuation of Privileges. Thirty files or a hundred percent review if less than 30 files will be audited for the presence of evaluation results in support of the Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation recommendation.

This recommendation will be considered compliant when ninety percent or greater of (Numerator) the number of initial and continued privileges based on Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation results; (Denominator) the number of initial and continued privileges due for review or renewal of Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation files audited for six consecutive months. Compliance will be monitored by Supervisor, Credentialing and Privileging and reported monthly to the Professional Standards Board 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."[67] Among the 20 providers that departed the medical center in the previous 12 months, the OIG found that nine exit forms were completed within seven calendar days. A delay in completing exit forms could result in untimely reporting of healthcare professionals' potential substandard care to SLBs. The Credentialing Supervisor and Deputy Chief of Staff cited that service chiefs had difficulty receiving timely notifications informing them of the last working day of LIPs at the medical center, resulting in late completion of provider exit review forms.

[67] VHA Notice 2018-05.

Recommendation 9

9. The Medical Center 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 medical center.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Medical Center Director will ensure that provider exit review forms are completed within seven calendar days of licensed healthcare professionals departing the medical center. Service Chiefs will ensure that all providers submit the provider exit review form within seven-calendar days to their Service Department. The Credentialing and Privileging department, Supervisor will review the monthly gains and loss report to confirm the receipt of the Exit Review forms within seven calendar days of a healthcare professional departing the medical center.

This recommendation will be considered compliant when ninety percent or greater of (Numerator) the number of providers with an exit review form completed within seven calendar days of a licensed healthcare provider; (Denominator) the number of providers that departed the facility on the Gains and Losses Report are audited for six consecutive months. Compliance will be monitored by Supervisor, Credentialing and Privileging and reported monthly to the Professional Standards Board 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.[68]

The purpose of this facet of the OIG inspection was to determine whether the medical center maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the medical center 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 medical center'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

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

- Environmental cleanliness and infection prevention
- Privacy
- Privacy for women veterans
- Logistics

During its review of the environment of care, the OIG team inspected the Aurora VA Clinic and the following 11 patient care areas of the medical center:

- Acute mental health unit (2 South)
- CLC (1C and 2C)
- Dental clinic
- Emergency Department
- Inpatient units (medical and surgical – 7th floor)
- Intensive care units (medical and surgical)
- Outpatient clinic
- Post-anesthesia care unit

The OIG reviewed relevant documents and interviewed key employees and managers.

Environment of Care Findings and Recommendations

The medical center generally complied with requirements for general safety, privacy, and the inpatient mental health unit. However, the OIG identified opportunities within the medical center to remove expired supplies and improve environmental cleanliness in clinical areas. During OIG's subsequent review of *VHA's COVID-19 Screening Processes and Pandemic Readiness*, medical center leaders reported a need for additional surgical masks and face shields.[69]

VHA requires that "expiration dates on commercial products must be adhered to as they reflect product usability or stability rather than sterility of the contents."[70] In 3 of 12 areas inspected, the OIG found outdated commercial sterile supplies, such as an automated external defibrillator replacement pad and culture swabs, which could prove harmful to patients and hinder access to appropriate medical treatment.[71] The nurse managers and dental program specialist attributed the noncompliance to the lack of attention to detail.

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

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

[71] Dental clinic, medical intensive care unit, and outpatient clinic.

Recommendation 10

10. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that Sterile Processing Services employees remove expired commercial sterile supplies from service.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Associate Director for Patient Care Service ensures that the Sterile Processing Service removes expired commercial supplies from service. Clinical Managers and the Reusable Medical Equipment Coordinator will document monthly completion of Environment of Care rounds by completing the facility's checklist, which includes expired commercial sterile supplies. All areas will submit monthly checklist with appropriate action plans for noncompliance to the Assistant Chief, Quality and System Improvement.

This recommendation will be considered compliant when the audit shows ninety percent or greater compliance for six consecutive months. (Numerator) the number of audits completed addressing findings and removal of commercial sterile supplies from clinical area; (Denominator) the total number of clinical areas. Compliance will be reported to Quality Board monthly.

TJC requires facilities to continually monitor environmental conditions and remediate conditions that do not meet requirements.[72] Of the 12 clinical areas inspected, the OIG observed three with a general appearance of disrepair as evidenced by stained or cracked ceiling tiles and surfaces and peeling or cracked paint on the walls. For example, in a primary care clinic, the OIG noted a severe crack on the wall causing a visible gap between the wall and an electrical panel in the hallway.[73] This resulted in a lack of assurance of a clean and safe patient care environment. The Assistant Chief of Environmental Management Service stated that work orders requesting repairs were submitted; but the repairs had not yet been completed due to staffing shortages and competing priorities.

Recommendation 11

11. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures clinical areas are in good repair and that a safe and clean environment is maintained throughout the medical center.

[72] TJC, Environment of Care standard LS.03.01.30, EP 17.

[73] Emergency department, CLC 1C, and PACT C-GMC clinic

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Associate Director ensures that the Occupational Safety office reviews and monitors Environment of Care (EOC) findings related to clinical areas in good repair and that the environment is safe and clean through weekly Environment of Care rounds. Deficiencies are tracked through Performance Logic Environment of Care Deficiencies software and reported monthly to Hospital Safety Committee chaired by Associate Director and Co-Chaired by the Chief of Safety. Negative trends are identified through Performance Logic with corrective action documented by service.

