DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center in Chicago, Illinois

CHIP REPORT | REPORT #20-00077-211 | AUGUST 13, 2020

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Figure 1. *Jesse Brown VA Medical Center in Chicago, 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 at the Jesse Brown VA Medical Center, which includes an inpatient facility and multiple outpatient clinics in Illinois and Indiana. 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 Jesse Brown VA Medical Center and the Adam Benjamin, Jr. VA Outpatient Clinic. The OIG held interviews and reviewed processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this 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 leadership team consisted of the acting Medical Center Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Deputy Director, and Assistant Director. At the time of the site visit, the medical center's executive leadership committee, referred to as the Governing Board, had not met in two years and did not have an active charter. According to the Chief of Quality, Safety, and Value Service, executive leaders and chairs of top tier councils and committees report to the Medical Center Director outside of Governing Board meetings. The leaders monitor patient safety and care through the Quality Leadership Council which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the medical center leaders had been working together for approximately two weeks. The acting Medical Center Director was the newest member of the leadership team, having been detailed to the position in January 2020. The Chief of Staff had served a little over three months, and the ADPCS, Deputy Director and Assistant Director had been in their positions for more than a year. The Assistant Director, the most tenured leader, was permanently assigned in January 2017.

The OIG reviewed employee satisfaction survey results and concluded that there were opportunities for the leaders, except for the Deputy Director, to improve employee attitudes toward medical center leaders and various aspects of the workplace.[1] Selected patient experience survey scores showed that patients appeared satisfied with the care provided, but male and female patients' specialty care results were less favorable than corresponding gender-specific results for VHA patients nationally.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[2]

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.

[1] It is important to note that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current acting Medical Center Director and Chief of Staff, who assumed the roles after the survey was administered.

[2] 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."

The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[3]

In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. Further, the Chief of Staff, ADPCS, and Deputy Director were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. The Chief of Staff, ADPCS, and Deputy Director also demonstrated understanding of CLC SAIL measures.[4]

The OIG noted opportunities for improvement in seven clinical areas reviewed and issued 22 recommendations to the acting Medical Center Director, Chief of Staff, and ADPCS. These are briefly described below.

Quality, Safety, and Value

The medical center complied with requirements for quality, safety, and value committee establishment and most patient safety elements. However, the OIG identified deficiencies with utilization management processes.[5]

Medical Staff Privileging

The OIG identified deficiencies with professional practice evaluations, provider exit reviews, and state licensing board reporting.[6]

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[3] 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.)

[4] 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.

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

[6] 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."

Medication Management

The OIG observed compliance with initial pain screening. However, the OIG found deficiencies with aberrant behavior risk assessments, justification for concurrent opioid and benzodiazepine therapy, urine drug testing, informed consent, patient follow-up, and program oversight.

Mental Health

The OIG found compliance with requirements for a designated suicide prevention coordinator and suicide prevention-related data. However, the OIG noted concerns with missed appointment follow-up, suicide safety plans, and suicide prevention training.

Care Coordination

The medical center complied with expectations for the supervision of designees. However, there was no formal multidisciplinary committee to review proposed life-sustaining treatment plans.

Women's Health

The OIG found compliance with most requirements for women's health, including the provision of care and staffing requirements. The OIG noted concerns with the designation of women's health primary care providers and the Women Veterans Health Committee.

High-Risk Processes

The medical center complied with most elements of expected performance for reprocessing reusable medical equipment. However, the OIG identified concerns with standard operating procedures, the annual risk analysis, and competency assessments.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued 22 recommendations for improvement to the Medical Center Director, Chief of Staff, and ADPCS. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this medical center. The intent is for medical center leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if not addressed, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and System Director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 77–78, and the responses within the body of the report for the full

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

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Contents

Purpose and Scope

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

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

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

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (targeting long-term opioid therapy for pain)
6. Mental health (focusing on the suicide prevention program)
7. Care coordination (spotlighting life-sustaining treatment decisions)
8. Women's health (examining comprehensive care)
9. High-risk processes (emphasizing reusable medical equipment)[3]

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

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

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

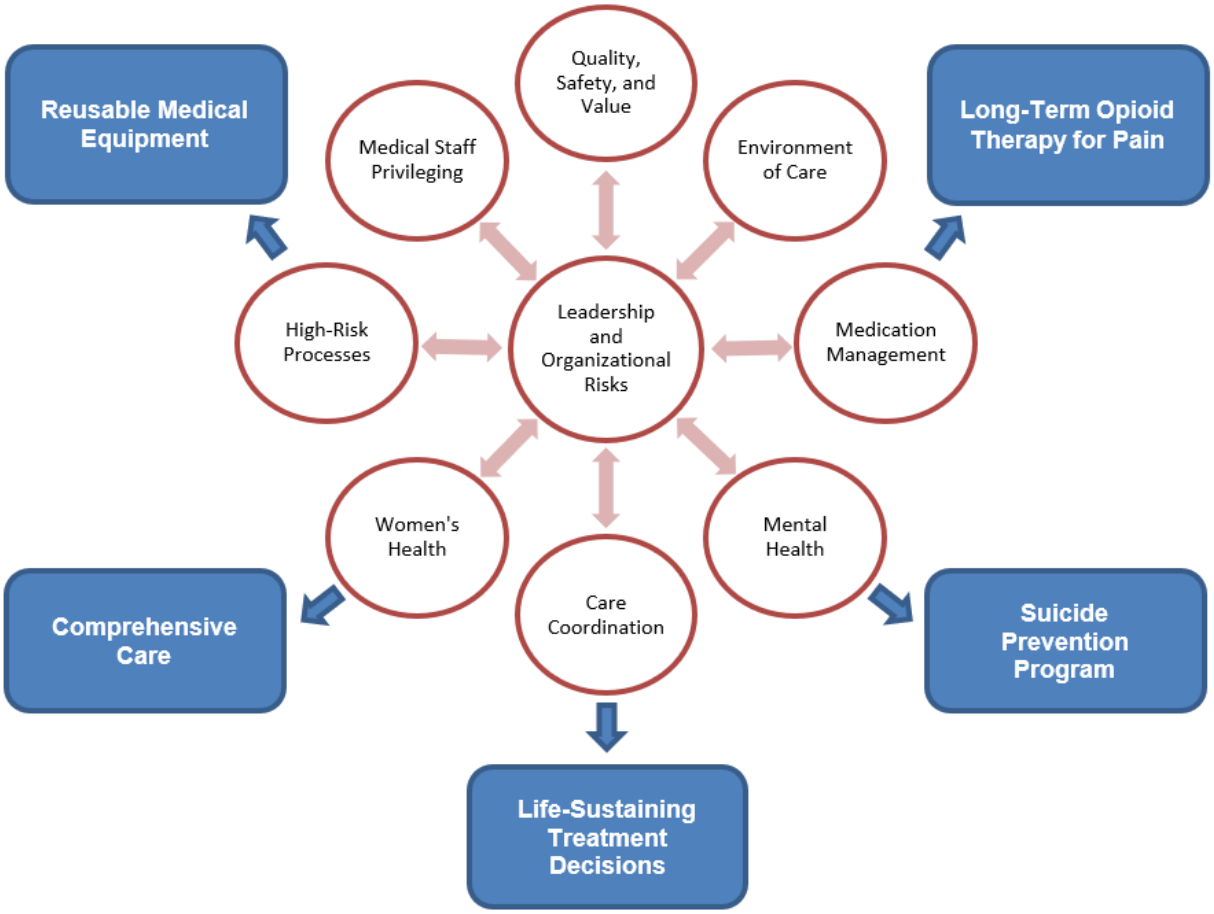

Figure 2. *Fiscal Year (FY) 2020 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

Methodology

The Jesse Brown VA Medical Center includes an inpatient facility and multiple outpatient clinics in Illinois and Indiana. 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 Adam Benjamin, Jr. VA Outpatient Clinic and the following areas of the Jesse Brown VA Medical Center:

- Acute psychiatric units
- Cardiology clinic
- Community living center (CLC)[5]
- Dental clinic
- Emergency Department
- Fast track/urgent care clinic
- Intensive care unit
- Medical/surgical inpatient units
- Pain clinic
- Primary care outpatient clinic (Red)
- Sterile Processing Services
- Telemetry/step-down unit
- Women's health clinic

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

[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.

The inspection examined operations from November 10, 2018, through January 30, 2020, the last day of the unannounced multiday site visit.[6] While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (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 system leaders developed based on the reasons for noncompliance.

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

[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.

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 (CLCs)

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this medical center's reported organizational structure. The medical center has a leadership team consisting of the acting Medical Center Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Deputy Director, and Assistant Director. The Chief of Staff, ADPCS, and Deputy Director 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.)

