DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Marion VA Medical Center in Illinois

CHIP REPORT | REPORT # 20-00206-180 | JULY 15, 2020

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Figure 1. *Marion VA Medical Center in Illinois (Source: https://vaww.va.gov/directory/guide/, accessed on January 28, 2020)*

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Marion VA Medical Center and multiple outpatient clinics in Illinois, Indiana, and Kentucky. 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 medical center. 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 November 18, 2019, at the Marion VA Medical Center and Mount Vernon VA Clinic. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this medical center's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this medical center and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

Leadership and Organizational Risks

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

When the team conducted this inspection, the medical center's leaders had been working together for almost 17 months. The Medical Center Director had served since 2016, and all team members had been in their positions for more than one year.

The OIG noted that specific medical center survey scores related to employees' satisfaction with the facility were similar to or better than VHA averages. The Medical Center Director, ADPCS, and Associate Director for Operations results were consistently higher than the VHA averages. The Chief of Staff scores were generally similar or lower than those for the VHA and medical center. The OIG also reviewed responses to relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Medical center patients appeared generally satisfied with the care provided.

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.[1] However, the OIG identified a repeat finding from the September 2018 CHIP inspection related to ongoing professional practice evaluations (OPPEs).[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. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[3]

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

[2] Office of Inspector General, *Comprehensive Healthcare Inspection Program Review of the Marion VA Medical Center, Illinois*, Report No. 18-01155-48, December 27, 2018.

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

The Medical Center Director and Associate Director for Operations were generally knowledgeable within their scope of responsibilities about VHA data and/or medical center-level factors contributing to specific poorly performing SAIL measures, while the Chief of Staff and ADPCS were minimally knowledgeable. The OIG noted opportunities for improvement in all eight clinical areas reviewed and issued 29 recommendations that are directed to the Medical Center Director, Chief of Staff, ADPCS, and Associate Director for Operations. These are briefly described below.

Quality, Safety, and Value

The medical center complied with requirements for protected peer reviews and patient safety elements, including the development of action plans for identified problems. However, the OIG expressed concerns with the Executive Leadership Council's lack of implementation of these action plans and the medical center's utilization management processes.[4]

Medical Staff Privileging

The OIG generally found compliance with focused professional practice evaluation processes. However, the OIG identified deficiencies with OPPE and healthcare provider exit review processes.[5] The OPPE deficiency is a repeat finding from the September 2018 CHIP inspection.

Environment of Care

The medical center met many of the general safety, special use spaces, and women veterans program requirements reviewed. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified deficiencies in infection prevention procedures for damaged wheelchairs and the security of protected health information.

Medication Management

The medical center was generally compliant with the interdisciplinary Pain Management Committee membership. The OIG found deficiencies with pain screening, aberrant behavior risk

[4] 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."

[5] 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 medical center."

assessments, urine drug testing, informed consent, patient follow-up after therapy initiation, and quality measure oversight.

Mental Health

The OIG found compliance with the requirements for a suicide prevention coordinator. However, areas for improvement included suicide safety plans and suicide prevention training.

Care Coordination

Generally, the medical center met expectations with Life-Sustaining Treatment Decisions (LSTD) Committee processes and completion of LSTD notes by an authorized provider. Life-sustaining treatment progress notes, however, were not consistently completed as required.

Women's Health

The medical center complied with many of the requirements reviewed for women's health, including staffing and performance improvement monitoring. The OIG noted concerns with Women's Health Patient Aligned Care Teams, processes to ensure 24/7 access to gynecological care, designated women's health primary care providers at community-based outpatient clinics, access to emergency contraceptives, and the Women Veterans Committee membership.

High-Risk Processes

The medical center met the requirements for monitoring of quality assurance and physical inspections of reprocessing and storage areas. However, the OIG identified deficiencies with administrative processes and staff training and competency.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued 29 recommendations for improvement to the Medical Center Director, Chief of Staff, ADPCS, and Associate Director for Operations. 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 86-87, 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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Assistant Inspector General
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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 Marion 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]

[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.

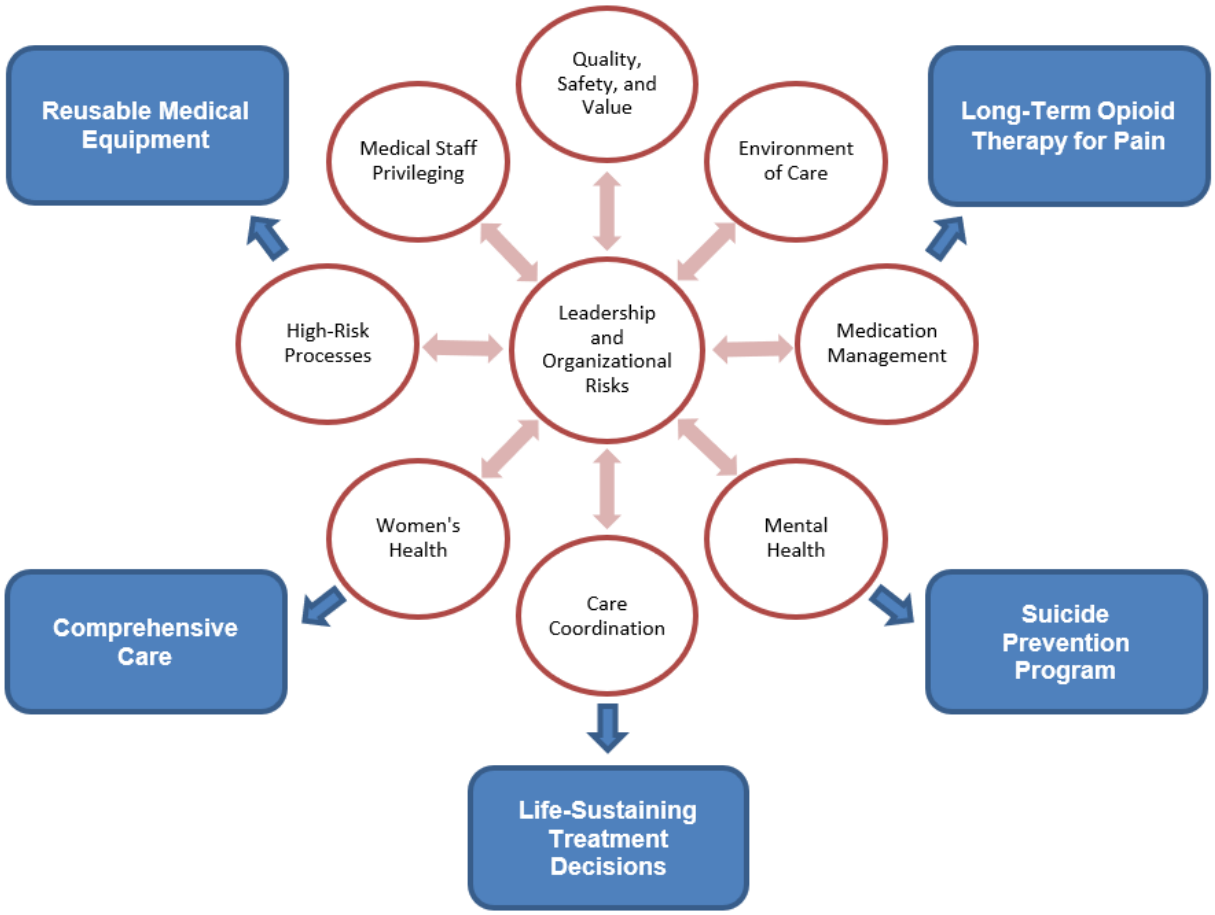

Figure 2. *Fiscal Year (FY) 2020 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

Methodology

The Marion VA Medical Center includes multiple outpatient clinics in Illinois, Indiana, and Kentucky. 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 Mount Vernon VA Clinic and the following areas of the Marion VA Medical Center:

- Combined intensive care unit
- Community Living Center (CLC)[5]
- Emergency department
- Heartland Street Primary Care Clinic
- Medical/surgical inpatient unit
- Outpatient clinics
- Palliative care clinic
- Post-anesthesia care unit
- Sterile Processing Services
- Women's health clinic

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

The inspection period examined operations from September 11, 2018, through November 21, 2019, the last day of the unannounced multiday site visit.[6] While on site, the OIG referred

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

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

[6] The range represents the time period from the prior CHIP inspection to the completion of the unannounced, multiday CHIP site visit in November 2019.

concerns beyond the scope of the CHIP inspection to the OIG's hotline management team for further review.