This recommendation will be considered compliant when the audit of all Environment of Care assessments show a ninety percent or greater compliance with recommendations for corrections for six consecutive months. (Numerator) the number of findings; (Denominator) number of findings addressed and closed out. Compliance will be monitored and reported by Chief of Safety monthly to the Hospital Safety Committee Chaired by the Associate Director.

Medication Management: Long-Term Opioid Therapy for Pain

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

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

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

- Completion of initial screening for pain
- Assessment of aberrant behavior risk
- Avoidance of concurrent therapy with benzodiazepines
- Completion of urine drug testing with intervention, when indicated

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

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

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

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

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

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

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

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

- Documentation of informed consent
- Timely follow-up with patients included required elements

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

- Performance of pain management committee activities
- Monitoring of quality measures
- Following the quality improvement process

The OIG interviewed key employees and managers and reviewed relevant documents and the electronic health records of 22 outpatients who had newly-dispensed (no VA dispensing in previous six months) long-term opioids for pain, daily or intermittently for 90 or more calendar days through VA from July 1, 2018, through June 30, 2019. The team considered whether providers acted in accordance with guidelines for the provision of pain management and the medical center's oversight process for evaluating pain management outcomes and quality.

Medication Management Findings and Recommendations

The medical center addressed many indicators of expected performance, including documented justification for concurrent therapy with benzodiazepines and establishment of a multidisciplinary pain management committee. However, the OIG found deficiencies with pain screenings, aberrant behavior risk assessments, urine drug testing, informed consent, and patient follow-ups.

VHA requires that all elements of pain management are documented in the patient record, including completion of screening for pain in the initial visit prior to dispensing long-term opioid therapy.[83] The OIG found that providers provided pain screening in 82 percent of the patients at the facility, based on electronic health records reviewed.[84] This resulted in inconsistent assessment of pain intensity and its effects on function and quality of life. The Pain Committee chairperson stated noncompliance was due to providers' lack of understanding of the requirement.

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

[83] VHA Directive 2009-053.

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

Recommendation 12

12. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers complete pain screening for all patients prior to initial dispensing of long-term opioid therapy.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff will ensure that Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers complete pain screening for all patients prior to initial dispensing of long-term opioid therapy. Prescribing Providers complete required pain screening and document screening prior to initial dispensing of long-term opioid therapy.

This recommendation will be considered compliant when the audits of medical records demonstrate ninety percent or greater compliance with documentation of pain screening prior to initial dispensing of long-term opioid therapy for six consecutive months. (Numerator) the number of records with documented pain screening prior to initial dispensing of long-term opioid medication; (Denominator) the number of records with new orders for long-term opioid medication. Compliance will be monitored and reported monthly by the Chair of Pain Committee to the Medical Executive Board.

VA/DoD clinical practice guidelines recommend that providers complete an aberrant behavioral risk assessment that includes a history of substance abuse, mental health problems or disorders, and aberrant drug related behaviors[85] prior to "initiating or continuing long-term opioid therapy".[86] The OIG determined that providers completed a behavioral risk assessment in 41 percent of the patients reviewed.[87] This may have resulted in providers prescribing opioids for patients at high risk for misuse. The Pain Committee chairperson attributed the noncompliance to providers' lack of understanding of the requirement.

Recommendation 13

13. 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.

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

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

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

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: Chief of Staff ensures that providers complete an aberrant behavior risk assessment on all patients prior to initiating long-term opioid therapy. Thirty records or a hundred percent review if less than 30 records will be audited monthly to assure compliance.

This recommendation will be considered compliant when ninety percent of the records with new orders for long-term opioid therapy contain an aberrant behavior risk assessment for six consecutive months. (Numerator) number of records containing an aberrant behavior risk assessment; (Denominator) number of new orders for long-term opioid therapy. Compliance will be monitored and reported monthly by the Chair of Pain Committee to the Medical Executive Board.

VA/DoD clinical practice guidelines also recommend that "providers obtain UDT [urine drug test] prior to initiating or continuing LOT [long-term opioid therapy] and periodically thereafter."[88] The OIG found that providers conducted initial urine drug testing in 45 percent of the patients reviewed.[89] This resulted in providers' inability to identify whether the remaining 55 percent of patients had substance use disorders, determine potential diversion, or ensure patients adhered to the prescribed medication regimen. The Pain Committee chairperson attributed the noncompliance to providers' occasional lack of attention to detail.

Recommendation 14

14. 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.

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

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

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: Chief of Staff ensures that providers consistently conduct urine drug testing as required for patients on long-term opioid therapy. Co-Chair of Pain committee will ensure that all the opioid prescribing providers are conducting urine drug testing and reviewing the results prior to prescribing the opioids. Thirty records or a hundred percent review if less than 30 records will be audited monthly to assure compliance.

This recommendation will be considered compliant when ninety percent of the records for patients on long-term opioid therapy contain the urine drug testing per policy for six consecutive months. (Numerator) number of records with documented urine drug screening; (Denominator) Records audited (thirty). Compliance will be monitored and reported monthly by the Chair of Pain Committee to the Medical Executive Board.