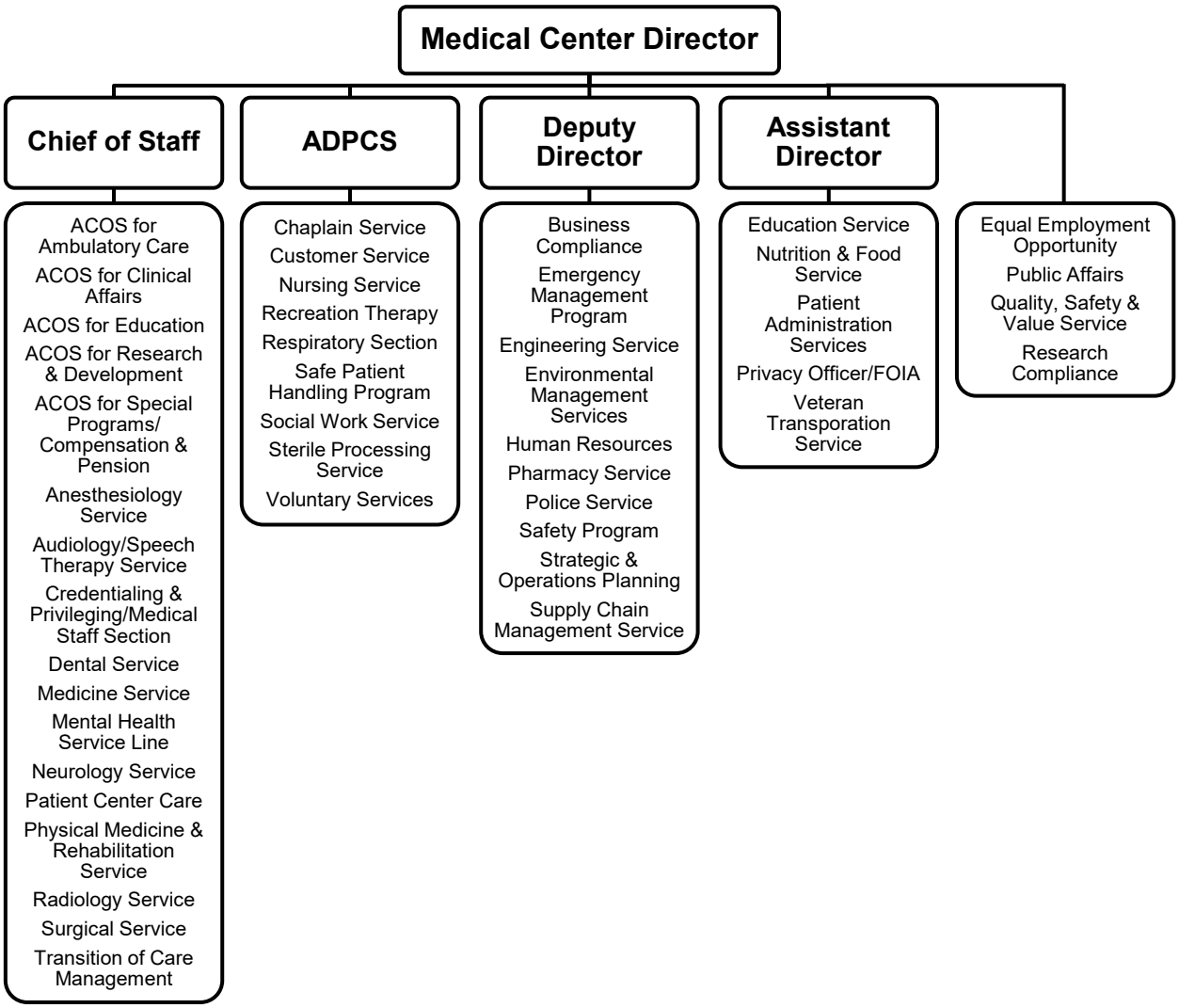

Figure 3. *Medical Center Organizational Chart*
Source: Jesse Brown VA Medical Center (received January 27, 2020)
ACOS = Associate Chief of Staff

At the time of the OIG site visit, the executive team had been working together as a group for approximately two weeks. The acting Medical Center Director, the newest member of the team, was assigned on January 9, 2020. The Chief of Staff had served in the role for just over three months, and the ADPCS, Deputy Director, and Assistant Director had been in their positions for more than a year. The Assistant Director, the most tenured leader, was permanently assigned in January 2017 (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	January 9, 2020 (acting)
Chief of Staff	October 13, 2019
Associate Director for Patient Care Services	April 29, 2018
Deputy Director	August 5, 2018
Assistant Director	January 22, 2017

Source: Jesse Brown VA Medical Center Chief of Human Resources Specialist (received January 27, 2020)

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

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

At the time of the site visit, the medical center's executive leadership committee, referred to as the Governing Board, had not met in two years and did not have an active charter. The Chief of Quality, Safety & Value Service (QSV) stated that executive leaders and chairs of top tier councils and committees reported to the Medical Center Director outside of Governing Board meetings.

The leaders monitor patient safety and care through the Quality Leadership Council, which the Medical Center Director co-chairs. The Quality Leadership Council is responsible for tracking and trending quality of care and patient outcomes. See Figure 4.

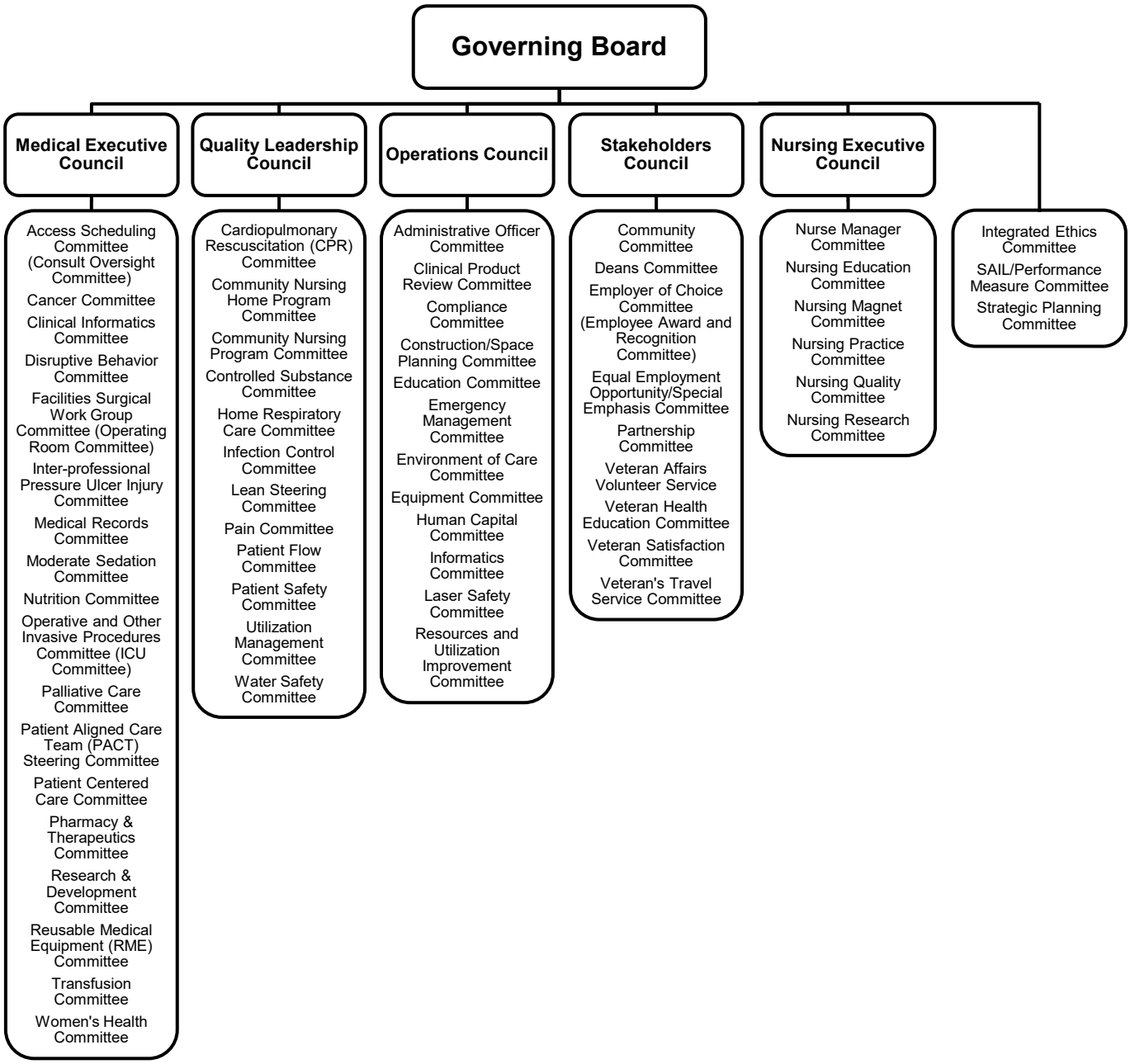

Figure 4. *Medical Center Committee Reporting Structure*
Source: Jesse Brown VA Medical Center Chief of QSV (received January 30, 2020)

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. The OIG found that the medical center averages for the specific survey leadership questions were similar to the VHA average.[9] The Deputy Director averages were markedly better than the VHA and medical center averages, and those for the Assistant Director scores were generally similar to or higher than the VHA and medical center averages. The OIG notes that the survey results reflect employee attitudes for the former medical center director but remains concerned that multiple opportunities appear to exist for the acting Medical Center Director, Chief of Staff, and ADPCS to improve employee attitudes toward medical center leaders.[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	Deputy 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	28.5	66.0	83.3	85.9	90.7

[8] Ratings are based on responses by employees who report to or are aligned under the Medical Center Director, Chief of Staff, ADPCS, Deputy Director, and 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 that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current acting Medical Center Director or Chief of Staff, who assumed the roles after the survey was administered.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Deputy Director Average	Asst. Director Average
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.4	3.5	1.9	2.6	3.1	4.0	3.4
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.6	1.9	2.4	3.1	4.1	3.5
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.7	2.1	3.2	3.3	4.3	3.1

Source: VA All Employee Survey (accessed 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 averages were similar to the VHA averages. Again, the Deputy Director scores were consistently better than those for VHA and the medical center; however, the other executive leaders appear to have opportunities to improve various aspects of the workplace.[13]

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

[13] It is important to note that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current acting Medical Center Director and Chief of Staff, who assumed the roles after the survey was administered.

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	Deputy Director Average	Asst. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.8	2.1	3.4	4.8	4.5	4.3
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	3.7	2.4	4.0	4.1	4.0	4.3
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.4	1.6	3.4	2.0	1.8	0.8	2.3

Source: VA All Employee Survey (accessed 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 Jesse Brown VA 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 center, the patient survey results generally reflected similar ratings compared to 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	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	63.5
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	87.4
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	81.3
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	77.2

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed 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,

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

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 most of the results for male and female respondents were on par with or above VHA national averages. However, male and female specialty care scores were consistently lower than the VHA average.

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	85.6	87.6
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	82.3	82.2
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	63.4	65.3

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

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

[16] The VHA averages are based on 48,259–48,789 male and 2,342–2,359 female respondents, depending on the question.

[17] The medical center averages are based on 444–448 male and 16–17 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	53.4	45.8
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.9	49.7	60.7	56.7
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.6	65.7	78.4	76.1

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

[18] The VHA averages are based on 79,450–241,828 male and 5,726–13,041 female respondents, depending on the question.

[19] The medical center averages are based on 457–1,110 male and 37–71 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	44.8	19.0
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	55.0	51.6	44.6
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	69.7	55.3

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed 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.[23] The Chief of QSV reported continuing to work with medical center managers to address the 11 open

[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 580–1,453 male and 32–77 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.