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

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

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

Results and Recommendations

Leadership and Organizational Risks

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

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation surveys and oversight inspections
5. Identified factors related to possible lapses in care and medical center response
6. VHA performance data (medical center)
7. VHA performance data (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 Medical Center Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director for Operations. The Chief of Staff and ADPCS oversee patient care which requires managing service directors and chiefs of programs and practices.

[7] L. Botwinick, M. Bisognano, and C. Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare Improvement, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on November 6, 2019.)

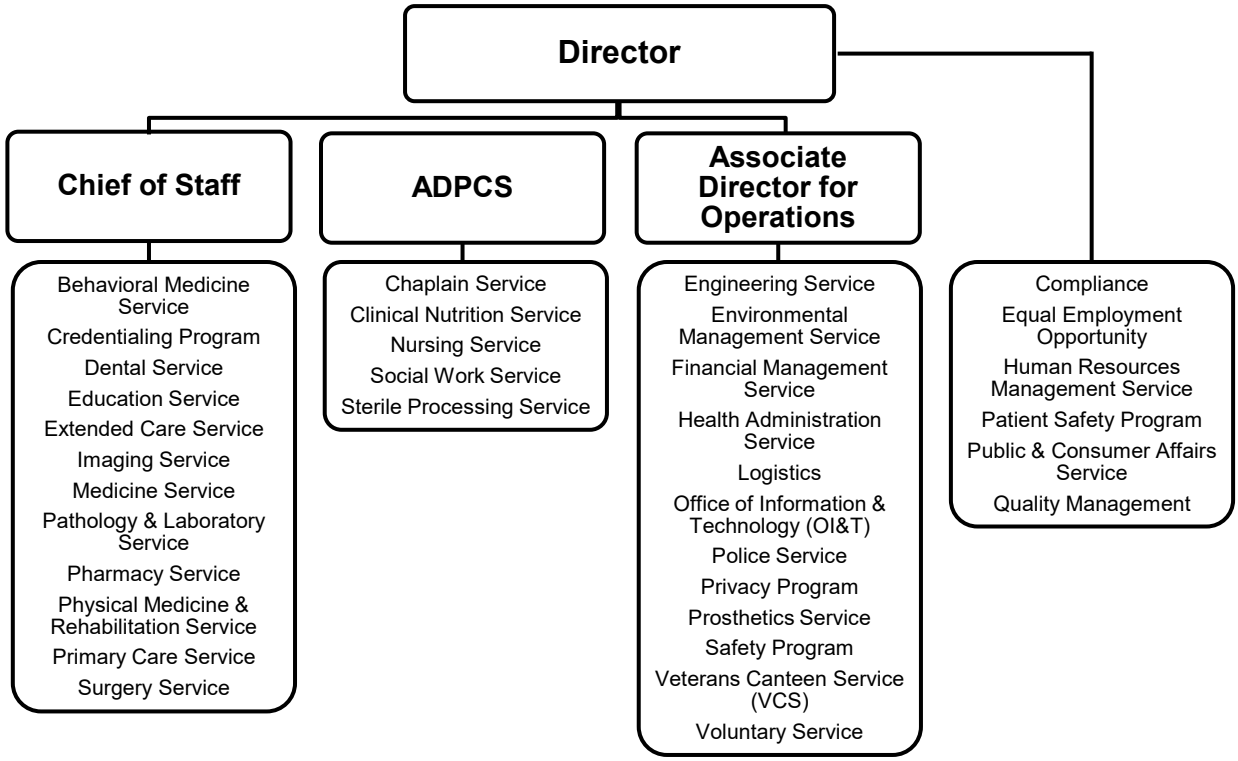

Figure 3. *Medical Center Organizational Chart*
Source: Marion VA Medical Center (received November 18, 2019)

At the time of the OIG site visit, the executive team had been working together as a group for almost 17 months. The Medical Center Director had served since 2016, and all team members had been in their positions for more than one year (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	September 8, 2016
Chief of Staff	December 24, 2017
Associate Director for Patient Care Services	July 8, 2018
Associate Director for Operations	July 9, 2017

Source: Marion VA Medical Center Supervisory Human Resources Specialist (received November 18, 2019)

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

The Medical Center Director and Associate Director for Operations were generally knowledgeable within their scope of responsibilities about VHA data and/or medical center-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) and Community Living Center (CLC) SAIL measures, while the Chief of Staff and ADPCS were minimally knowledgeable. In individual interviews, the Medical Center Director and Associate Director for Operations were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

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

These leaders monitor patient safety and care through the Clinical Executive Board which is responsible for tracking and trending quality of care and patient outcomes. See Figure 4.

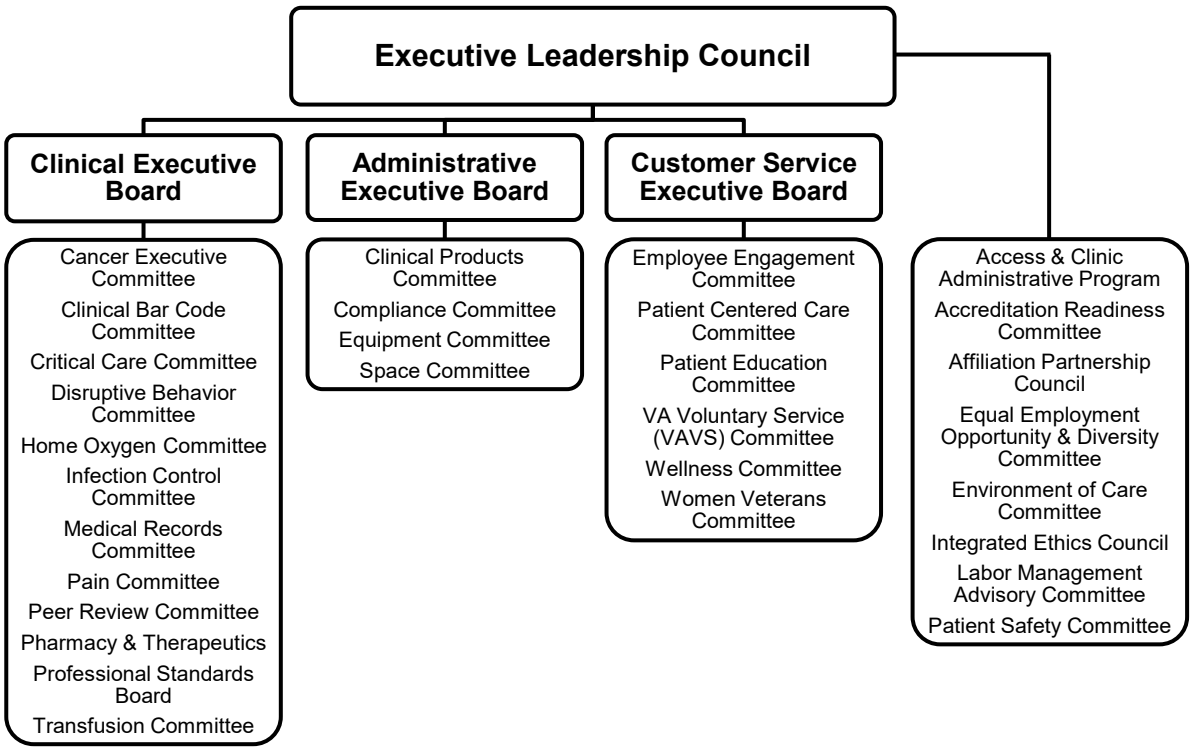

Figure 4. *Medical Center Committee Reporting Structure*
Source: Marion VA Medical Center (received November 18, 2019)

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 the medical center average for the specific survey leadership questions was similar to or higher than the VHA average.[9] The Medical Center Director, ADPCS, and Associate Director for Operations results were consistently higher while the scores related to the Chief of Staff were similar to those for VHA and the medical center.