VHA requires providers to obtain and document informed consent prior to the initiation of therapeutic treatments that have a "significant risk of complication or morbidity," including long-term opioid therapy, prior to initiation.[90] VHA also recommends that the informed consent conversation cover the risks and benefits of opioid therapy, as well as alternative therapies.[91] The OIG determined that providers documented informed consent prior to initiating long-term opioid therapy in 55 percent of the patients at the medical center.[92] The remaining 45 percent of patients, therefore, may have been receiving treatment without knowledge of the associated risks, including opioid dependence, tolerance, addiction, and intentional or unintentional fatal overdose. The Pain Committee chairperson reported a lack of understanding of the requirement as the reason for noncompliance.

Recommendation 15

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

[90] VHA Directive 1005.

[91] VHA Directive 1005.

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

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: Chief of Staff ensures that providers consistently obtain and document informed consent for patients initiating long-term opioid therapy. Co-Chair of Pain committee will educate all the opioid prescribing providers on obtaining informed consents before initiating long term opioids therapy. Thirty records or a hundred percent review if less than 30 records will be audited monthly to assure compliance.

This recommendation will be considered compliant when ninety percent or greater of the patient charts of patients on long-term opioid therapy contain the appropriate informed consent prior to initiating long-term opioid therapy for six consecutive months. (Numerator) number of patient charts with informed consent prior to initiating long-term opioid therapy; (Denominator) Number of patient charts audited (Thirty). Compliance will be monitored and reported monthly by the Chair of Pain Committee to the Medical Executive Board.

VA/DoD clinical practice guidelines also recommend that providers follow up with patients within three months after initiating long-term opioid therapy[93] to assess adherence to pain management plans of care and to evaluate the effectiveness of the intervention.[94] The OIG found that providers followed up with patients, assessed adherence to pain management plans of care, and assessed effectiveness of interventions in 27 percent of patient records reviewed.[95] Among the remaining patients, failure to conduct timely assessment of adherence to the therapy plan and effectiveness of treatment can result in missed opportunities to determine the benefits of continued opioid therapy. The Pain Committee chairperson stated that some patients were seen by other providers who assessed adherence and effectiveness of interventions at various intervals of care. Further, the Pain Committee chairperson affirmed that the provider's clinical judgment guided the need for additional appointments.

Recommendation 16

16. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that follow-up with patients receiving long-term opioid therapy include an assessment of adherence to the pain management plan of care and the effectiveness of the intervention.

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

[94] VHA Directive 2009-053.

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

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: Chief of Staff ensures that the providers follow-up with patients receiving long-term opioid therapy, include an assessment of adherence to the pain management plan of care, and the effectiveness of the intervention. The Pain Committee Chairperson will ensure timely assessment, follow up, management of plan of care, effectiveness of interventions and documentation. Thirty records or a hundred percent review if less than 30 records will be audited monthly to assure compliance.

This recommendation will be considered compliant when ninety percent or greater of the records for patients on long-term opioid therapy contain an assessment of adherence to the plan of care and documentation of effectiveness of interventions at each visit for six consecutive months. (Numerator) the number of records with assessment of adherence to pain management plan of care and effectiveness of therapy; (Denominator) the number of records audited (thirty). Compliance will be monitored and reported monthly by the Chair of Pain Committee to the Medical Executive Board.

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.[96] 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.[97] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[98]

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.[99]

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.[100] The OIG examined various requirements related to SPCs:

- Assignment of a full-time SPC
- Tracking and follow-up of high-risk veterans
  - Patients' completion of four appointments within the required time frame
  - Safety plan completion within the required time frame
  - Mental health teams' contacts with patients for missed appointments
- Provision of suicide prevention training for nonclinical employees at new employee orientation
- Completion of at least five outreach activities per month

VHA also requires that any patient determined to be at high risk for suicide be added to the facility high-risk list and have a High Risk for Suicide (HRS) Patient Record Flag (PRF) placed

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

[97] 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*.

[98] 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.*

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

[100] 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.

in his or her electronic health record "as soon as possible but no later than 1 business day after such determination by the SPC."[101] 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."[102] The HRS PRF is reviewed at least every 90 days and depending on changes to the suicide risk status, will remain active or be removed.[103] 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.[104]

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."[105] 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."[106] 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."[107]

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

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

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

[103] *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.

[104] 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*.

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

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

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

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 PRF on the subsequent Monday (a week after referral).

On March 27, 2020, VHA also updated existing policy requirements to allow the review of HRS PRFs to "occur no earlier than 10 days before and no later than 10 days after the 90-day due date."[108]

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.[109] VHA also requires that all staff receive annual refresher training.[110] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[111]

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

- Relevant documents;

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

[109] 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.

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

[111] 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.

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

Mental Health Findings and Recommendations

The medical center met the requirements associated with a designated SPC, completion of mental health appointments, suicide safety plans, and patient follow-up for missed appointments. However, the OIG had concerns.