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

recommendations resulting from the prior OIG CHIP that was published on June 18, 2019.[24] At the time of the OIG visit, the medical center leaders had submitted all follow-up reports for the recommendations to the OIG for review.

The OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[25] The Long Term Care Institute also conducted an inspection of the medical center's CLC on April 22, 2019. Although one recommendation remained open at the time of the OIG's site visit, the Chief of QSV provided documentation showing the facility's progress toward recommendation closure.

Table 8. Office of Inspector General Inspection

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the Jesse Brown VA Medical Center, Chicago, Illinois*, Report No. 18-04673-138, June 18, 2019)	November 2018	11	11[26]

Source: OIG and TJC (inspection/survey results verified with the Chief of QSV and QSV Specialist on February 20, 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 system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 9 lists the reported patient safety events from

[24] OIG. *Comprehensive Healthcare Inspection Program Review of the Jesse Brown VA Medical Center, Chicago, Illinois*, Report No. 18-04673-138, June 18, 2019.

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

[26] As of June 2020, three recommendations from the FY 2019 CHIP inspection remained open.

November 10, 2018 (the day after the prior OIG comprehensive healthcare inspection), through January 27, 2020.[27]

The Chief of QSV, Patient Safety Manager, and Risk Manager provided details of one sentinel event that resulted in an institutional disclosure for a patient; however, the incident did not result in a death.

Table 9. Summary of Selected Organizational Risk Factors (November 10, 2018, through January 27, 2020)

Factor	Number of Occurrences
Sentinel Events[28]	1
Institutional Disclosures[29]	1
Large-Scale Disclosures[30]	0

Source: Jesse Brown VA Medical Center Patient Safety and Risk Managers (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 limitations for identifying all areas of clinical risk. The data are presented as one way to

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

[28] 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."

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

[30] 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."

"understand the similarities and differences between the top and bottom performers" within VHA.[31]

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 Jesse Brown VA Medical Center (for example, in the areas of mental health (MH) population (popu) coverage, registered nurse (RN) turnover, and best place to work). Metrics that need improvement are denoted in orange and red (for example, capacity, complications, and ambulatory care sensitive condition (ACSC) hospitalization).[32]

[31] 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.)

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

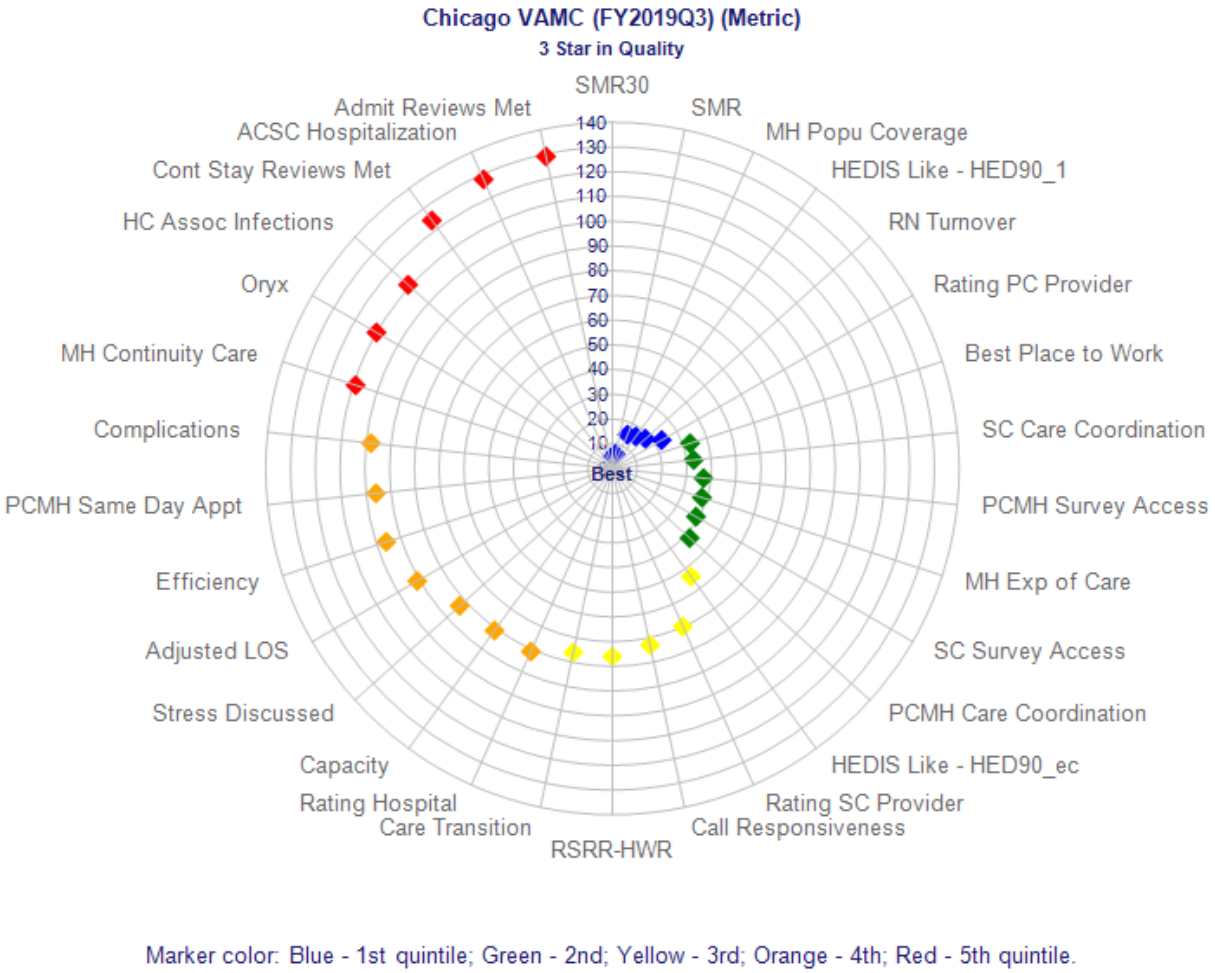

Figure 5. *System Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

Veterans Health Administration Performance Data for Community Living Centers

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

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

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 medical center's CLC (moderate-severe pain–short-stay (SS) and rehospitalized after nursing home (NH) admission (SS)). Metrics that need improvement are denoted in orange (discharged to community (SS) and improvement in function (SS)).

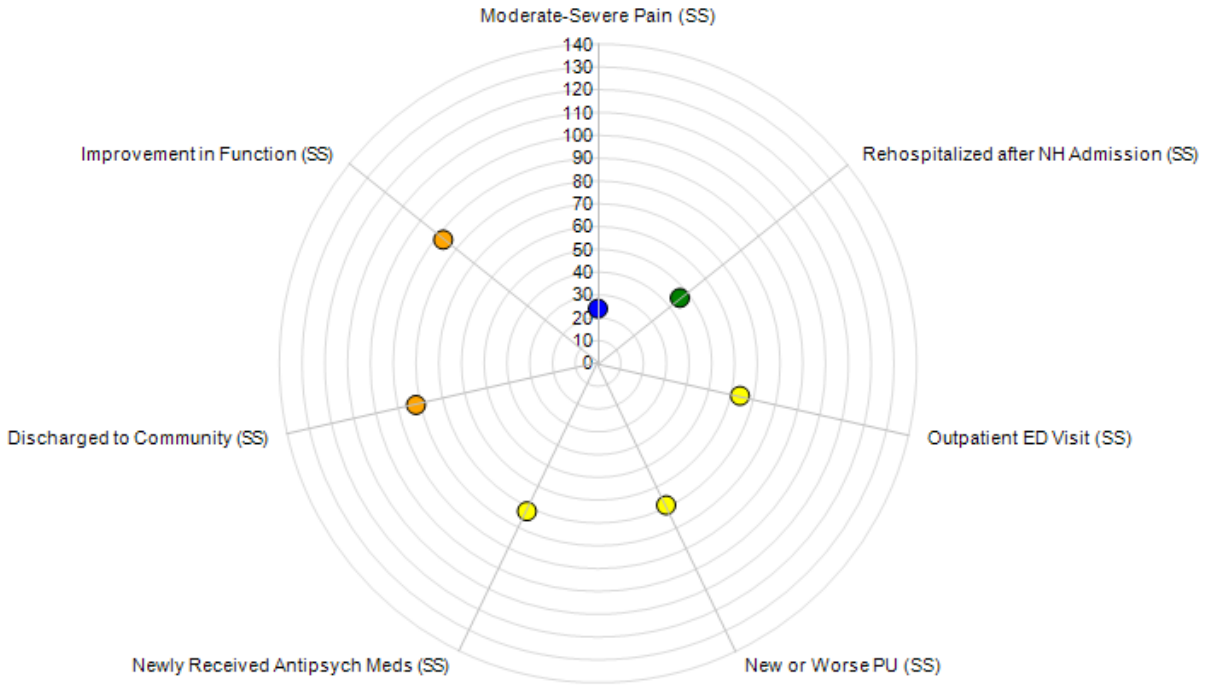

Figure 6. *Chicago CLC Quality Measure Rankings (as of September 30, 2019)*
LS = Long-Stay Measure *SS = Short-Stay Measure*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

[33] 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."

Leadership and Organizational Risks Conclusion

The medical center's executive leadership team was relatively new and had one vacancy in its five positions at the time of the January 27, 2020, site visit. The Medical Center Director had only served in an acting capacity for two weeks, and the Chief of Staff position had been filled for a little over three months. Survey scores related to employees' satisfaction revealed opportunities for the leaders to improve employee attitudes toward medical center leaders and various aspects of the workplace. Patient experience survey data showed that patients generally appeared satisfied with the care provided, but male and female specialty care experiences were less favorable than VHA patients nationally. The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. In individual interviews, the executive leaders were able to speak in depth about actions taken during the previous 12 months in order to maintain or improve employee satisfaction and patient experiences. In addition, the Chief of Staff, ADPCS, and Deputy Director were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models.

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.[34] 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.[35] 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.[36]

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.[37] 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.[38] 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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[34] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

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

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

[37] 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."

[38] 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[39]
- 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.[40] 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.[41] 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.[42] Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the medical center.[43] The medical center was assessed for its performance on several dimensions:

[39] VHA Directive 1190.