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	Medical Center Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director for Ops Average
All Employee Survey: *Servant Leader Index Composite.*[10]	0–100 where higher scores are more favorable	72.6	74.8	89.1	72.5	91.4	90.0

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

[9] The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Medical Center Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director for Ops 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	3.4	4.4	3.4	3.9	4.4
All Employee Survey: My organization's senior leaders maintain high standards of honesty and integrity.	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.5	4.4	3.5	4.3	4.7
All Employee Survey: I have a high level of respect for my organization's senior leaders.	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.6	4.5	3.4	4.3	4.7

Source: VA All Employee Survey (accessed October 8, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[11] Note that the medical center average for the specific survey questions was similar to the VHA average. Scores related to the Medical Center Director, ADPCS, and Associate Director for Operations were consistently better than those for VHA and the medical center. Scores for the Chief of Staff were generally similar to the VHA averages.

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

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	Medical Center Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director for Ops Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.7	4.3	3.4	4.1	4.8
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.8	4.3	3.8	4.3	4.4
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	1.3	0.8	1.6	0.4	0.9

Source: VA All Employee Survey (accessed October 8, 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 June 30, 2019. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its

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

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

Table 4. Survey Results on Patient Experience (October 1, 2018, through June 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.	68.1	66.6
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	86.2
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	77.3	79.4
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	78.0	79.2

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 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,

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

from almost 240,000 to 455,875.[13] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients' experiences by gender (see Tables 5–7). The OIG team noted that results for male respondents were generally similar to the corresponding VHA averages, while the Patient-Centered Medical Home and Specialty Care Survey results for female respondents were consistently more positive when compared with female VHA patients nationally. The Women's Health Medical Director appeared to be actively engaged with female patients (for example, conducting women veteran town hall meetings and presenting at community gatherings).

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

Questions	Scoring	VHA[14]		Medical Center[15]	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.3	83.6	81.8	–[16]
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).	84.7	83.0	82.8	–[17]
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).	68.5	62.0	66.9	–[18]

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 2019)

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

[14] The VHA averages are based on 34,077–34,469 male and 1,647–1,665 female respondents, depending on the question.

[15] The medical center averages are based on 294-297 male respondents, depending on the question.

[16] The SHEP inpatient composite percentages are weighted to reflect the numbers of patients at different locations and respondent characteristics (i.e., age, gender). Weighted response percentages cannot be derived from the N (number of results) for fewer than 30 respondents at a location. Introduction page of VISN Patient Experience FY report. http://vaww.car.rtp.med.va.gov/programs/shep/shepReportsOuthQLImp.aspx. (The website was accessed on March 10, 2020, but is not accessible by the public).

[17] Data are not available due to the low number of respondents.

[18] Data are not available due to the low number of respondents.

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

Questions	Scoring	VHA[19]		Medical Center[20]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.8	43.2	48.5	53.9
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).	59.8	49.5	64.1	62.0
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.0	64.8	68.6	66.9

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 2019)

[19] The VHA averages are based on 60,437–183,790 male and 4,400–9,816 female respondents, depending on the question.

[20] The medical center averages are based on 823-2,498 male and 34–81 female respondents, depending on the question.

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

Questions	Scoring	VHA[21]		Medical Center[22]	
		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).	48.3	44.4	52.4	–[23]
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	53.9	64.6	65.6
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).	69.9	69.4	70.2	81.6

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 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.[24] Table 8 summarizes the relevant medical center inspections most recently performed by the OIG and The

[21] The VHA averages are based on 50,373–158,294 male and 2,617–8,357 female respondents, depending on the question.

[22] The medical center averages are based on 331-909 male and 14-32 female respondents, depending on the question.

[23] Data are not available due to the low number of respondents.

[24] 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.

Joint Commission (TJC).[25] Of note, at the time of the OIG visit, the medical center had closed all recommendations for improvement issued since the previous comprehensive healthcare inspection conducted in September 2018.

At the time of the site visit, 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.[26] Additional results reviewed included the Long Term Care Institute's inspection of the medical center's CLCs.[27]

Table 8. Office of Inspector General Inspection/The Joint Commission Surveys

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the Marion VA Medical Center, Illinois,* Report No. 18-01155-48, December 27, 2018*)*	September 2018	6	0
TJC For Cause Survey	April 2019	0	0
TJC For Cause Survey	July 2019	0	0

Sources: OIG and TJC (Inspection/survey results verified with the Chief of Quality Management on November 19, 2019)

[25] According to VHA Directive 1100.16, *Accreditation of Medical Center 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."

[26] 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.

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

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. The OIG identified no concerns related to the potential for patient harm.

Table 9 lists the reported patient safety events from September 11, 2018 (the prior OIG comprehensive healthcare inspection), through November 18, 2019.[28]

Table 9. Summary of Selected Organizational Risk Factors (September 11, 2018, through November 18, 2019)

Factor	Number of Occurrences
Sentinel Events[29]	0
Institutional Disclosures[30]	0
Large-Scale Disclosures[31]	0

Source: Marion VA Medical Center Risk Manager (received November 18, 2019)

[28] 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 medical center. (Note that the Marion VA Medical Center is a medium complexity (2) system as described in Appendix B.)

[29] 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."

[30] 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 center 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."

[31] 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."

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[32]

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 Marion VA Medical Center (for example, in the areas of registered nurse (RN) turnover, mental health (MH) continuity (of) care, and healthcare (HC) associated (assoc) infections). Metrics that need improvement are denoted in orange and red (for example, patient centered medical home (PCMH) same day appointment (appt), care transition, and rating (of) hospital).[33]

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

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

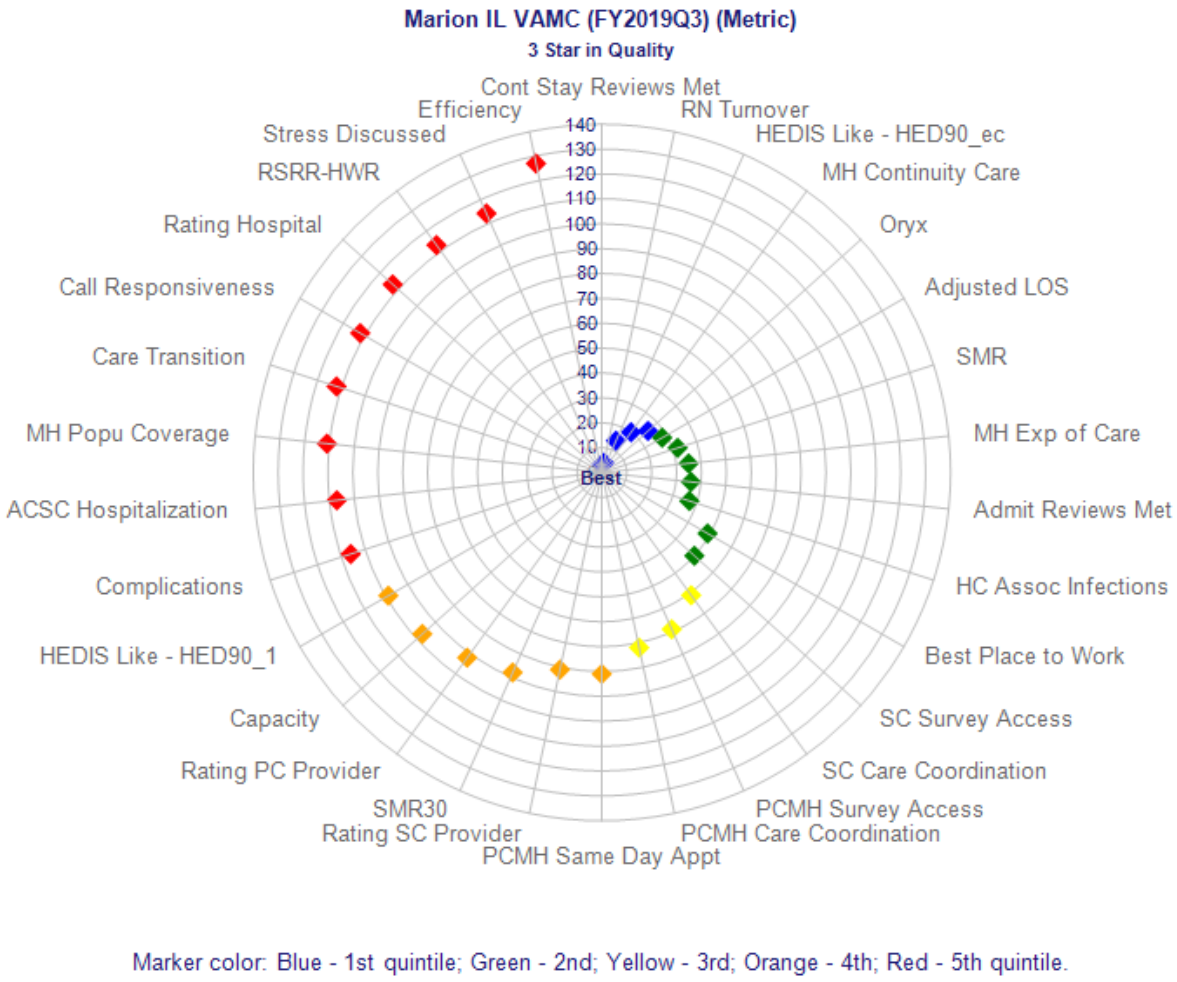

Figure 5. *Medical Center Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

Veterans Health Administration Performance Data for Community Living Centers

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

Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource to review quality measures and health inspection results.[34]