With VHA's original requirement that was in place at the time these patients received care—that "[a]ny 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"[112] —the OIG estimated that 48 percent of HRS PRFs were placed within 24 hours of referral to the SPC.[113] Based on the current updated requirement that the SPC be responsible for determining placement of the HRS PRF (without a defined timeframe), the OIG further calculated that the average time from referral to HRS PRF placement for the patients reviewed was five days (observed range was 0–35 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.[114] The OIG estimated that 31 percent of patients with an HRS PRF were reevaluated at least every 90 days.[115] 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 all patients were reviewed within the expected time frame (observed range was 87–97 days).

Additionally, the OIG identified a deficiency with the annual suicide prevention refresher training. VHA requires that all staff (clinical and nonclinical) receive annual refresher training.[116] The OIG found that 15 of 20 staff received the required training at or within one year of initial training. Lack of training could prevent staff from providing optimal treatment to veterans who are at risk for suicide. The lead SPC, Social Work Supervisor, and Mental Health Chief attributed the noncompliance to a lack of oversight and sole reliance on VA Talent Management System alerts to prompt staff to complete the required training.

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

[113] The OIG estimated that 95 percent of the time, the true compliance rate is between 32.5 and 62.5 percent, which is statistically significantly below the 90 percent benchmark.

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

[115] The OIG estimated that 95 percent of the time, the true compliance rate is between 17.1 and 45.5 percent, which is statistically significantly below the 90 percent benchmark.

[116] VHA Directive 1071.

Recommendation 17

17. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures staff receive annual suicide prevention refresher training.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Medical Center Director will ensure all clinical and nonclinical staff receive annual suicide prevention refresher training. From June 2020, all staff were assigned to the suicide refresher training. The deficiency report from Talent Management System (TMS) is generated, and the deficient staff is followed up by their supervisor to ensure compliance. The compliance will be monitored by Chief of Education and reported to the Quality Board.

This recommendation will be considered compliant when the monthly Domain Compliance Deficiency Report from the Talent Management System, for suicide refresher training shows rate of ninety percent or greater for six consecutive months. (Numerator) the total number of staff required; (Denominator) the total number of staff assigned.

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."[117]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.[118] 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.[119] 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.[120]

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

- Decision-making capacity,
- Identification of a surrogate if the patient loses decision-making capacity,
- Patient or surrogate understanding of the patient's condition,
- Goals of care,
- Plan of care for the use of LST, including whether cardiopulmonary resuscitation will be attempted in the event of cardiac arrest, and
- Informed consent for the LST plan.

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[117] 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.

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

[119] 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.

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

However, on March 19, 2020, VHA amended the requirements related to documenting patients' goals of care.[121] Although the elements of the goals of care conversation are still required, the LST progress note must document at a minimum

- Decision-making capacity,
- Goal(s) of care,
- Plan of care for the use of LST, and
- Informed consent for the LST plan.

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

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

- Completion of LSTD notes
- Timely documentation of LSTD
- Inclusion of required elements in LSTD documentation
- Completion of LSTD note/orders by an authorized provider or delegation to a designee met all requirements

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[122] Inspectors examined if the medical center established an LSTD committee that was comprised of a multidisciplinary membership, which included representation from Ethics Consultation Service, and reviewed proposed LST plans.

To determine whether the medical center complied with the OIG-selected requirements related to LSTD for hospice patients, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 43 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

[121] VHA Handbook 1004.03(1).
[122] VHA Handbook 1004.03(1).

Care Coordination Findings and Recommendations

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

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[123] 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.[124] 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."[125] 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."[126]

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.[127] 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."[128]

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

- Provision of care requirements

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[123] 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.)

[124] 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.)

[125] 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.)

[126] 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.)

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

[128] VHA Directive 1330.01(3).

  - Designated Women's Health Patient Aligned Care Team established
  - Primary Care Mental Health Integration services available
  - Gynecologic care coverage available 24/7
  - Gynecology care accessible
  - Facility women health primary care providers designated
  - CBOC women's health primary care providers designated
  - Emergency contraception accessible
- Oversight of program and monitoring of performance improvement data
  - 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
  - Women Veterans Program Manager
  - Women's Health Medical Director or clinical champion
  - Maternity Care Coordinator
  - Women's health clinical liaison at each CBOC

Women's Health Findings and Recommendations

Generally, the medical center achieved the requirements listed above. The OIG did note that the Women Veterans Health committee membership did not include all required members, based on committee meeting minutes reviewed. However, the OIG did not issue an additional recommendation since the medical center is actively working on improvement after the previous November 2018 CHIP inspection.[129]

[129] OIG *Comprehensive Healthcare Inspection Program Review of the Edward Hines, Jr. VA Hospital, IL*, Report No. 18-04676-142, June 18, 2019.

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."[130] The goal of SPS is to "provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[131] 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[132]
- 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[133]

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.[134] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[135]

In addition, RME reprocessing areas must be clean, restricted, and airflow-controlled. All areas where RME reprocessing occurs must have safety data sheets, an unobstructed eyewash station, personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[136]

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

[131] 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.)

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

[133] VHA Directive 1116(2).

[134] 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.

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

[136] VHA Directive 1116(2).

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued annual and essential staff competency assessments, and monthly continuing education. This ensures that staff have sufficient aptitude, knowledge, and skills to effectively and safely reprocess and sterilize RME.[137]

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

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

[137] VHA Directive 1116(2).