[40] 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."

[41] VHA Directive 1117(2).

[42] 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."

[43] VHA Handbook 1050.01.

- Annual completion of a minimum of eight root cause analyses[44]
- 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.[45]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with the requirement to establish a committee responsible for QSV oversight and most patient safety elements reviewed. However, the OIG identified weaknesses with UM processes.

VHA requires UM reviews be completed for at least 80 percent of all inpatient admissions.[46] The OIG found that UM reviewers performed 74 percent of required reviews from October 1, 2018, through September 30, 2019. This may have resulted in insufficient "evaluation of the appropriateness, medical need, and efficiency of health care services."[47] The Chief of QSV, Chief of Geriatrics, and UM Nurse Manager reported that a UM nurse vacancy and frequent unplanned downtimes for the national database were reasons for noncompliance.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that a minimum of 80 percent of inpatient utilization management reviews are completed.

[44] 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]."

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

[46] VHA Directive 1117(2).

[47] VHA Directive 1117(2).

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: Medical Center Response: The Medical Center Director did not determine any additional reasons for noncompliance and will ensure that a minimum of 75 percent of inpatient utilization management reviews are completed per UM Bulletin 20-4, dated March 27, 2020 reducing the minimum review threshold from 80 percent to 75 percent from the current VHA Directive 1117(2) Utilization Management Program, published April 20, 2019. Minimum requirements for completion will be increased as appropriate when UM Bulletin 20-4 is lifted or when VHA Directive 1117 (2) is updated. The inpatient utilization management reviews will be monitored for 6 consecutive months by the Utilization Management Committee with the expectation of 75 percent or greater compliance. The numerator will be the number of completed inpatient utilization management reviews and the denominator will be the number of required utilization management reviews of 75 percent or greater. This recommendation will be considered compliant when six consecutive months of required inpatient utilization management reviews have been completed at the required threshold of 75 percent. Compliance will be reported to the Utilization Management Committee monthly which reports to the Quality Leadership Council quarterly, which is co-chaired by the Medical Center Director.

VHA requires that "UM data are reviewed on an ongoing basis by an interdisciplinary group, including but not limited to representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR [chief business office revenue-utilization review]."[48] The OIG found the interdisciplinary committee responsible for reviewing UM data did not have consistent representation from CBO R-UR for 6 of 10 meetings from January 10, 2019 through November 14, 2019. Lack of consistent representation from all required disciplines may result in inefficient management of patient flow activities. The Chief of QSV reported that a compliance officer was mistakenly designated as a CBO R-UR representative for four meetings; this was corrected, but the new CBO R-UR representative missed two additional meetings.

Recommendation 2

2. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures all required representatives consistently participate in interdisciplinary utilization management data reviews.

[48] VHA Directive 1117(2).

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Medical Center Director evaluated reasons for noncompliance and determined no further reasons for noncompliance and will ensure that all required representatives consistently participate in interdisciplinary utilization management data reviews. Attendance will be taken monthly by the Chair of the Utilization Management Committee to ensure required members are present. This measure will be considered compliant when required members are present and documented as such at the monthly Utilization Management Committee meeting (numerator) compared to the required members of the Utilization Management meeting (denominator). This recommendation will be considered compliant when 90 percent or greater of the required members attend the Utilization Management monthly meetings for six consecutive months. Compliance will be reported to Quality Leadership Council quarterly, which is co-chaired by the Medical Center Director.

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).[49]

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 Medical Center Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[50]

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

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[52]
  - 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[53]
  - Evaluation by another provider with similar training and privileges

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

[50] VHA Handbook 1100.19.

[51] VHA Handbook 1100.19.

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

[53] 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.[54] 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."[55] 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:

- No solo/few practitioners who underwent initial or reprivileging during the previous 12 months[56]
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs privileged within 12 months before the visit
- Twenty LIPs who left the healthcare system in 12 months before the visit

Medical Staff Privileging Findings and Recommendations

The OIG identified deficiencies with FPPEs, provider exit reviews, and SLB reporting.

VHA requires FPPE results to be documented in an LIP's profile and reported to the Executive Committee of the Medical Staff (referred to locally as the Medical Executive Council) for

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

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

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

privileging decisions.[57] The Medical Executive Council is required to review and evaluate LIP privileging requests, and minutes must reflect the documents reviewed, the conclusion, and the recommendation for continuing privileges.[58] The OIG found the Professional Standards Board, a subgroup of the Medical Executive Council, did not document recommendation for continuing privileges in 8 of 10 profiles reviewed. This resulted in incomplete evidence to support privileging. The Chief of Staff was reportedly aware of this deficiency and believed the lack of credentialing staff to verify documentation in meeting minutes caused this outcome.

Recommendation 3

3. The Chief of Staff evaluates and determines additional reasons for noncompliance and makes certain that the Medical Executive Council documents conclusions and recommendations for continuation of privileges that are based on focused professional practice evaluation results.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Chief of Staff has evaluated and has not found any additional reasons for noncompliance. The Chief of Staff will ensure that documentation is provided for conclusions and recommendations for continuation of privileges based upon reporting of focused professional practice evaluation results with documentation included in the Medical Executive Council. Monitoring will be conducted by the Credentialing Coordinator and the Chief of Staff who will monitor compliance with the numerator being the inclusion of providers with documentation of continuation of privileges based on focused professional practice evaluation results and the denominator will be the number of focused professional practice evaluation reviewed. This recommendation will be considered compliant when documentation of 90 percent of focused professional practice evaluations demonstrate compliance for six consecutive months in Medical Executive Council.

VHA requires provider exit review forms, which document the review of a provider's clinical practice, to be completed within seven days of departure from the facility.[59] The OIG found that supervisors did not complete 16 of 20 provider exit review forms within the required timeframe. Failure to complete forms in a timely manner could delay reporting providers' potential substandard practice to state licensing boards. The Chief of Staff acknowledged the requirement and explained that the program specialist tasked with oversight had not developed a process to ensure timely completion of forms.

[57] VHA Handbook 1100.19.

[58] VHA Handbook 1100.19.

[59] VHA Notice 2018-05.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and verifies that first- or second-line supervisors complete provider exit review forms within seven calendar days of providers' departure from the medical center.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Chief of Staff has evaluated the reasons for noncompliance and has found no further reasons for noncompliance. The Chief of Staff will ensure completion of the exit form within seven calendar days of the providers departure from the Medical Center and it will be monitored by the Special Assistant to the Chief of Staff. The numerator will be the number of first- or second-line supervisors who completed the exit forms within seven calendar days of providers' departure and the denominator will be the number of identified providers who departed the medical center each month. This will be considered compliant when 90 percent or greater of exit reviews have been completed within seven days of the providers departure from the Medical Center for six consecutive months. Compliance will be reported to the Medical Executive Council chaired by the Chief of Staff.

VHA requires that service leaders immediately report a provider's failure to meet generally accepted practice standards to SLBs.[60] The OIG found that leaders did not report one provider who failed to meet practice standards as required. This could impact the SLB's evaluation of an LIP's practice and compromise patient safety. The Chief of Staff explained that the National Practitioner Data Bank reporting is only performed after the appeals process is completed; this process was confused with the immediate SLB reporting, which resulted in the delay.

Recommendation 5

5. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that service leaders immediately report a provider's failure to meet generally accepted standards of practice to state licensing boards.

[60] VHA Notice 2018-05.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Chief of Staff has reviewed and has found no further reasons for noncompliance. The reporting of providers who failed to meet generally accepted standard of practice to state licensing boards will be monitored monthly by the Special Assistant to the Chief of Staff for six consecutive months with the expectation of 90 percent or greater compliance. The numerator is the number of providers reported to the state licensing board and the denominator will be the number of providers required to be reported to the state licensing boards. Compliance will be reported monthly to the Medical Executive Council in which minutes are signed by the Medical Center Director.

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.[61]

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

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

- Special use spaces
- Environmental cleanliness and infection prevention
- Privacy
- Privacy for women veterans
- Logistics

During its review of the environment of care, the OIG team inspected the Adam Benjamin, Jr. VA Outpatient clinic and 14 patient care areas of the medical center:

- Acute psychiatric units (7 east and west)
- Cardiology clinic
- CLC (6 west)
- Dental clinic
- Emergency Department
- Fast track/urgent care clinic
- Intensive care unit
- Medical/surgical inpatient units (5 east and west)
- Pain clinic
- Primary care outpatient clinic (Red)
- Telemetry/step-down unit (6 east)
- Women's health clinic

The inspection team reviewed relevant documents and interviewed key employees and managers.

Environment of Care Findings and Recommendations

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

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[62] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[63] 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.[64] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[65]

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.[66] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[67] 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.[68] 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.[69]

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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[62] 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.)

[63] 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.)

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

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

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

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

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

[69] *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.[70] 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 24 selected outpatients who had newly-dispensed (no VA dispensing in previous six months) long-term opioids for pain, daily or intermittently for 90 or more calendar days through VA from July 1, 2018, through June 30, 2019. The team considered whether providers acted in accordance with guidelines for the provision of pain management and the medical center's oversight process for evaluating pain management outcomes and quality.

Medication Management Findings and Recommendations

The medical center met the requirements for initial pain screening. However, the OIG found deficiencies with aberrant behavior risk assessments, justification for concurrent opioid and benzodiazepine therapy, urine drug testing, informed consent, patient follow-up, and program oversight.

The VA/DoD clinical practice guidelines recommend that clinicians complete an aberrant behavior risk assessment that includes a history of substance abuse, psychological disease, and aberrant drug-related behaviors[71] prior to initiating long-term opioid therapy.[72] The OIG determined that clinicians assessed patients for a history of substance abuse in 58 percent of electronic health records and psychological disease and aberrant drug-related behaviors in 46 percent.[73] This may have resulted in clinicians prescribing opioids for patients at high risk for

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

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

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

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

misuse.[74] The Chief of Medicine and Chief of Primary Care reported that clinicians believed reviewing the existing medical history met the requirement. The chiefs also stated that clinicians initiate long-term opioid therapy infrequently which resulted in unintentional omissions.