Figures 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2019. Figure 6 uses blue and green data points to indicate high performance for the Marion CLC (for example, in the areas of falls with major injury–long-stay (LS), moderate-severe pain (LS), and improvement in function–short-stay (SS). Metrics that need improvement are denoted in orange and red (for example, newly received antipsych (antipsychotic) meds (SS), urinary tract infection (LS), new or worse pressure ulcer (PU) (SS), and help with activities (of) daily living (ADL) (LS)).[35]

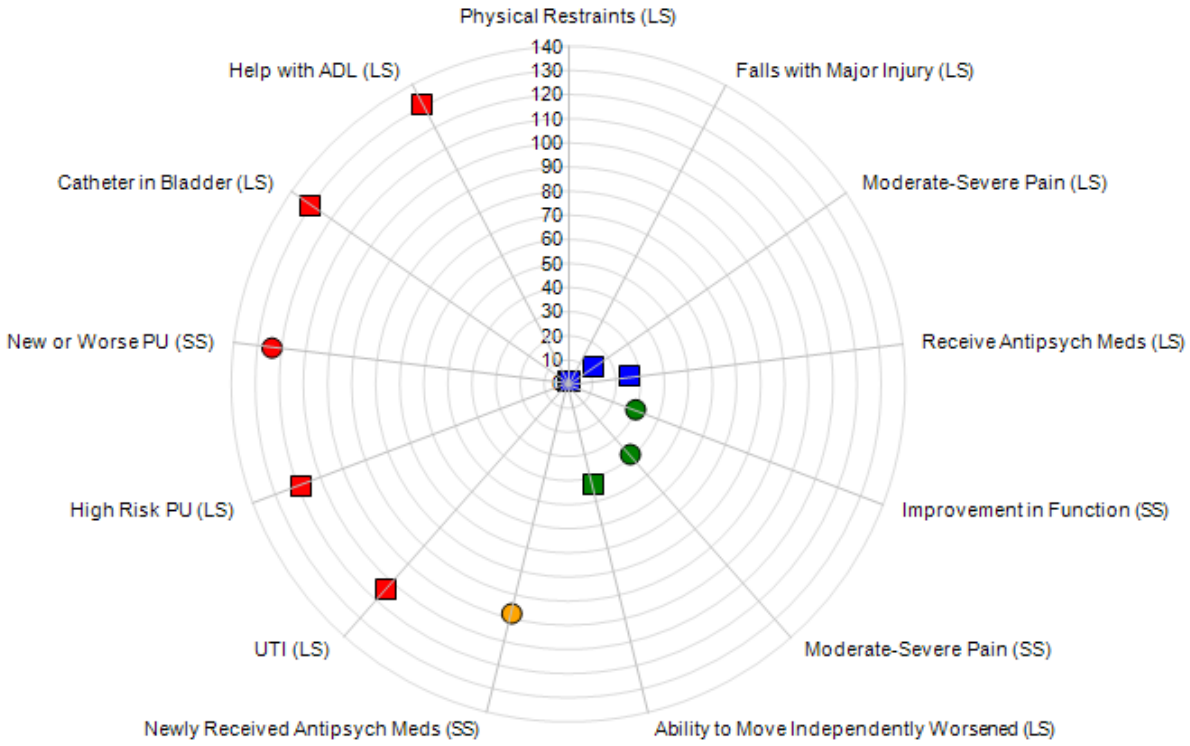

Figure 6. *Marion CLC Quality Measure Rankings (as of June 30, 2019)*
LS = Long-Stay Measure *SS = Short-Stay Measure*
Source: VHA Support Service Center

[34] 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."

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

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

Leadership and Organizational Risks Conclusion

The medical center's executive leadership team appeared stable and had been working together for approximately 17 months at the time of the OIG's onsite inspection. Specific survey results related to employees' satisfaction with the medical center leaders were similar to or better than VHA averages. Patient experience survey results were also generally similar to or better than VHA averages. The medical center leaders stated they were engaged with staff and patients and were working to sustain and improve engagement and satisfaction. The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial risk factors. The leadership team, specifically the Chief of Staff and ADPCS, had opportunities to improve their knowledge within their scopes of responsibility about selected VHA data used by the SAIL and CLC SAIL models and should continue to take actions to sustain and improve performance.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.[36] 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.[37] 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.[38]

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.[39] 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.[40] The OIG team examined the completion of the following elements:

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

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

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

[39] The definition of a peer review can be found within VHA Directive 1190. 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."

[40] VHA Directive 1190.

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[41]
- 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.[42] 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.[43] 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.[44] Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly

[41] VHA Directive 1190.

[42] According to VHA Directive 1117(2), 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."

[43] VHA Directive 1117(2).

[44] 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."

communicate potential and actual causes of harm to patients throughout the medical center.[45] The medical center was assessed for its performance on several dimensions:

- Annual completion of a minimum of eight root cause analyses[46]
- 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.[47]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for protected peer review and patient safety processes. The OIG identified significant weaknesses in the recommendation and implementation of improvement actions and UM processes.

TJC requires that the medical center's governing body provides structure and resources to support quality and safety.[48] TJC also requires facilities to measure and analyze performance,[49] using data so that improvement "effectiveness can be sustained, assessed, and measured."[50]

The medical center's Executive Leadership Council reviews relevant data and information and ensures that when actions are recommended by the committee, they are fully implemented and changes are monitored.[51] The Executive Leadership Council is responsible for ensuring an integrated quality management program that oversees the safety and quality of care delivered to patients.[52] The OIG reviewed Executive Leadership Council minutes from October 2018 through August 2019 and did not find evidence that action items for identified problems or opportunities

[45] VHA Handbook 1050.01.

[46] 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]."

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

[48] TJC. Leadership standard and rationale LD.01.03.01.

[49] TJC. Leadership standard and rationale LD.03.02.01.

[50] TJC. Leadership rationale LD.03.05.01.

[51] VHA Directive 1100.16; TJC. Leadership standards LD.01.01.01, LD.02.01.01, and LD.03.01.01.

[52] TJC. Leadership standard LD.03.05.01.

for improvement were fully implemented. This may have resulted in missed opportunities to improve the quality of care and patient safety processes. The Medical Center Director and the Chief of Quality Management Service reported that discussions of recommendations and actions took place at the meetings; however, the OIG found no evidence that the action plans were implemented or documented in minutes.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures action items are implemented when problems or opportunities for improvement are identified and documented in Executive Leadership Council minutes.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Medical Center Director reviewed the Executive Leadership Council minutes and determined that additional steps were needed to identify and track actions when problems or opportunities for improvement are identified. Based on the review, the Chief of Quality Management developed a monthly tracking log that will be used to follow-up on the actions and ensure implementation when problems or opportunities for improvement are identified.

The Chief of Quality Management will audit monthly minutes for the Executive Leadership Council meeting to ensure action items are implemented when problems or opportunities for improvement are identified. Data will be collected monthly and aggregated quarterly until 90 percent compliance has been reached for two consecutive quarters. The numerator will be the number of minutes that contain tracking of actions and the denominator will be the total number of Executive Leadership Council minutes that had actions identified. Audit results will be reported to the Executive Leadership Council which the Medical Center Director chairs.