- Completion of staff training, competency, and continuing education
  - Required training completed in a timely manner
  - Competency assessments performed
  - Monthly continuing education received

High-Risk Processes Findings and Recommendations

The medical center met many of the requirements for the proper operations and management of reprocessing RME. However, the OIG identified deficiencies with quality assurance monitoring; reprocessing and storage area physical inspections; and staff training, competency, and ongoing education.

SPS must have a quality assurance program that includes testing of at least 10 percent of endoscopes for bioburden.[138] The OIG found that SPS staff tested less than 10 percent of endoscopes to ensure bioburden was removed after reprocessing. This resulted in a lack of assurance that appropriate and safe reprocessing had been performed. The SPS Chief acknowledged the lack of a formal process for bioburden testing and stated that Gastroenterology staff were unaware of the requirement and were only testing the first scope used each business day.

Recommendation 18

18. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that at least 10 percent of reprocessed endoscopes are tested for bioburden.

[138] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: Associate Director for Patient Care Services ensures that the institution evaluates and determines any reasons for noncompliance and ensures that ten percent of reprocessed endoscopes are tested for bioburden. From June 1, 2020, the Sterile Processing Service Supervisor implemented the standard operating procedure to test bioburden for all reprocessed endoscopes. A Monthly audit will be conducted for ten percent of reprocessed endoscopes to assure no bioburden by Sterile Processing Service Supervisor.

This recommendation will be considered compliant when the audit of the reprocessed endoscopes shows ninety percent or greater compliance for bioburden evaluation for six consecutive months. (Numerator) the number of reprocessed endoscopes with ten percent bioburden checks completed; (Denominator) number of bioburden audits required. Compliance will be reported monthly to the Reusable Medical Equipment Committee that is Chaired by the Associate Director of Patient Care.

Despite VHA requiring strict traffic flow of people in SPS, the OIG did not find a keyed entry or other mechanism to restrict access to the gastroenterology clean storage area.[139] This could have compromised the integrity of the SPS environment by increasing the potential spread of microorganisms. The SPS Chief did not provide a reason for noncompliance and reported being aware of the requirement and initiating a work order request to secure the door.

Recommendation 19

19. The Associate Director for Patient Care Services determines the reasons for noncompliance and ensures that traffic flow in the gastroenterology clean storage area is restricted.[140]

[139] VHA Directive 1116(2).

[140] The OIG reviewed evidence that sufficiently demonstrated that the medical center had completed improvement actions and therefore closed the recommendation before publication of the report.

Medical center concurred.

Target date for completion: Completed

Medical center response: Associate Director for Patient Care Services ensures that the gastroenterology clean storage area is now restricted to only staff performing sterilization processes. A secure access key padlock was installed with a numeric access code which is currently in use hundred percent of the time by Sterile Processing Service technicians and Gastroenterology laboratory personnel.

This recommendation is considered compliant as of March 6, 2020 as the work order for keyed entry is completed and entrance is restricted to gastroenterology laboratory staff and sterile processing service technicians. We request closure of this recommendation based on the evidence provided.

VHA requires a strict temperature range of 66–72 degrees Fahrenheit in SPS clean/sterile storage areas.[141] During a physical inspection of the gastroenterology clean storage area, the OIG found that the temperature exceeded 72 degrees Fahrenheit (the average temperature was 77 degrees Fahrenheit). Failure to maintain the required temperature range can lead to the spread of healthcare-associated infections through environmental fungi and bacteria. The SPS Chief stated that since the clean storage area is a shared space for Gastroenterology RME and Logistics (supplies), temperature alerts were sent to Logistics staff only, resulting in SPS staff being unaware when temperature readings exceeded acceptable level.

Recommendation 20

20. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that Sterile Processing Services maintains required climate control parameters for areas where reusable medical equipment is reprocessed and stored.

[141] 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.

Medical center concurred.

Target date for completion: November 1, 2020

Medical center response: The Associate Director for Patient Care Services will ensure that the Sterile Processing Service maintains required climate control parameters for areas where reusable medical equipment is reprocessed and stored. Gastroenterology laboratory technician, and the Chief, Sterile Processing Service Supervisor receive automatic alerts when temperature and humidity are out of range for reusable medical equipment storage in Gastroenterology laboratory. Sterile Processing Service Supervisor monitors when a room is out of the required temperature range. Monthly audit of temperature and humidity ranges will be completed by Sterile Processing Service Supervisor.

This recommendation will be considered compliant when the temperature range audit shows ninety percent or greater compliance for six consecutive months (Numerator) the number of rooms where climate control was demonstrated; (Denominator) the number of rooms where climate control is required. Compliance will be reported monthly by the Sterile Processing Service Supervisor to the Reusable Medical Equipment Committee that is Chaired by the Associate Director of Patient Care.

Since March 23, 2016, VHA has required that "all new SPS employees must complete the SPS Level 1 training program within 90 days of hire."[142] Of the five selected SPS employees hired after March 23, 2016, the OIG found that three completed the training within 90 days of hire. Failure to complete training timely could result in improper cleaning of the RME and compromise patient safety. The current SPS Chief and RME Educator had not yet assumed their positions at the time the two staff were hired and did not provide a reason for noncompliance.