Recommendation 6

6. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that clinicians complete an aberrant behavior risk assessment that includes a history of substance abuse, psychological disease, and aberrant drug-related behaviors on all patients prior to initiating long-term opioid therapy.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Chief of Staff has reviewed the reasons for noncompliance and has found no additional reasons for noncompliance. The Chief of Staff will ensure that clinicians complete an aberrant risk assessment that includes, history of substance abuse, psychological disease, and aberrant drug-related behaviors prior to initiating long-term opioid therapy. Thirty records will be reviewed monthly by the Pain Specialty Provider to ensure each element is completed prior to initiating long-term opioid therapy (numerator). If less than thirty records are available, a 100% review will be completed (denominator). This recommendation will be considered compliant when 90% or greater of records reviewed include each element for six consecutive months. Compliance will be reported to Medical Executive Council monthly.

VA/DoD clinical practice guidelines recommend avoiding co-administration of drugs, such as an opioid and benzodiazepine, that could induce fatal drug-drug interactions.[75] The OIG found that 2 of 24 patients reviewed were concurrently prescribed opioids and benzodiazepines. For both patients, there was no documented justification for concurrent therapy.[76] This may have resulted in an increased risk of harm and potentially fatal interactions.[77] The Chiefs of Medicine and Primary Care reportedly believed that clinicians who ordered opioids reviewed the notes of other providers who had prescribed benzodiazepines; however, they acknowledged there was no evidence that clinicians discussed the risks and benefits with patients or justified concurrent therapy.

[74] Edward Michna, Edgar Ross, Wilfred Hynes, Srdjan Nedeljkovic, Sharonah Soumekh, David Janfaza, Diane Palombi, and Robert Jamison, "Predicting Aberrant Drug Behavior in Patients Treated for Chronic Pain: Importance of Abuse History," *Journal of Pain and Symptom Management,* 28, no. 3 (September 2004). https://doi.org/10.1016/j.jpainsymman.2004.04.007. (The website was accessed on December 4, 2019.)

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

[76] Estimates are not calculated for sample sizes less than 11.

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

Recommendation 7

7. The Chief of Staff determines the reasons for noncompliance and makes certain that clinicians document justification for concurrent opioid and benzodiazepine medication therapy.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Chief of Staff has reviewed the reasons for noncompliance and has found no additional reasons for noncompliance. The Chief of Staff and Pain Specialty Provider will ensure that the clinicians address need for documentation of justification for the concurrent opioid and benzodiazepine medication therapy. A monthly audit will be completed with the numerator being the number of patients with assessments completed and denominator is number of new patients newly identified as being on concurrent therapy reviewed at 60-90 days. This recommendation will be considered compliant when 90 percent or greater of medical records reviewed each month include the documented justification for concurrent opioid and benzodiazepine medication therapy for six consecutive months. Compliance will be reported monthly to the Medical Executive Council in which the Chief of Staff is chair.

VA/DoD clinical practice guidelines recommend that clinicians conduct urine drug testing prior to initiating long-term opioid therapy and in the event of a significant change in the patient's condition and periodically thereafter.[78] The OIG determined that clinicians conducted initial urine drug testing in 67 percent of electronic health records reviewed.[79] This could have resulted in missed identification of patients who had active substance use disorders, tested positive for illicit substances, or diverted controlled substances.[80] The Chief of Medicine explained that providers initiate long-term opioid therapy infrequently which resulted in unintentionally omitting required elements.

Recommendation 8

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

Medical center concurred.

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

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

[80] Edward Michna, Edgar Ross, Wilfred Hynes, Srdjan Nedeljkovic, Sharonah Soumekh, David Janfaza, Diane Palombi, and Robert Jamison, "Predicting Aberrant Drug Behavior in Patients Treated for Chronic Pain: Importance of Abuse History," Journal of Pain and Symptom Management, 28, no. 3 (September 2004). *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

Target date for completion: January 31, 2021

Medical center response: The Chief of Staff has reviewed the reasons for noncompliance and has found no additional reasons for noncompliance. The Chief of Staff will ensure that health care providers conduct and document urine drug testing for patients prior to initiating or continuing long-term opioid therapy, and periodically thereafter. A monthly list of new patients compiled by pharmacy will be reviewed by the Pain Specialty Provider at 60-90 days. Thirty records will be reviewed by the Pain Specialty Provider to ensure healthcare providers have obtained and documented urine drug testing as required for patients on long term opioid therapy. If less than thirty records are noted from the monthly list, 100 percent of eligible patients will be reviewed monthly by the Pain Committee for six consecutive months with the expectations of 90 percent or greater compliance. The numerator will be the number of patients with documentation having urine drug testing prior to initiating or continuing on long term opioid therapy and the denominator will be the patients identified as urine drug testing being required. Compliance will be reported monthly in Medical Executive Council which the Chief of Staff is chair.

VHA requires opioid prescribers to obtain and document informed consent prior to initiating long-term opioid therapy. VHA also recommends that informed consent conversations cover the risks and benefits of opioid therapy, as well as alternative therapies.[81] The OIG determined that clinicians documented informed consent in 67 percent of electronic health records reviewed.[82] Failure to document informed consent may result in patients receiving treatment without knowledge of the risks associated with long-term opioid therapy, which include opioid dependence, tolerance, addiction, and intentional or unintentional fatal overdose.[83] The Chief of Medicine stated that providers did not initiate informed consent when a patient transferred long-term opioid therapy management from a non-VA provider to a VA provider.

Recommendation 9

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

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Chief of Staff has reviewed the reasons for noncompliance and has found no additional reasons for noncompliance. The Chief of Staff will ensure that healthcare

[81] VHA Directive 1005.

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

[83] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*; VHA Directive 1005.

providers consistently obtain and document informed consent prior to initiating long-term opioid therapy. Thirty records will be reviewed monthly by the Pain Specialty Provider to ensure healthcare providers obtain and document informed consents for patient prior to initiating long-term opioid therapy. If less than 30 records are available, a 100 percent review will be completed. The number of patients newly started on long-term opioid therapy that have documented informed consent will be the numerator and the number of patients newly started on long-term opioid therapy will be the denominator. This recommendation will be considered compliant when 90 percent or greater of records reviewed include an informed consent prior to initiating long-term opioid therapy for six consecutive months. Compliance will be reported monthly to the Medical Executive Council in which the Chief of Staff is chair.

VHA requires clinicians to follow up with patients within three months after initiating long-term opioid therapy to evaluate the "benefits of continued opioid therapy and risk for opioid-related adverse events" [84] and assess adherence, effectiveness of interventions, and achievement of goals in the pain management plan.[85] The OIG determined that clinicians completed timely follow-up in 75 percent of the patient records reviewed.[86] In addition, the OIG identified that follow-up included assessment of adherence to the pain management care plan in 87 percent of records and intervention effectiveness in 80 percent of electronic health records reviewed.[87] This may have resulted in missed opportunities to assess effectiveness of treatment and risks associated with continued opioid therapy.[88] The Chiefs of Medicine and Primary Care reported that follow-up occurred prior to the beginning of long-term opioid therapy, during the short-term opioid therapy period, believing that this met requirements. The chiefs also explained that the patient appointment time is limited which providers find challenging when trying to address the chief compliant and follow up on several chronic issues.

Recommendation 10

10. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that clinicians follow up with patients within the required time frame after initiating long-term opioid therapy.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Chief of Staff has reviewed and evaluated the reasons and has found no additional reasons for noncompliance for provider follow-up with patients within the

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

[85] VHA Directive 2009-053.

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

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

[88] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*; VHA Directive 2009-053.

required three-month time frame after initiating long term opioid therapy. Thirty records will be reviewed monthly by Pain Specialty Provider to ensure healthcare providers follow-up with patients at the three-month time frame after initiating long term opioid therapy. If less than thirty records are available, a 100 percent review will be completed. The numerator will be number of eligible patients receiving the required three-month time frame documented follow-up care and denominator will be number of eligible patients reviewed with the need for follow-up documentation. This recommendation will be considered compliant when 90 percent or greater of records reviewed include documentation of the follow-up care within the required time frame after initiating long-term opioid therapy for six consecutive months. Compliance will be reported monthly to the Medical Executive Council in which the Chief of Staff is chair.

Recommendation 11

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

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Chief of Staff has reviewed and evaluated the reasons for noncompliance and has found no additional reasons for noncompliance with providers providing follow-up with patients receiving long-term opioid therapy ensuring that there is a pain management care plan adherence and documentation of intervention effectiveness. Thirty records will be reviewed monthly by the Pain Specialty Care Provider to ensure healthcare providers follow-up care includes an assessment of pain management care plan adherence and intervention effectiveness. If less than thirty records are available, a 100 percent of eligible patients will be reviewed. The numerator will be the number of patient charts that have documentation for pain assessments care plan adherence and effectiveness of interventions documented and the denominator will be the number of eligible patients required to have pain assessment care plans adherence and effectiveness of pain interventions documented. This recommendation will be considered compliant when 90 percent or greater of the charts reviewed include the above elements for six consecutive months. Compliance will be reported monthly to the Medical Executive Council in which the Chief of Staff is chair.

VHA requires the medical center to have a multidisciplinary pain management committee to provide oversight of pain management activities and processes, including "the quality of pain assessment and effectiveness of pain management interventions".[89] TJC requires the medical center to ensure that deficiencies or opportunities for improvement are identified and action plans are implemented.[90] The OIG reviewed the Pain Committee minutes from July 26, 2019 through October 18, 2019, and found no evidence that the committee monitored the required quality measures. As a result, the committee was unable to report patterns or trends for quality improvement to medical center leaders.[91] The Chief of Pain Service stated that QSV staff monitored quality measures and agreed that this was the Pain Committee's responsibility.

Recommendation 12

12. The Medical Center Director determines the reasons for noncompliance and makes certain that the Pain Committee monitors the quality of pain assessment and effectiveness of pain management interventions.

[89] VHA Directive 2009-053.

[90] TJC. Leadership standards LD.03.02.01, LD.03.05.01; Performance Improvement standard PI.03.01.01.