VHA requires that physician UM advisors document at least 75 percent of their decisions regarding appropriateness of acute setting stays in the National UM Integration database.[53] The OIG found that physician UM advisors documented 66 percent of reviews from April 1, 2019, through September 30, 2019. Incomplete documentation of UM decisions may result in a lack of assurance that the appropriate level of care and treatment was provided to patients. The Chief of Medicine Service reported being aware of the requirement but that the assigned advisor was unable to complete the reviews due to competing patient care and administrative priorities.

[53] VHA Directive 1117(2).

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that physician utilization management advisors consistently document their decisions in the National Utilization Management Integration database.

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Chief of Staff evaluated Physician Utilization Management (UM) Advisor coverage and determined that a backup was needed to ensure that acute admissions are reviewed. The Chief of Medicine Service assigned a second Physician UM Advisor who completed training in the VHA Talent Management System education system on December 23, 2019.

The UM Nurse will monitor results in the National UM Integration database monthly to determine if Physician UM Advisors conducted reviews and entered results into the database. Results of the monitor will be aggregated into a quarterly report and monitoring will continue until the VHA target* for Physician UM Advisor reviews has been achieved for two consecutive quarters. The sample size will be 100 percent of acute admissions referred to Physician UM Advisors. The numerator will be the number of admissions reviewed by the Physician UM Advisor and the denominator will be the number of admissions referred to them. Results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

*Note: At the time of this response, due to COVID-19, VHA temporarily relaxed the requirement that Physician UM Advisors complete at least 75 percent of secondary referrals within 7 days from the expected review date. (Ref. UM Bulletin 20-4, Relaxation of Percent UM and PUMA Reviews – COVID-19 Impact, dated March 27, 2020.)

VHA requires that an interdisciplinary group review UM data on an ongoing basis. This group must include, but not be limited to, "representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR [Chief Business Office Revenue-Utilization Review]."[54] The OIG found that from November 1, 2018, through August 1, 2019, the chief business office revenue-utilization review representative was not involved in UM data review. This resulted in a lack of expertise in the review and analysis of utilization management data by the Clinical Executive Board, the group responsible for the review of UM data at the medical center. The Chief, Quality Management Service reported that due to ineffective program oversight, the chief business office revenue-utilization review was not represented or identified as a required member.

[54] VHA Directive 1117(2).

Recommendation 3

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

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Chief of Staff reviewed the Clinical Executive Board membership and determined that, while all other required members were represented, it did not include the Chief Business Office Revenue-Utilization Review representative. The Administrative Support Personnel to the Chief of Staff updated the Clinical Executive Board membership to include the VISN Central Plains Consolidated Accounts Management Revenue Utilization Review Nurse or their designee on February 01, 2020.

The Chief of Quality Management will monitor to ensure that the VISN Central Plains Consolidated Accounts Management Revenue Utilization Review Nurse or designee attends meetings where utilization management data is presented until 90 percent compliance is achieved for two consecutive quarters. The numerator will be the number of Clinic Executive Board meetings that included the VISN Central Plains Consolidated Accounts Management Revenue Utilization Review Nurse when the utilization management data was presented, and the denominator will be the number of Clinical Executive Board meetings where utilization management data is presented. Results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[55]

Clinical privileges need to be specific and based on the individual practitioner's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[56]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance." The FPPE process occurs when a provider is hired at the facility and granted initial privileges and before any new clinical privileges are granted. Additionally, VA facilities must continuously monitor the performance of their providers. VHA requirements state that "the on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered."[57] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[58]
  - Clear documentation of the results and time frames
  - Evaluation by another provider with similar training and privileges
- OPPEs
  - Application of criteria specific to the service or section
  - Use of minimum criteria for selected specialty LIPs[59]
  - Evaluation by another provider with similar training and privileges

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

[56] VHA Handbook 1100.19.

[57] VHA Handbook 1100.19.

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

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

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

Further, VA must put processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former licensed practitioner's clinical practice, VA has an obligation to notify state licensing boards (SLBs) and to subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[60] Further, "VA medical facility directors must designate an individual, and backup, to be responsible for the SLB reporting process. This individual will be the subject matter expert (SME) for the facility…and ensure oversight of the exit review process, including receipt, review, and maintenance of the Provider Exit Review Forms."[61] The OIG reviewers assessed whether the medical center's staff

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

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

- Three solo/few practitioners who underwent initial or reprivileging during the previous 12 months[62]
- Five LIPs hired within 18 months before the site visit
- Twenty-one LIPs privileged within 12 months before the visit
- Fifteen LIPs who left the medical center in 12 months before the visit

Medical Staff Privileging Findings and Recommendations

Generally, the OIG found compliance with FPPE processes. However, the OIG noted concerns with OPPE and provider exit review processes.

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

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

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

VHA requires that each service chief "establish additional criteria for granting of clinical privileges within the service consistent with the needs of the service and the facility as well as within the available resources to provide these services."[63] In 8 of 24 OPPEs reviewed, one of which was a solo provider, the OIG noted there was insufficient evidence of service-specific criteria. This resulted in LIPs providing care without a thorough evaluation of their competency, which could potentially impact quality of care and patient safety. The Executive Assistant to Chief of Staff and the credentialing supervisor stated that although each service chief created their own criteria, they were not service-specific, and the medical center staff were awaiting guidance from the VISN regarding a standardized plan.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that reprivileging decisions are based on service-specific ongoing professional practice evaluation data.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff reviewed the ongoing professional evaluation (OPPE) process and determined that all services had not included criteria based on services provided. The Chief of Staff communicated the expectation of having service-specific criteria in OPPEs on May 19, 2020 during the Professional Standards Board meeting. Clinical Service Chiefs will conduct a review of clinical OPPE templates to ensure that service-specific criteria are included and utilized for reprivileging decisions.

The Chief of Staff will ensure that monitoring occurs and that service-specific OPPE data is used for reprivileging decisions by reviewing monthly audit results. The Credentialing Program Supervisor will conduct monthly audits of five OPPEs per month or 100 percent if less than five. Aggregate results will be reported quarterly until 90 percent compliance is achieved for two consecutive quarters. The numerator will be the number of OPPEs with service-specific criteria and the denominator will be the number of providers reprivileged. Results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

VHA also requires that the competency of LIPs is evaluated by another provider with similar training and privileges.[64] The OIG found that in 7 of 24 OPPE provider profiles, including two solo providers, the evaluations were not completed by another similarly trained and privileged provider. As a result, the LIPs continued to deliver care without a thorough evaluation of their

[63] VHA Handbook 1100.19.

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

competencies which could have impacted quality of care and patient safety. This was a repeat finding from the September 2018 CHIP review.[65]

The credentialing supervisor stated that the previous processes allowed administrative staff to manage the completion of OPPEs. Having been in the role since December 2017, the Chief of Staff stated that previous practices had residual impact on the OPPE process and, due to the short time elapsed from the previous CHIP review, the improvements made were not entirely reflected in the current review. The Chief of Staff also indicated that occasional LIP staff shortages caused competing priorities among similarly trained providers.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that providers with similar training and privileges complete ongoing professional practice evaluations of licensed independent practitioners.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff reviewed the OPPE process and determined that the facility policy did not include a requirement for providers with similar training and privileges to complete OPPE reviews for licensed independent practitioners (LIP). The Credentialing Program Supervisor will modify the facility policy to include this requirement.

The Credentialing Program Supervisor will conduct monthly audits of five OPPEs per month or 100 percent if less than five. Aggregate results will be reported quarterly until 90 percent compliance is achieved for two consecutive quarters. The numerator will be the number of OPPEs where a provider with similar training and privileges completed OPPEs and the denominator will be the number of OPPEs reviewed for reprivileging. Results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

Additionally, VHA's expectation is "…that Provider Exit Review forms are completed within 7-calendar days of departure of any licensed health care professional…" from a medical center to ensure timely reporting to the state licensing boards of practitioners who fail to meet professional practice standards for delivering patient care.[66] The OIG found 2 of the 13 forms were not completed within seven calendar days. This may have resulted in delayed reporting of licensed health care professionals to the state licensing board when indicated. The Chief of Staff and the

[65] The previous CHIP review was conducted in September 2018, followed by the publication of the CHIP review report in December 2018.

[66] VHA Notice 2018-05.