Recommendation 21

21. The Associate Director for Patient Care Services determines the reasons for noncompliance and ensures Sterile Processing Services staff complete Level 1 training within 90 days of hire.[143]

[142] VHA Directive 1116(2).

[143] The OIG reviewed evidence that sufficiently demonstrated that the medical center had completed improvement actions and therefore closed the recommendation before publication of the report.

Medical center concurred.

Target date for completion: Completed

Medical center response: Associate Director for Patient Care Services ensures that all Sterilization Process Service technicians were re-assigned Level 1 training.

This recommendation is considered compliant with level 1 training completed at a hundred percent except for two employees on extended leave. Employees on extended leave will complete training within 30 days of return to duty. (Numerator) number of employees completed level 1 training; (Denominator) number of SPS employees requiring Level 1 training. We request closure of this recommendation based on evidence provided.

Additionally, VHA requires the SPS Chief to ensure that staff who reprocess RME complete competency assessments.[144] The OIG found that all 10 selected SPS staff had incomplete or expired competency assessments for the RME reviewed. This could result in improper cleaning of the RME and compromise patient safety. The SPS Chief, RME Nurse Educator, and Infection Control Manager cited recent turnover of key SPS positions as the reason for noncompliance.

Recommendation 22

22. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that the Sterile Processing Services Chief complete competency assessments for staff reprocessing reusable medical equipment.

[144] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: Associate Director for Patient Care Services ensures that all Sterilization Process Service technicians complete the annual competency assessments. Sterile Processing Service supervisor is monitoring the competency completion through competency tracker tool. Monthly audit of staff competency completion is conducted by the Sterile Processing Service Supervisor.

This recommendation will be considered compliant when the monthly audit of staff Competency assessments shows a ninety percent or greater compliance for Competency Assessment for six consecutive months. (Numerator) number of employees completed annual competency training; (Denominator) number of Sterile Processing Services employees requiring Annual Competency Assessment. Compliance will be reported by the Sterile Processing Service Supervisor monthly to the Reusable Medical Equipment Committee that is Chaired by the Associate Director of Patient Care.

VHA also requires SPS staff to participate in continuing education at least once per month.[145] From October to December 2019, the OIG found evidence of monthly continuing education for 7 of 10 SPS staff. This resulted in a potential knowledge gap in reprocessing duties for the remaining staff. The SPS Chief and RME Nurse Educator stated that Gastroenterology staff received monthly continuing education but were unable to provide evidence of compliance.

Recommendation 23

23. The Associate Director for Patient Care Services determines the reasons for noncompliance and ensures Sterile Processing Services staff receive monthly continuing education.

VHA Directive 1116(2).

Medical center concurred.

Target date for completion: October 1, 2020

Medical center response: Associate Director for Patient Care Services ensures that Sterile Processing Services staff receive monthly continuing education. A monthly continuing education calendar will be developed for 2021 for the ongoing education for Sterile Process Service (SPS) technicians. Sterile Processing Service Supervisor will coordinate the continuing education according to the calendar. Compliance will be monitored by the Sterile Processing Service Supervisor by doing monthly audits of completed continuous staff education.

This recommendation will be considered compliant when the audit of completion of staff education shows ninety percent or greater for six consecutive months. (Numerator) number of employees completing continuing education; (Denominator) number of Sterile Processing Service Technicians requiring education. Compliance will be reported by Sterile Processing Service Supervisor monthly to the Reusable Medical Equipment Committee that is Chaired by the Associate Director of Patient Care.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• Peer review all applicable deaths within 24 hours of admission to the hospital.	• Quality Board monitors fully implemented improvement actions. • The Medical Executive Board reviews quarterly peer review summary analysis. • Utilization management data is reviewed by required representatives.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• Service chiefs initiate and complete FPPEs on all newly hired LIPs. • Service chiefs include the minimum pathology and radiation oncology specific criteria for OPPEs of LIPs. • Service chiefs consistently collect and review and use OPPE data, in part, in decisions for continuing privileges. • The Medical Executive Board reviews and considers all required FPPE and OPPE results in the decision to recommend continuation of privileges.	• Provider exit review forms are completed within seven calendar days of licensed healthcare professionals departing the medical center.

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
		• Staff remove expired supplies from service.
		• Managers maintain a clean and safe environment.	

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 screening for pain in the initial visit prior to dispensing of long-term opioid therapy. • Providers complete an aberrant behavior risk assessment on all patients prior to initiating long-term opioid therapy. • Providers consistently conduct urine drug testing for patients for patients on long-term opioid therapy. • Providers obtain and document informed consent prior to initiating patients on long-term opioid therapy. • Provider assess adherence to the pain management plan of care and effectiveness of the intervention during follow-up with patients.	• None
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements	• None	• Employees receive annual suicide prevention refresher training.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• None	• None
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• None	• None
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Data monitoring • Physical inspection • Staff training	• Ten percent of endoscopes are bioburden tested. • Temperature is maintained where RME is stored.	• Traffic flow to SPS gastroenterology clean storage area is restricted. • SPS staff receive monthly continuing education. • New SPS staff complete Level 1 training within 90 days of hire. • SPS staff receive complete and timely competency assessments.