[91] TJC. Leadership Standard (LD).03.02.01.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Medical Center Director has determined the reasons for noncompliance and has found no additional reasons for noncompliance. The Medical Center Director has directed the Pain Specialty Provider to conduct monitors to evaluate the quality of pain assessments and effectiveness of the pain management interventions. Thirty records will be reviewed monthly by the Pain Committee to ensure that the quality of pain assessment and effectiveness of pain management interventions are documented. If less than thirty records are available, a 100 percent review will be completed. The numerator will be the number of patient records with documentation of appropriate pain assessment and management of interventions for effectiveness and the denominator will be the number of eligible patients who require pain assessment and management of interventions for effectiveness. This recommendation will be considered compliant when 90 percent or greater of the charts reviewed include the above elements for six consecutive months. Compliance will be reported monthly to the Medical Executive Council in which minutes are signed by the Medical Center Director.

Mental Health: Suicide Prevention Program

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

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

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

- Assignment of a full-time SPC
- Tracking and follow-up of high-risk veterans
    - 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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[92] Centers for Disease Control and Prevention. *Preventing Suicide*. https://www.cdc.gov/violenceprevention/suicide/fastfact.html. (The website was accessed on March 4, 2020.)

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

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

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

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

in his or her electronic health record "as soon as possible but no later than 1 business day after such determination by the SPC."[97] According to VHA, "Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death…The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions."[98] The HRS PRF is reviewed at least every 90 days and depending on changes to the suicide risk status, will remain active or be removed.[99] Additionally, VHA requires designated high-risk patients to have a completed suicide safety plan and four face-to-face visits with an acceptable provider within the first 30 days of designation.[100]

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

- The "SPC exclusively controls the HRS-PRF and must limit their use to patients who meet the criteria of being placed on the facility high-risk suicide list."
- "The time frame of placing the flag begins once the SPC makes the determination that an HRS-PRF is warranted."
- The SPC's determination process "may be beyond 24 hours after a referral, due to case consultation and review."[103]

The OIG is concerned that the updated requirement may result in delayed placement of HRS PRFs for at-risk patients. Without defined time frames for SPC determination that the HRS PRF

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

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

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

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

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

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

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

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."[104]

Inspectors examined the completion of several requirements:

- Review of HRS PRFs within the required time frame
- Completion of at least four mental health visits within 30 days of HRS PRF placement
- Appropriate follow-up for no-show high-risk appointments
- Completion of suicide safety plans with the required elements within the required time frame

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

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

- Relevant documents;

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

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

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

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

- The electronic health records of 46 outpatients whose electronic health records were flagged as high risk for suicide from July 1, 2018, to June 30, 2019; and
- Staff training records.

Mental Health Findings and Recommendations

The OIG found the medical center had complied with requirements for a designated SPC and suicide prevention-related data.

However, the OIG found deficiencies. With VHA's original requirement that was in place when these patients received care—that "Any patient determined to be High Risk for Suicide must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"[108]—the OIG estimated that 46 percent of HRS PRFs were placed by the end of the next day following referral to the SPC.[109] But based on the current updated requirement that the SPC be responsible for determining placement of the HRS PRF (without a defined timeframe for doing so), the OIG further calculated the average time from referral to HRS PRF placement for the patients reviewed was 3 days (observed range was 0–11 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.[110] The OIG estimated that 70 percent of patients with an HRS PRF were reevaluated at least every 90 days.[111] However, based upon the updated requirement that an HRS PRF be reviewed up to 10 days prior to or after the due date for reevaluation, the OIG found that 26 of 46 patients were reviewed within the expected time frame (observed range was 1–114 days).

Additionally, the OIG noted concerns with missed appointment follow-up, suicide safety plans, and suicide prevention training.

VHA requires that mental health teams attempt to contact patients with an HRS PRF who miss or fail to attend mental health or substance abuse appointments. Further, when attempted contact is unsuccessful, the SPC is required to collaborate with the treatment provider(s) to determine the next appropriate step.[112] The OIG estimated that mental health providers contacted the patient or collaborated with the SPC in 55 percent of electronic health records reviewed.[113] Failure to

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

[109] The OIG estimated that 95 percent of the time, the true compliance rate is between 31.8 and 60.0 percent, which is statistically significantly below the 90 percent benchmark.

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

[111] The OIG estimated that 95 percent of the time, the true compliance rate is between 55.8 and 82.8 percent, which is statistically significantly below the 90 percent benchmark.

[112] DUSHOM Memorandum, *Guidance on Patients Failure to Attend Appointments (No Shows)*, August 6, 2013.

[113] The OIG estimated that 95 percent of the time, the true compliance rate is between 31.8 and 76.9 percent, which is statistically significantly below the 90 percent benchmark.

connect with patients after missed appointments could result in providers not being able to evaluate safety plan efficacy or assess for suicidality.[114] The SPC was unable to provide a reason for noncompliance and stated that teams may have forgotten to document in-person or telephonic collaborations.

Recommendation 13

13. The Chief of Staff determines the reasons for noncompliance and ensures that mental health providers consistently contact or attempt to contact high-risk patients who miss mental health or substance abuse appointments and properly document those efforts.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Chief of Staff has reviewed the noncompliance of mental health providers consistently contacting or attempting to contact high risk patients who miss mental health or substance abuse appointments as well as the documentation of those efforts and found no additional reasons for noncompliance. The Chief of Staff will ensure that the Suicide Prevention Coordinators update the Mental Health Service Line policy High Risk for Suicide, No-Show Follow-up Procedures to align with Deputy Under Secretary for Health Operations and Management (10N) Guidance on Patients Failure to Attend Appointments (No-Shows) Memorandum dated August 6, 2013. The No Show report will be reviewed by the Suicide Prevention Coordinator to conduct audits of Mental Health and Substance Abuse appointment to ensure proper follow-up has been conducted and documented. Thirty records or 100 percent of eligible patients (whichever is the greater number) medical records will be reviewed monthly by the Suicide Prevention Coordinator for six consecutive months with the expectation of 90 percent compliance. The numerator is the number of Mental Health or substance abuse patient appointments from the no show report with documented follow-up and the denominator being the number of patients required to receive follow-up for no show Mental Health or substance abuse appointments. Monthly reports will be provided to the Medical Executive Council in which the Chief of Staff is chair.

VHA also requires that any patient with a high-risk designation have a completed suicide safety plan within seven days of the current HRS PRF.[115] The OIG estimated that safety plans were

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

[115] *VA's Integrated Approach to Suicide Prevention: Ready Access to Care Suicide Prevention Coordinator Guide*, January 5, 2018; VHA suicide subject matter expert response to timing of safety plan completion, July 8, 2019.

completed within the required time frame in 69 percent electronic health records reviewed.[116] Completion of safety plans within the required time ensures the patient has a "prioritized written list of coping strategies…to help them lower their imminent risk of suicidal behavior."[117] The SPC stated that patient scheduling preferences, cancellations, and no-shows pushed face-to-face safety plan appointments outside the required time frame.

Recommendation 14

14. The Chief of Staff evaluates and determines any additional reasons for noncompliance and verifies that providers complete safety plans within the required time frame for patients with High Risk for Suicide Patient Record Flags.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Chief of Staff has reviewed the reasons for noncompliance with completion of safety plans being placed in the required time frame for patients with High Risk for Suicide Patient Record Flags and has found no additional reasons for noncompliance. The Chief of Staff will ensure that the inpatient Mental Health treatment team complete safety plans for High Risk for Suicide Patients prior to discharge from the medical center. Outpatient Mental Health providers will complete the Suicide Prevention Safety Plan on the same day of referral. The Suicide Prevention Coordinators will audit the Safety Plan completion for all newly assigned /reactivated High Risk for Suicide patients. Thirty records or 100 percent of eligible patients (whichever is the greater number) will be reviewed monthly until there is six consecutive months with 90 percent compliance or above. The numerator will be the number of patients with a safety plan completed for high risk for suicide in the required time frame and the denominator will be the number of patients reviewed which required safety plan completion for high risk for suicide. Monthly reports will be provided to the Medical Executive Council in which the Chief of Staff is chair.

VHA also requires that suicide safety plans include contact information for mental health professionals or agencies.[118] The OIG estimated that 77 percent of safety plans included contact information for mental health professionals or agencies.[119] Failure to complete safety plans with all required elements may impede a patient's ability to access support before or during suicidal

[116] The OIG estimated that 95 percent of the time, the true compliance rate is between 54.8 and 83.3 percent, which is statistically significantly below the 90 percent benchmark.

[117] VHA manual, *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version*, August 20, 2008.

[118] VHA manual, *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version*.

[119] The OIG estimated that 95 percent of the time, the true compliance rate is between 63.4 and 89.5 percent, which is statistically significantly below the 90 percent benchmark.

crises.[120] The SPC was reportedly unaware that contact information was incomplete and believed that including only the name of the mental health professional or agency met requirements.

Recommendation 15

15. The Chief of Staff evaluate and determines any additional reason for noncompliance and makes certain that suicide prevention safety plans include all required elements.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Chief of Staff has reviewed the reasons for noncompliance with suicide prevention safety plans having all the required elements and has found no additional reasons for noncompliance. The Chief of Staff will ensure that all the required elements are addressed in the suicide prevention safety plan. Thirty medical records or 100 percent of eligible patients (whichever is the greater number) will be reviewed monthly by the Suicide Prevention Coordinator for six consecutive months with the expectation of 90 percent compliance. The numerator will be the number of patients reviewed with safety plan that includes all of the required elements and denominator will be the number of patients reviewed that required a Suicide Prevention safety plan. Monthly reports will be provided to the Chief of Staff and quarterly reporting to the Medical Executive Council in which the Chief of Staff is chair.

VHA requires that all employees complete suicide risk and intervention training within 90 days of entering their position. VHA also requires that all staff , regardless of hire date, complete annual refresher training thereafter.[121] The OIG found that of the 20 staff records reviewed, four of the six staff hired after January 1, 2018, did not complete training within the expected time frame and 16 of 20 staff had no evidence of annual refresher training. Lack of training could prevent staff from providing optimal treatment for patients with suicidal ideations.[122] The Chief of Mental Health stated that each service chief was responsible for monitoring respective staff's compliance; therefore, the SPCs did not monitor training completion.

Recommendation 16

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

[120] VHA manual, *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version*.

[121] VHA Directive 1071.