Executive Assistant to Chief of Staff stated there was a lack of adequate follow-through by the responsible services to meet the requirement.

Recommendation 6

6. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures the licensed healthcare professional's first- or second-line supervisor completes and signs the exit review forms within seven calendar days of the professional's departure from the medical center.

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Chief of Staff reviewed the licensed healthcare professionals exiting process and determined that a realignment of duties would improve consistent completion of exit forms. Monitoring the timely completion of the licensed healthcare professional exit forms was assigned to the Credentialing Program Supervisor.

The Credentialing Program Supervisor will conduct monthly audits of five exiting providers per month or 100 percent if less than five. Aggregate results will be reported quarterly until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of exiting licensed healthcare professionals with exit review forms completed in seven calendar days of departure and the denominator is the number of exiting licensed healthcare professionals. Results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

Environment of Care

Any medical center, 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.[67]

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 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 (CBOC)
  - General safety

[67] 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 Mount Vernon VA Clinic and the following eight patient care areas in the medical center:

- CLC
- Combined intensive care unit
- Emergency department
- Heartland Street Primary Care Clinic
- Medical/surgical inpatient unit
- Palliative care clinic
- Post-anesthesia care unit
- Women's health clinic

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

Environment of Care Findings and Recommendations

Generally, the OIG found compliance with many of the performance indicators including general safety and women veterans program requirements. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified deficiencies in infection prevention procedures for damaged wheelchairs and the security of protected health information.

TJC requires hospitals to minimize the possibility of transmitting infections by ensuring that "…furnishings and equipment are safe and in good repair."[68] In two clinical care areas, the OIG found wheelchairs with cracked and torn vinyl coverings on armrests or backrests which prevented effective cleaning and disinfection.[69] The Chief, Environmental Management Service stated the monthly wheelchair cleaning process lacked a provision for identifying and reporting damage and that there was a lack of attention to detail during environment of care rounds.

[68] TJC, Infection Prevention and Control standard IC.02.02.01, EP 1; and Environment of Care standard EC.02.06.01, EP 26.

[69] CLC and the Emergency Department which included the adjacent waiting area.

Recommendation 7

7. The Associate Director for Operations evaluates and determines any additional reasons for noncompliance and ensures that medical center managers repair or remove damaged wheelchairs from service.

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Associate Director for Operations reviewed and determined that there was no standardized facility process for checking wheelchairs for damage and removing them from service. The Chief of Environmental Management Service developed and implemented a weekly Environment of Care Rounds checklist on December 18, 2019 that included checking and removing damaged wheelchairs. Additionally, checking for wheelchair damage was added to the wheelchair cleaning spreadsheet to assist in identifying damaged wheelchairs so they could be repaired on December 18, 2019.

The Chief of Environmental Management will ensure that wheelchairs are monitored for damage and that those that are damaged are removed from service. Monitoring will continue until 90 percent compliance is demonstrated for two consecutive quarters. The numerator will be the number of Environment of Care Rounds checklist completed where wheelchairs were checked for damage and removed from service and the denominator will be the total number of Environment of Care Rounds checklist reviewed. Results will be reported to the Administrative Executive Board which the Associate Director of Operations chairs.

The US Department of Health and Human Services publication *Summary of the HIPAA [Health Insurance and Portability and Accountability] Privacy Rule* states that "[h]ealth care organizations must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent unintentional use or disclosure of protected health information."[70] Furthermore, VHA requires that access to protected health information be limited to the minimum necessary for carrying out official job duties.[71] The OIG found that Mount Vernon VA Clinic staff did not adequately secure laboratory specimens containing protected health information during courier transport to the medical center. The staff used a commonly available plastic cable fastener that could be removed and replaced; this could result in unauthorized access to protected health information. The clinic Nurse Manager and the Facility Chief Supply

[70] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. To fulfill this requirement, HHS published the HIPAA Privacy Rule, or *Standards for Privacy of Individually Identifiable Health Information.* https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html.

[71] VHA Directive 1605.02, *Minimum Necessary Standard for Access, Use, Disclosure, and Requests for Protected Health Information*, April 4, 2019.

Chain Officer stated they believed that the current method provided adequate security and met the requirement.

Recommendation 8

8. The Associate Director for Operations evaluates and determines any additional reasons for noncompliance and ensures that staff secure protected health information within laboratory transport containers.

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Associate Director for Operations reviewed and determined that the current device did not adequately keep health information secure. The Pathology and Laboratory Service Supervisor purchased a new device with a numbered padlock seal to ensure health information is protected during transport. The new device was implemented on January 21, 2020.

The Pathology and Laboratory Service Supervisor will ensure that random monthly laboratory transports are monitored for use of the new device. Quarterly aggregated results will be monitored until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of laboratory transports using the new device and the denominator is 10 random transports reviewed. Results will be reported to the Administrative Executive Board which the Associate Director of Operations chairs.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[72] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[73] 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.[74] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[75]

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.[76] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[77] To achieve VHA's vision of providing patient-driven healthcare, practitioners 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.[78] 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.[79]

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

- Completion of initial screening for pain
- Assessment of aberrant behavior risk
- Avoidance of concurrent therapy with benzodiazepines

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[72] 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.)

[73] 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.)

[74] *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.)

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

[76] 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.)

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

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

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

- Completion of urine drug testing with intervention, when indicated
- Documentation of informed consent
- Timely follow-up with patients included required elements

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures include, but are not limited to, adherence to published clinical practice guidelines, timeliness of treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment, patient satisfaction, and quality of life.[80] 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 18 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 was generally compliant with the interdisciplinary Pain Management Committee membership. However, the OIG identified deficiencies with initial pain screening, aberrant behavior risk assessment, urine drug testing, informed consent, patient follow-up, and quality measure oversight.

VHA requires clinicians to routinely screen for and document the presence and intensity of pain using "pain as the 5th vital sign," or a validated alternative tool for special populations.[81] The OIG found that clinicians provided screening for pain prior to, or within 30 days of, dispensing opioid medication, in 89 percent of the patients reviewed.[82] This resulted in inconsistent recognition and assessment of pain intensity and effects on function and quality of life. The Chief of Staff reported VHA pain screening requirements are time consuming and that clinicians have inadequate time to complete all required documentation.

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

[81] VHA Directive 2009-053.

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

Recommendation 9

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

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff reviewed the initial long-term opioid therapy process and determined there was a lack of standardized documentation and a need for additional provider education. Therefore, a standardized facility electronic medical record template titled, "Controlled Subs Prescribing MA," was developed and implemented on April 17, 2020 (MA in the title of the template stands for 'Marion'). The template includes all required fields for completing a pain screening prior to initiating long-term opioid therapy. The Pain Committee Pharmacy designee provided education regarding pain screening requirements on January 09, 2020 during the Medicine and Surgery Services staff meeting.

A Pain Committee designee will audit 10 random charts monthly for completion of pain screening prior to initiating long-term opioid therapy. Aggregated quarterly data will be monitored until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of completed pain screenings prior to initiating long-term opioid therapy and the denominator is 10 random patient charts who were initially prescribed long-term opioid therapy. Audit results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

VHA recommends completion of a behavior risk assessment that includes untreated substance abuse,[83] unstable psychological disease, and aberrant drug-related behaviors,[84] prior to initiating long-term opioid therapy.[85] The OIG determined that providers assessed 56 percent of patients for history of personal or family substance abuse, 78 percent for psychological disease, and 50 percent for aberrant drug-related behaviors.[86] This may have resulted in providers prescribing opioids for patients at high risk for misuse. The Chief of Staff reported insufficient staffing, large patient panels for primary care providers, and recruiting challenges due to the medical center's rural location as the reasons for noncompliance.

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

[84] Examples of aberrant drug related behaviors include lost prescriptions, multiple requests for early refills, unauthorized dose escalation, apparent intoxication, and frequent accidents.

[85] VHA, *Pain Management Opioid Safety*, Educational Guide, 2014.

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

Recommendation 10

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

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff reviewed the long-term opioid therapy process and determined there was a lack of documentation. Therefore, a standardized facility electronic medical record template titled, "Controlled Subs Prescribing MA," was developed and implemented on April 17, 2020 (MA in the title of the template stands for 'Marion'). The new template includes all the required fields for documenting an opioid behavior risk assessment including a history of substance abuse, psychological disease and aberrant drug-related behaviors. The Chief of Staff will reinforce accountability for clinicians completing the behavior risk assessment and all required elements prior to initiating long-term opioid therapy by monitoring audit outcomes and providing additional education when indicated.