Appendix B: Medical Center Profile

The table below provides general background information for this high complexity (1a) affiliated[1] medical center reporting to VISN 12.[2]

Table B.1. Profile for Edward Hines, Jr. VA Hospital (578)
(October 1, 2016, through September 30, 2019)

Profile Element	Medical Center Data FY 2017[3]	Medical Center Data FY 2018[4]	Medical Center Data FY 2019[5]
Total medical care budget in dollars	$684,997,411	$712,853,467	$759,665,020
Number of:			
• Unique patients	58,288	58,208	57,326
• Outpatient visits	867,445	875,165	882,182
• Unique employees[6]	3,215	3,369	3,458
Type and number of operating beds:			
• Blind rehabilitation	34	34	34
• Community living center	210	210	210
• Domiciliary	25	25	25
• Medicine	66	66	66
• Mental health	29	29	29
• Rehabilitation medicine	10	10	10
• Spinal cord injury	68	68	68
• Surgery	41	41	41
Average daily census:			
• Blind rehabilitation	28	27	30
• Community living center	128	123	127
• Domiciliary	20	18	20
• Medicine	74	70	69

[1] Associated with a medical residency program.

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

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

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

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

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

Profile Element	Medical Center Data FY 2017[3]	Medical Center Data FY 2018[4]	Medical Center Data FY 2019[5]
• Mental health	17	16	17
• Rehabilitation medicine	5	5	5
• Spinal cord injury	36	33	39
• Surgery	19	20	20

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.

Appendix C: VA Outpatient Clinic Profiles[1]

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Joliet, IL	578GA	16,046	7,629	Cardiology Dermatology Eye Podiatry Poly-Trauma Rehab physician	n/a	Nutrition Pharmacy Social work Weight management
Bourbonnais, IL	578GC	7,392	2,399	Dermatology Endocrinology Eye Nephrology Poly-Trauma	n/a	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.

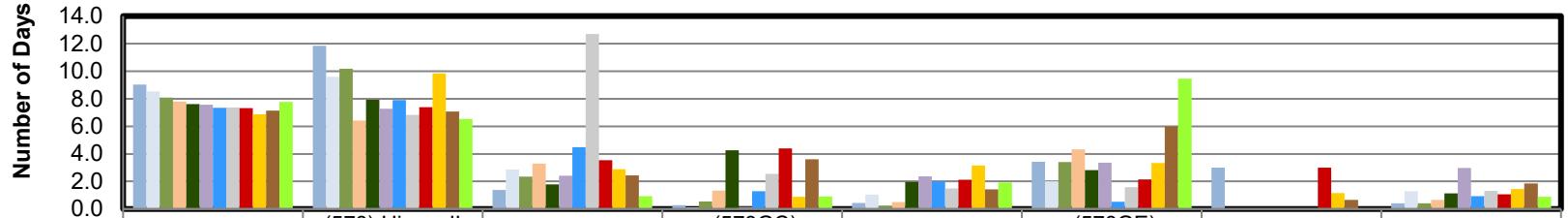
[5] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
North Aurora, IL	578GD	9,879	4,435	Dermatology Endocrinology	n/a	Nutrition Pharmacy Social work Weight management
Hoffman Estates, IL	578GE	8,197	4,041	Dermatology Endocrinology	n/a	Nutrition Pharmacy Social work Weight management
Peru, IL	578GF	6,630	3,920	Dermatology Endocrinology Eye Poly-Trauma	n/a	Nutrition Pharmacy Social work Weight management
Oak Lawn, IL	578GG	12,901	3,751	Dermatology Endocrinology	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[6]

Quarterly New Primary Care Patient Average Wait Time in Days



	VHA Total	(578) Hines, IL (Edward Hines, Jr.)	(578GA) Joliet, IL	(578GC) Kankakee County, IL	(578GD) Aurora, IL	(578GE) Hoffman Estates, IL	(578GF) LaSalle, IL	(578GG) Oak Lawn, IL
JAN-FY19	9.0	11.8	1.4	0.3	0.4	3.4	3.0	0.4
FEB-FY19	8.5	9.6	2.9	0.1	1.0	2.0	0.0	1.3
MAR-FY19	8.1	10.2	2.3	0.6	0.2	3.4	n/a	0.4
APR-FY19	7.8	6.4	3.3	1.3	0.5	4.3	n/a	0.7
MAY-FY19	7.6	7.9	1.8	4.3	2.0	2.8	0.0	1.1
JUN-FY19	7.6	7.3	2.4	0.1	2.4	3.4	0.0	3.0
JUL-FY19	7.3	7.9	4.5	1.3	2.0	0.5	0.0	0.9
AUG-FY19	7.4	6.8	12.7	2.6	1.5	1.6	0.0	1.3
SEP-FY19	7.3	7.4	3.5	4.4	2.1	2.2	3.0	1.1
OCT-FY20	6.9	9.8	2.9	0.9	3.2	3.3	1.2	1.4
NOV-FY20	7.1	7.1	2.4	3.6	1.4	6.0	0.7	1.8
DEC-FY20	7.8	6.5	0.9	0.9	1.9	9.5	0.0	0.9