[122] VHA Directive 1071.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Medical Center Director has reviewed and determined the reasons for noncompliance of completion of suicide risk and intervention training within 90 days of entering their position and annual suicide prevention refresher training thereafter and has found no additional reasons for noncompliance. The Medical Center Director has implemented monthly compliance reviews of the suicide prevention mandatory training. Training compliance will be monitored for suicide risk and intervention training for staff provided within 90 days of entering their position and annual suicide prevention refresher training for all medical center staff by the Suicide Prevention Coordinator and the TMS Coordinator. The numerator will be number of personnel who have completed the training within 90 days of entering their position and annually for all other medical center staff and the denominator is all medical center staff who are required to complete the training within 90 days of entering the position and those who are to complete annual suicide prevention training. The service specific compliance lists will be monitored for six consecutive months with expectation of 90 percent compliance for training within 90 days of hire and annually. Compliance will be reported monthly by the Suicide Prevention Coordinator at the Quality Leadership Council. Quality Leadership Council is co-chaired by the Medical Center Director.

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."[123]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.[124] 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.[125] 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.[126]

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.

[123] 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.

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

[125] 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.

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

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

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

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

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

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

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[127] 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 49 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

[127] VHA Handbook 1004.03(1).

Care Coordination Findings and Recommendations

The OIG found that the medical center generally complied with requirements for supervision of designees. Additionally, with VHA's original requirements that were in place when these patients received care, the OIG estimated that

- 77 percent of patients' LST progress notes addressed identification of a surrogate if the patient loses decision-making capacity,[128]
- 62 percent of patients' LST progress notes addressed previous advance directive(s), state-authorized portable orders, and/or LST notes, and[129]
- 70 percent of patients' LST progress notes addressed the patient's or surrogate's understanding of the patient's condition.[130]

However, VHA recently dropped requirements for the documentation of these elements in the LST progress note. The OIG remains concerned that this change could result in practitioners not addressing these important goals of care conversation elements.

Additionally, the OIG identified concerns with a multidisciplinary committee to review proposed LST plans.

VHA requires the Medical Center Director to appoint "a multidisciplinary committee for review of proposed LST plans for patients who lack decision-making capacity and have no surrogate."[131] The OIG found that the medical center lacked a multidisciplinary committee. Not having an established committee or formal review process may impede effective decision-making for initiation, limitation, or discontinuation of life-sustaining treatments for incapacitated patients.[132] The Chair of the Integrated Ethics Council detailed an informal process to review LST plans; however, acknowledged that there was no formal multidisciplinary committee.

Recommendation 17

17. The Medical Center Director determines the reasons for noncompliance and makes certain that a multidisciplinary life-sustaining treatment decisions committee is established to review all proposed plans.

[128] The OIG estimated that 95 percent of the time, the true compliance rate is between 63.8 and 87.8 percent, which is statistically significantly below the 90 percent benchmark.

[129] The OIG estimated that 95 percent of the time, the true compliance rate is between 47.8 and 75.5 percent, which is statistically significantly below the 90 percent benchmark.

[130] The OIG estimated that 95 percent of the time, the true compliance rate is between 56.5 and 83.0 percent, which is statistically significantly below the 90 percent benchmark.

[131] VHA Handbook 1004.03(1).

[132] University of Washington School of Medicine, *Ethics Committees, Programs and Consultation*, accessed June 4, 2019.

Medical center concurred.

Target date for completion: August 31, 2020

Medical center response: The Medical Center Director has reviewed the reasons for noncompliance and has found no additional reasons for noncompliance. The Medical Center Director has determined the Palliative Care Committee will be the multidisciplinary committee in which life sustaining treatment decisions will be reviewed and monitored. The item of life sustaining treatment decisions will be added as a standing agenda item for the committee so when needed for review this committee will do so. The Palliative Committee charter will be changed to reflect this additional responsibility. This recommendation will be considered compliant when the Palliative Care Committee charter is updated with the life-sustaining treatment decision responsibility and it is added as a standing agenda item to the Palliative Care Committee agenda. Completion of the action will be reported to Quality Leadership Council in which the Medical Center Director is co-chair.

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[133] 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.[134] 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."[135] 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."[136]

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.[137] 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."[138]

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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[133] 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.)

[134] 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.)

[135] 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.)

[136] 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.)

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

[138] VHA Directive 1330.01(2).

  - 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 position filled
  - Women's Health Medical Director or clinical champion on staff
  - Maternity Care Coordinator position filled
  - Women's health clinical liaison is assigned at each CBOC

Women's Health Findings and Recommendations

The medical center complied with most of the provision of care indicators and staffing requirements. However, the OIG identified weaknesses with the designation of women's health primary care providers and the Women Veterans Health Committee.

Specifically, VHA requires that each site of care, including CBOCs, have at least two designated women's health primary care providers (WH-PCPs) or arrangements for leave coverage when there is only one designated WH-PCP.[139] The OIG found that the parent facility and all four CBOCs lacked appropriate arrangements for coverage when the sole designated WH-PCP was on leave. Inadequate staffing of WH-PCPs may limit the system's ability to provide comprehensive healthcare services to women veterans. The Women Veterans Program Manager

[139] VHA Directive 1330.01(2).

expressed awareness of the requirement and reported that limited space, inadequate availability of workstations, and construction projects resulted in delays in hiring WH-PCPs.

Recommendation 18

18. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that each site of care has at least two designated women's health primary care providers or arrangements for leave coverage when there is only one designated provider.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Medical Center Director has reviewed the reasons for noncompliance and has found no additional reasons for noncompliance. The status and monitoring of staffing of two designated women's health primary care providers at each site of care will be completed by the Women's Health Coordinator. This recommendation will be considered compliant when there are two designated women's health primary care providers or more staffed at each site of care and there is a written plan for leave coverage that is reported to the Medical Executive Council in which minutes are signed by the Medical Center Director.

VHA requires that the Women Veterans Health Committee meets quarterly, reports to executive leadership, and includes all required members. The required members includes a Women Veterans Program Manager; Women's Health Medical Director; and "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership."[140]

While the Women Veterans Health Committee membership included the required members, the OIG noted that from September 26, 2019 through December 12, 2019, the committee had inconsistent representation from Laboratory and Business Office/Non-VA medical care. This resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality and equitable women veterans care. The Women Veterans Program Manager stated there were conflicts in scheduling for both representatives and reported that the Business Office/Non-VA medical care representative also had several collateral duties that contributed to noncompliance.

[140] VHA Directive 1330.01(2)

Recommendation 19

19. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that required members consistently attend the Women Veterans Health Committee meetings.

Medical center concurred.

Target date for completion: January 31, 2021

Medical center response: The Medical Center Director evaluated reasons for noncompliance and determined no further reasons for noncompliance and will ensure that all required representatives consistently participate in the Women's Health Committee. The Women's Veteran Health Coordinator will monitor attendance at the Women's Veteran Health Committee. The numerator will be the number of required members attending the Women's Veteran Health Committee and the denominator will be the total number of required members for the Women's Veteran Health Committee. This recommendation will be considered complete when 90 percent or greater attendance of required members is documented at Women's Health Committee for two consecutive quarters. The Women's Veteran Health Committee will report compliance quarterly to the Medical Executive Council in which minutes are signed by the Medical Center Director.

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 service (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment…"[141] The goal of SPS is to "...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[142] 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[143]
- 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[144]

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.[145] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[146]

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.[147]

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

[142] 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.)

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

[144] VHA Directive 1116(2).

[145] 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.

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

[147] 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.[148]

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

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

[148] 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 complied with most elements of expected performance for reprocessing reusable medical equipment. However, the OIG identified deficiencies with SOPs, the annual risk analysis, and competency assessments.

As previously mentioned, VHA requires that facilities have standard operating procedures (SOPs) based on manufacturer's guidelines[149] and that "all SOPs are kept up-to-date, reviewed at least every 3 years and updated when there is a change in process or a change in manufacturer's IFU [instructions for use]."[150] The OIG found that the SOPs for a colonoscope and microscope attachments did not align with the manufacturer's instructions for use. Failure to follow the manufacturer's instructions could result in inadequate reprocessing, damage to the scope, and significant patient safety risks.[151] The Chief of SPS was reportedly unaware that some steps were omitted and steps that did not align with the manufacturer's IFU were added in the SOPs.

Recommendation 20

20. The Associate Director for Patient Care Services determines the reasons for noncompliance and makes certain that standard operating procedures align with manufacturers' guidelines and instructions for use.

[149] VHA Directive 1116(2).
[150] VHA Directive 1116(2)
[151] VHA Directive 1116(2)

Medical center concurred.

Target date for completion: September 30, 2020

Medical center response: The Associate Director for Patient Care Services has reviewed and evaluated the reasons for noncompliance and determined no further reasons for noncompliance. The Associate Director for Patient Care Services has ensured that all standard operating procedures are in alignment with manufacturer's guidelines and have been approved. The Associate Director for Patient Care Services has ensured the standard operating procedures align with the manufacturers' guidelines and instructions for use are forwarded to Sterile Processing Services Chief, Infection Prevention and Control and Associate Director for Patient Care Services for signage and approval. This recommendation will be considered complete when this has been reported to the Reusable Medical Committee in which the Associate Director for Patient Care Services is a member.

VHA requires that the Chief of SPS perform an annual risk analysis and report the results to the VISN SPS Management Board.[152] The OIG found that an FY20 annual risk analysis was performed. However, there was no evidence that the results were reported to the VISN SPS Management Board. This may have impeded the identification and mitigation of potential process failures. The Chief of SPS and Nurse Educator reported being unaware of the requirement and stated the annual risk analysis was reported and discussed during the RME Committee meeting.

Recommendation 21

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

[152] VHA Directive 1116(2)

Medical center concurred.

Target date for completion: September 30, 2020

Medical center response: The Associate Director for Patient Care Services has reviewed and evaluated the reasons for noncompliance and submitted the risk analysis dated February 21, 2020 to the Veterans Integrated Service Network Sterile Processing Services Management Board on February 26, 2020. The risk analysis dated February 21, 2020 was forwarded to VISN 12 on February 26, 2020 and reported compliance/requirement was met for FY20, as evidenced and recorded by VISN 12 SPS Management Board Meeting minutes dated May 16, 2020. This documentation will be provided to request closure by September 30, 2020.