A Pain Committee designee will monitor 10 random charts monthly for the use of the new template until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of patients screened prior to initiating long-term opioid therapy who had a completed behavior risk assessment that included a history of substance abuse, psychological disease, and aberrant drug-related behaviors, and the denominator is 10 random chart audits of patients on newly initiated long-term opioid therapy. Audit results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

Additionally, the VA/DoD clinical practice guidelines state, "clinicians should obtain a UDT [urine drug test] prior to initiating or continuing LOT [long-term opioid therapy] and periodically thereafter."[87] The OIG found that providers conducted urine drug testing in 83 percent of patients reviewed.[88] This may have resulted in providers' inability to identify the lack of adherence to opioid therapy or potential for drug diversion for the remaining patients. The Chief of Staff reported large patient panels and a shortage of primary care providers as reasons for noncompliance.

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

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

Recommendation 11

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

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff reviewed the long-term opioid therapy process and determined providers were not consistently completing urine drug testing. A standardized facility electronic medical record template titled, "Controlled Subs Prescribing MA", was developed and implemented on April 17, 2020 (MA in the title of the template stands for 'Marion'). The new template includes the requirements for documenting urine drug testing for patients on long-term opioid therapy.

A Pain Committee designee will conduct 10 monthly random charts audits of patients on long-term opioid therapy validating that healthcare providers conduct urine drug testing. Aggregated quarterly data will be monitored until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of patients with completed urine drug testing and the denominator is 10 random chart audits of patients on newly initiated long-term opioid therapy. Results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

VHA requires healthcare providers to obtain and document informed consent prior to initiating long-term opioid therapy.[89] VHA also recommends that the informed consent conversation cover the risks and benefits of opioid therapy as well as alternative therapies.[90] The OIG determined that providers completed informed consent for 78 percent of the patients reviewed.[91] Failure to complete informed consent could result in patients not having a full understanding about the risks, benefits, and alternatives to long-term opioid therapy. The Chief of Staff reported that providers had inadequate time to complete and properly document informed consent.

Recommendation 12

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

[89] VHA Directive 1005.

[90] VHA Directive 1005.

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

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Chief of Staff reviewed the long-term opioid therapy process and determined that providers were not consistently completing informed consents. Therefore, a standardized facility electronic medical record template titled, "Controlled Subs Prescribing MA", was developed and implemented on April 17, 2020 (MA in the title of the template stands for 'Marion'). The template includes the requirement for documenting informed consent for patients who are initiated on long-term opioid therapy.

A Pain Committee designee will conduct 10 monthly random chart audits for patients who are initiated on long-term opioid therapy. Aggregated quarterly data will be monitored until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of patients who are initialed on long-term opioid therapy with an informed consent and the denominator is 10 random chart audits of patients on newly initiated long-term opioid therapy. Results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

The VA/DoD clinical practice guidelines recommend "evaluating benefits of continued opioid therapy and risk for opioid-related adverse events at least every three months."[92] The OIG found that providers documented follow-up with patients within three months in 67 percent of the electronic health records reviewed.[93] Lack of follow-up could result in missed opportunities to assess patients for adherence to and effectiveness of opioid therapy and any adverse reactions. The Chief of Staff reported that providers are not able to follow up with patients in a timely manner because of their large patient panels and a shortage of primary care providers.

Recommendation 13

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

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

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

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff reviewed the long-term opioid therapy process and determined there was a lack of documentation of provider follow-up after initiating long-term opioid therapy. Therefore, a standardized facility electronic medical record template titled, "Controlled Subs Prescribing MA" was developed on April 17, 2020 (MA in the title of the template stands for 'Marion'). The template includes the required fields for completing follow-up with patients within the required time frame after initiating long-term opioid therapy.

A Pain Committee designee will monitor 10 random charts monthly validating that providers follow-up with patients within the required time frame after initiating long-term opioid therapy. Aggregated quarterly data will be monitored until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of patients on long-term opioid therapy with provider follow-up within the required time frame and the denominator is 10 random chart audits of patients on long-term opioid therapy. Results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

Additionally, VHA requires "periodic evaluation of adherence, response to interventions, and achievement of time-limited therapeutic goals in the pain management plan."[94] The OIG found that 67 percent of patients reviewed had an assessment of adherence to a pain management plan of care during their follow-up evaluation.[95] Lack of patient adherence to the pain management plan of care can result in poor pain control. The Chief of Staff reported a shortage of primary care providers and the large panel sizes of current providers hindered appropriate follow-up evaluations.

Recommendation 14

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

[94] VHA Directive 2009-053.

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

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff reviewed the long-term opioid therapy process and determined that providers were not consistently following up with patients to assess their adherence to the pain management plan of care. Therefore, a standardized facility electronic medical record template titled, "Controlled Subs Prescribing MA" was developed on April 17, 2020 (MA in the title of the template stands for 'Marion'). The template includes the requirements for completing follow-up with patients to assess their adherence to the pain management plan of care.

A Pain Committee designee will monitor 10 random charts monthly validating providers follow-up with patients receiving long-term opioid therapy including an assessment of adherence to the pain management plan of care. Aggregated quarterly data will be monitored until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of patients on long-term opioid therapy with an assessment of adherence to the pain management plan of care and the denominator is 10 random charts of patients on long-term opioid therapy. Results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

VHA requires clinicians monitor patient's response to interventions in the pain management plan.[96] The OIG found evidence that providers assessed effectiveness of interventions during their follow-up evaluation in 58 percent of patients reviewed.[97] Failure to evaluate effectiveness of interventions may result in patients receiving sub-optimal pain management. Again, the Chief of Staff cited that the shortage of primary care providers and large panel sizes of current providers hindered this important aspect of follow-up evaluations.

Recommendation 15

15. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures providers' follow-up with patients receiving long-term opioid therapy includes effectiveness of intervention(s) provided.

[96] VHA Directive 2009-053.

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

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff reviewed the long-term opioid therapy process and determined providers were not consistently following up on patients receiving long-term opioid therapy to evaluate the effectiveness of interventions provided. Therefore, a standardized facility electronic medical record template titled, "Controlled Subs Prescribing MA" was developed on April 17, 2020 (MA in the title of the template stands for 'Marion'). The template includes the requirements for completing follow-up on patients receiving long-term opioid therapy to assess the effectiveness of interventions provided.

A Pain Committee designee will monitor 10 random charts per month validating that providers' document follow up with patients and effectiveness of interventions provided. Aggregated quarterly data will be monitored until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of patients on long-term opioid therapy with follow up that includes effectiveness of interventions provided and the denominator is 10 random chart audits of patients on long-term opioid therapy. Results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

Regarding the monitoring of quality measures, VHA requires that "a multidisciplinary pain management committee must be established at each VHA facility to provide oversight, coordination, and monitoring of pain management activities."[98] Additionally, VHA states "The quality of pain assessment and the effectiveness of pain management interventions must be monitored."[99] The OIG reviewed Pain Committee minutes from October 2018 through July 2019 and found that the Pain Committee did not monitor the quality of pain assessment and effectiveness of pain management, which could result in implementation of an ineffective pain management strategy. The Chief of Pharmacy Service reported that the Pain Committee was still in its infancy and was unaware of the monitoring requirements.

Recommendation 16

16. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the medical center's Pain Committee monitors the quality of pain assessment and the effectiveness of pain management interventions.

[98] VHA Directive 2009-053.

[99] VHA Directive 2009-053.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff with assistance from Pain Committee staff reviewed the existing quality metrics for long-term opioid management and determined that additional quality measures were needed. As a result, the Chair of the Pain Committee added a new metric to evaluate the quality of pain assessment and the effectiveness of pain management interventions for patients receiving long-term opioid medications. Results from this monitor will be reviewed during Pain Committee meetings to identify opportunities to improve long-term opioid management. Additionally, education on the requirements for managing patients receiving long-term opioid therapy was provided to medical staff during the January 09, 2020 Medicine Service meeting.