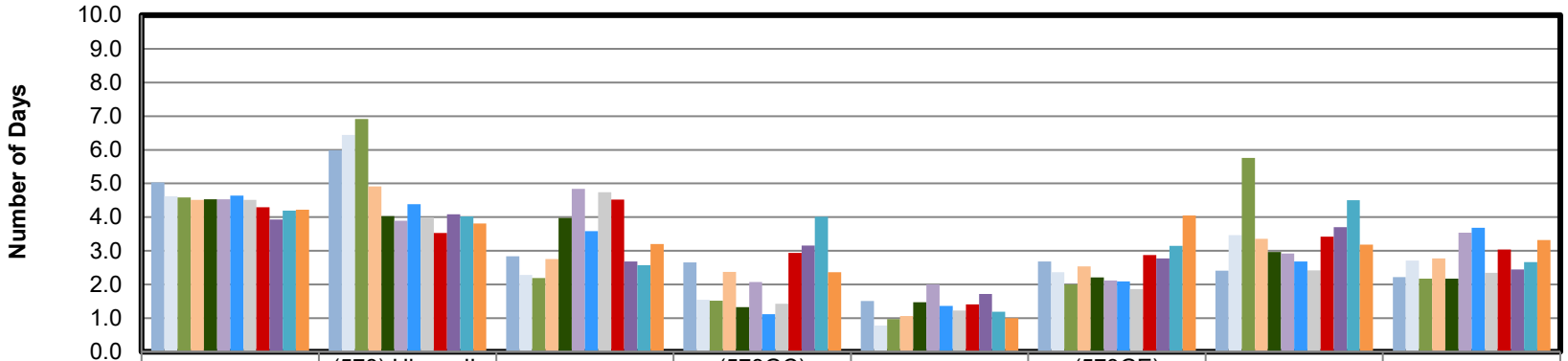
Source: VHA Support Service Center

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."

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

Quarterly Established Primary Care Patient Average Wait Time in Days



	VHA Total	(578) Hines, IL (Edward Hines, Jr.)	(578GA) Joliet, IL	(578GC) Kankakee County, IL	(578GD) Aurora, IL	(578GE) Hoffman Estates, IL	(578GF) LaSalle, IL	(578GG) Oak Lawn, IL
JAN-FY19	5.0	6.0	2.8	2.7	1.5	2.7	2.4	2.2
FEB-FY19	4.6	6.4	2.3	1.5	0.8	2.4	3.5	2.7
MAR-FY19	4.6	6.9	2.2	1.5	1.0	2.0	5.8	2.2
APR-FY19	4.5	4.9	2.8	2.4	1.1	2.5	3.4	2.8
MAY-FY19	4.5	4.0	4.0	1.3	1.5	2.2	3.0	2.2
JUN-FY19	4.5	3.9	4.8	2.1	2.0	2.1	2.9	3.5
JUL-FY19	4.6	4.4	3.6	1.1	1.4	2.1	2.7	3.7
AUG-FY19	4.5	4.0	4.7	1.4	1.2	1.9	2.4	2.3
SEP-FY19	4.3	3.5	4.5	2.9	1.4	2.9	3.4	3.0
OCT-FY20	3.9	4.1	2.7	3.2	1.7	2.8	3.7	2.4
NOV-FY20	4.2	4.0	2.6	4.0	1.2	3.1	4.5	2.7
DEC-FY20	4.2	3.8	3.2	2.4	1.0	4.0	3.2	3.3

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). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=9428. (The website was accessed on March 6, 2020, but is not accessible by the public.)

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

Source: VHA Support Service Center

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

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

[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.)

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

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 8, 2020

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

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

To: Director, Office of Healthcare Inspections (54CH01)

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

1. I have reviewed the Comprehensive Healthcare Inspection draft report of the Edward Hines, Jr. VA Hospital, Hines, IL.
2. I concur with the findings and recommendations proposed.
3. I concur with the submitted action plans from the facility.
4. I would like to thank the OIG Inspection team for a thorough review of the Edward Hines, Jr. VA Hospital, in Hines, IL.

(Original signed by:)

Lynnette J. Taylor, Deputy Network Director
for
Victoria P. Brahm, MSN, RN, VHA-C
Director, VA Great Lakes Health Care System (10N12)

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: June 23, 2020

From: Director, Edward Hines, Jr. VA Hospital (578/00)

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

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

1. Hines concurs with all recommendations. Reasons for noncompliance were considered and action plans were developed from our recent review.
2. Edward Hines, Jr. VA Hospital would like to respectfully request closure of recommendation 19 and recommendation 21 with attached documentation submitted to support closure. Attachments: Recommendation 19, Work Order Keypad and Recommendation 19 Keypad Picture; Recommendation 21 SPS Level 1 Training Certificates and Recommendation 21 SPS Employee Roster with Level 1 Completion Dates.
3. Edward Hines, Jr. VA Hospital would like to thank the Office of Inspector General (CHIP) Survey team for their professionalism and constructive feedback during our review.

(Original signed by:)

James Doelling
Hospital Director, Edward Hines Jr. VA Hospital

OIG Contact and Staff Acknowledgments

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