VHA requires that competencies for RME staff are completed prior to performing reprocessing duties.[153] The OIG found that all ten selected SPS staff had a competency assessment for reprocessing colonoscope and microscope attachments. However, the related SOPs did not align with manufacturer's IFU, thereby rendering the competency assessments invalid. This could result in improper cleaning of the RME and compromise patient safety.[154] The Chief of SPS reported being unaware of the SOP discrepancy.

Recommendation 22

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

Medical center concurred.

Target date for completion: September 30, 2020

Medical center response: The Associate Director for Patient Care Services has reviewed and evaluated the reasons for noncompliance and can attest to completion of all ten Sterile Processing Services staff received and completed competency assessments for reprocessing reusable medical equipment.

The Associate Director for Patient Care Services ensured that the Chief of Sterile Processing Services in conjunction with the Reusable Medical Equipment Coordinator and the Reusable Medical Equipment educator have aligned the manufacturers' instructions for use with the standard operating procedures and competency assessments for the colonoscope and microscope attachments. All ten staff have completed the competency assessments.

[153] VHA Directive 1116(2).
[154] VHA Directive 1116(2)

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• None	• At least 80 percent of inpatient UM reviews are completed. • All required representatives participate in interdisciplinary reviews of UM data.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• The Medical Executive Council documents recommendations for continuation of privileges are based on FPPE results. • Service leaders immediately initiate SLB reporting after a provider has failed to meet practice standards.	• Provider exit review forms are completed within the required time frame.

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• Providers complete aberrant behavior assessments for history of substance abuse, psychological disease, and aberrant drug-related behaviors prior to initiating long-term opioid therapy. • Providers document justification for prescribing opioids and benzodiazepines concurrently. • Providers obtain urine drug testing for patients on long-term opioid therapy. • Providers obtain and document informed consent for patients on long-term opioid therapy. • Providers follow up with patients within the required time frame after initiating long-term opioid therapy. • Provider follow-up after initiating long-term opioid therapy, includes assessment of adherence to care plan and intervention effectiveness.	• The Pain Committee monitors quality of pain assessment and the effectiveness of pain management interventions.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements	• Providers follow up with patients who are flagged as high risk for suicide after missed MH appointments. • Providers complete suicide safety plans within the required time frame. • Suicide safety plans include required contact information.	• Staff complete mandatory suicide prevention training within the required time frames.
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• A multidisciplinary committee reviews proposed LST plans.	• None
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• Each site of care has at least two designated WH-PCPs or arrangements for leave coverage when there is only one.	• Required members consistently attend the Women Veterans Health Committee meetings.
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Data monitoring • Physical inspection • Staff training	• SPS SOPs align with manufacturers' guidelines and instructions for use. • SPS staff receive completed competency assessments.	• The SPS Chief reports the annual risk analysis to the VISN SPS Management Board.

Appendix B: Medical Center Profile

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

Table B.1. Profile for Jesse Brown VA Medical Center (537)
(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	$480,570,412	$482,225,688	$541,334,459
Number of:			
• Unique patients	48,914	49,091	50,739
• Outpatient visits	644,369	629,209	634,179
• Unique employees[6]	2,136	2,197	2,196
Type and number of operating beds:			
• Community living center	22	22	22
• Domiciliary	40	40	40
• Medicine	75	75	85
• Mental health	40	40	40
• Rehabilitation medicine	8	8	8
• Surgery	25	25	25
Average daily census:			
• Community living center	19	18	19
• Domiciliary	32	33	31
• Medicine	70	65	70
• Mental health	32	28	27
• Rehabilitation medicine	4	4	2
• Surgery	10	11	9

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.

[1] Associated with a medical residency program.

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

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
Crown Point, IN	537BY	21,578	17,722	Anesthesia Cardiology Dermatology Endocrinology Eye Gastroenterology Infectious disease Nephrology Neurology Urology	Laboratory & Pathology Radiology	Dental Nutrition Pharmacy Social work Weight management

[1] Includes all outpatient clinics in the community that were in operation as of August 27, 2019. The OIG omitted (537QA) Chicago South California Avenue, IL as no workload/encounters or services were reported.

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

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

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

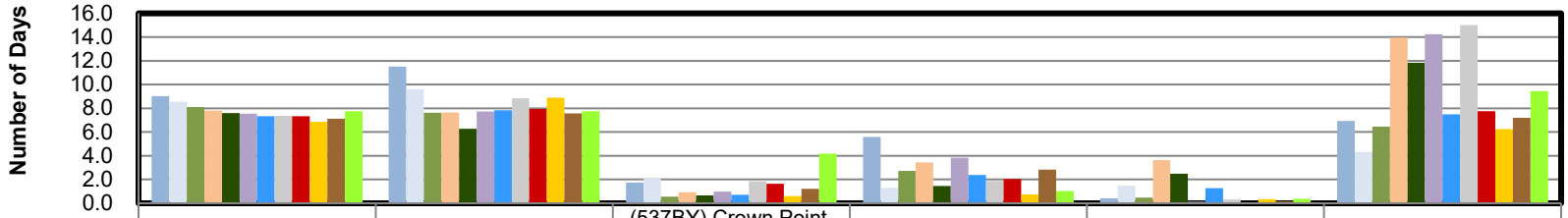
[5] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Chicago Heights, IL	537GA	5,180	3,036	Anesthesia Dermatology	Laboratory & Pathology	Nutrition Pharmacy Weight management
Chicago, IL	537GD	11,036	1,356	Dermatology	n/a	Nutrition Pharmacy Social work
Chicago, IL	537HA	5,154	2,618	Dermatology	n/a	Nutrition Pharmacy Social work Weight management

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

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

Quarterly New Primary Care Patient Average Wait Time in Days



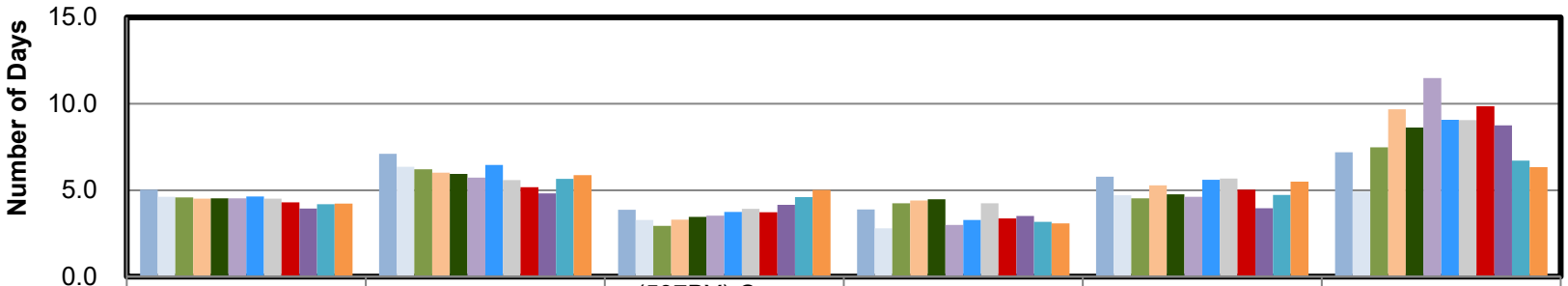
	VHA Total	(537) Chicago, IL (Jesse Brown)	(537BY) Crown Point, IN (Adam Benjamin Jr.)	(537GA) Chicago Heights, IL	(537GD) Lakeside, IL	(537HA) Auburn Gresham, IL
JAN-FY19	9.0	11.5	1.7	5.6	0.4	6.9
FEB-FY19	8.5	9.6	2.1	1.3	1.5	4.3
MAR-FY19	8.1	7.6	0.5	2.7	0.5	6.5
APR-FY19	7.8	7.7	0.9	3.4	3.6	14.0
MAY-FY19	7.6	6.3	0.7	1.5	2.5	11.8
JUN-FY19	7.6	7.7	1.0	3.9	0.1	14.3
JUL-FY19	7.3	7.8	0.7	2.4	1.3	7.5
AUG-FY19	7.4	8.8	1.8	1.9	0.3	15.0
SEP-FY19	7.3	7.9	1.6	2.0	0.0	7.8
OCT-FY20	6.9	8.9	0.6	0.8	0.3	6.2
NOV-FY20	7.1	7.6	1.2	2.8	0.1	7.2
DEC-FY20	7.8	7.8	4.2	1.0	0.4	9.5

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (537QA) Chicago South California Avenue, IL as no workload/encounters or services were reported.

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

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



	VHA Total	(537) Chicago, IL (Jesse Brown)	(537BY) Crown Point, IN (Adam Benjamin Jr.)	(537GA) Chicago Heights, IL	(537GD) Lakeside, IL	(537HA) Auburn Gresham, IL
JAN-FY19	5.0	7.1	3.9	3.9	5.8	7.2
FEB-FY19	4.6	6.4	3.3	2.8	4.7	4.9
MAR-FY19	4.6	6.2	2.9	4.3	4.5	7.5
APR-FY19	4.5	6.0	3.3	4.4	5.3	9.7
MAY-FY19	4.5	5.9	3.5	4.5	4.8	8.6
JUN-FY19	4.5	5.7	3.5	3.0	4.6	11.5
JUL-FY19	4.6	6.5	3.7	3.3	5.6	9.1
AUG-FY19	4.5	5.6	3.9	4.2	5.7	9.1
SEP-FY19	4.3	5.2	3.7	3.4	5.0	9.9
OCT-FY20	3.9	4.8	4.1	3.5	4.0	8.7
NOV-FY20	4.2	5.7	4.6	3.2	4.7	6.7
DEC-FY20	4.2	5.9	5.0	3.1	5.5	6.3

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

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

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

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

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

Source: VHA Support Service Center

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

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
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: June 26, 2020

From: Director, VISN 12 (10N12)

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

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

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

1. I have reviewed the Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center draft report.
2. I concur with the findings and recommendations proposed.
3. I concur with the submitted action plans from the facility.
4. I would like to thank the OIG Inspection team for a thorough review of the Jesse Brown VA Medical Center.

(Original signed by:)

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

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: June 26, 2020

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

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

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

1. Thank you for the opportunity to review the draft of the Inspector General report from the Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center CHIP Review.
2. I have reviewed each recommendation and concur with the findings, recommendations and submitted action plans. The plans have been carefully analyzed and will be implemented and monitored through satisfactory completion.

(Original signed by:)

Ricky Ament
Medical Center Director

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