The Chief of Staff will ensure that monitoring occurs, and that Pain Committee reviews the quality of pain assessment and the effectiveness of pain management interventions for patients receiving long-term opioid management. This will be accomplished by Quality Management staff auditing 100 percent of Pain Committee minutes to determine if they reviewed outcome data on the quality of pain assessment and the effectiveness of pain management interventions for this population. Monitoring will continue until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of Pain Committee minutes with documented review of outcome data on the quality of pain assessment and the effectiveness of pain management interventions. The denominator is the number of Pain Committee minutes reviewed. Results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

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.[100] 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.[101] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[102]

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.[103]

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.[104] 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

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

[101] 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*.

[102] 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.*

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

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

VHA also requires that any patient determined to be at high risk for suicide be added to the medical center high-risk list and have a High Risk for Suicide (HRS) Patient Record Flag (PRF) placed in his or her electronic health record "as soon as possible but no later than 1 business day after such determination by the SPC."[105] 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."[106] The HRS PRF is to be reviewed at least every 90 days and depending on changes to the suicide risk status, will remain active or be removed.[107] 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.[108]

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 HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination."[109] 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."[110] 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."

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

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

[107] *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.

[108] 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*.

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

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

- The SPC's determination process "may be beyond 24 hours after a referral, due to case consultation and review."[111]

The OIG is concerned that the updated requirement may result in delayed placement of HRS PRFs for at-risk patients. Without defined time frames for SPC determination that the HRS PRF is warranted, patients identified as at-risk for suicide could have flags placed in his or her chart several days after referral. For example, the current requirement would allow for a patient to be identified as high risk for suicide and referred to the SPC on Monday, the SPC to assess the patient for risk and determine the need for an HRS PRF on the following Friday, and the SPC to place an HRS 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."[112]

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.[113] VHA also requires that all staff receive

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

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

[113] 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.

annual refresher training.[114] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[115]

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

- Relevant documents;
- The electronic health records of 38 randomly selected 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 noted the medical center's compliance with an assigned full-time SPC. 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 HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"[116]—the OIG estimated that 68 percent of HRS PRFs were placed within 24 hours of referral to the SPC.[117] 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 that the average time from referral to HRS PRF placement for the patients reviewed was 3 days (observed range was 0-20 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.[118] The OIG estimated that 11 percent of patients with an HRS PRF were reevaluated at least every 90 days.[119] However, based upon the updated requirement that HRS PRFs be reviewed up to 10 days prior to or after the due

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

[115] 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.

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

[117] The OIG estimated that 95 percent of the time, the true compliance rate is between 53.1 and 82.9 percent, which is statistically significantly below the 90 percent benchmark.

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

[119] The OIG is 95 percent confident that the true compliance rate is somewhere between 2.4 and 21.4 percent, which is statistically significantly below the 90 percent benchmark.

date for reevaluation, the OIG found that 35 of 38 patients (92 percent) were reviewed within the expected time frame (observed range was 47–102 days).

Additionally, the OIG noted concerns with the completion of suicide safety plans with all required elements and suicide prevention training.

Specifically, VHA requires that "safety plan[s] include six basic elements."[120] The OIG estimated that 69 percent of patients' safety plans reviewed included identification of professional agencies that can support or help to resolve a crisis.[121] Failure to include this required element of safety plans may hinder veterans access to appropriate care and treatment when needed. The SPC reported being unaware that the suicide prevention counselors were not documenting contact information.

Recommendation 17

17. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that Suicide Prevention Safety Plans include all required elements.

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

[121] The OIG is 95 percent confident that the true compliance rate is somewhere between 53.3 and 84.4 percent, which is statistically significantly below the 90 percent benchmark.

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Chief of Staff reviewed the process for completing Suicide Prevention Safety Plans and determined that the six required elements of the safety plan were not completed consistently. Therefore, additional staff education was provided by the Suicide Prevention Coordinator during a Behavioral Medicine Service team meeting and via email, on December 02, 2019 to address the specific requirements of a Suicide Prevention Safety Plan, including providing key information about professional agencies. Other Behavioral Medicine clinical staff were educated during interdisciplinary team meetings by the Suicide Prevention Coordinator on January 2, February 6, and May 7, 2020, and an email regarding the safety plan recommendations was sent on February 27, 2020.

The Suicide Prevention Coordinator will conduct 10 monthly random chart audits to determine if clinicians documented all required elements in Suicide Prevention Safety Plans. Aggregated quarterly data will be monitored until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of Suicide Prevention Safety Plans that include all required elements and the denominator is the 10 random chart reviews with Suicide Prevention Safety Plans. Results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

VHA requires that all employees complete suicide risk and intervention training within 90 days of entering their position and annual refresher training thereafter.[122] The OIG found that 4 of 20 clinical and non-clinical employees did not complete the mandatory annual refresher suicide prevention training. Failure to complete the training could prevent employees from providing optimal treatment for patients with suicidal ideations. The SPC reported supervisors are responsible to ensure timely completion of employee training and was uncertain why individual supervisors did not require the timely completion of the annual Talent Management System suicide prevention training.[123]

Recommendation 18

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

[122] VHA Directive 1071.

[123] Talent Management System (TMS) is a centralized electronic location where VA employees complete mandatory training and learning history is stored.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Medical Center Director reviewed the staff education training requirements and determined that additional reminders were needed to ensure that all staff complete annual suicide prevention refresher training. All medical center clinical staff have been assigned to complete "Skills Training for Evaluation and Management of Suicide," which is mandated within 90 day of entering their position and annual thereafter. Non-clinical staff have been assigned to complete "S.A.V.E. Refresher" annually.

A member of the Education Service will conduct monthly audits to ensure clinical and non-clinical staff receive annual suicide prevention refresher training. Monitoring will continue until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of clinical and non-clinical staff who completed annual suicide prevention refresher training and the denominator is the number of clinical and non-clinical staff required to complete annual suicide prevention refresher training. Results of the monitoring will be reported to the Executive Leadership Council which the Medical Center Director chairs.

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."[124]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.[125] 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.[126] 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.[127]

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

[124] 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.

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

[126] 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.

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

- Informed consent for the LST plan.

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

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

The OIG is concerned that VHA's updated requirement could mislead practitioners to only address those goals of care conversation elements that are required to be documented in the LST progress note.[128]

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.[129] 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 randomly selected electronic health records of 46 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

[128] VHA Handbook 1004.03(1).
[129] VHA Handbook 1004.03(1).

Care Coordination Findings and Recommendations

Generally, the OIG found compliance with the LSTD multidisciplinary committee processes and completion of LSTD notes by an authorized provider. However, the OIG found that LST notes were not consistently completed as required.

VHA requires that patients deemed high risk and who are without active LST orders and/or LST progress notes have documented LST plans in the electronic health record prior to referral to VA or non-VA hospice.[130] The OIG estimated that practitioners documented an LST plan for 70 percent of hospice patients, based on electronic health records reviewed.[131] Failure to document an LST plan may prevent patients from having their "values, goals and preferences regarding the initiation, limitation or discontinuation of LSTs" identified and met.[132] The Chief of Extended Care Service attributed provider noncompliance to lack of knowledge of the requirement, limited provider contact with patients referred to community nursing homes, and limited participation in LST plan documentation by non-hospice certified LIPs.

Recommendation 19

19. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that practitioners enter life-sustaining treatment notes that include all required elements in patients' electronic health records as required.

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Chief of Staff reviewed the requirements for entering a life-sustaining plan and determined additional provider education was needed. On January 31, 2020 provider education was given by the Chief of Medicine Service and the Chief of Extended Care Service that included the steps for documenting required elements of Life-Sustaining Treatment, Goals of Care Conversations for patients referred for hospice services.

The Palliative Care Social Work Coordinator will complete 10 random audits monitoring that practitioners enter Life-Sustaining Treatment notes that include all required elements. Monitoring will continue until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of Life-Sustaining Treatment Progress Notes with all the required elements and the denominator is 10 random charts of newly referred/admitted hospice patients. Results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

[130] VHA Handbook 1004.03(1).

[131] The OIG is 95 percent confident that the true compliance rate is somewhere between 55.6 and 82.2 percent, which is statistically significantly below the 90 percent benchmark.

[132] VHA Handbook 1004.03(1).

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

Women's Health Findings and Recommendations

The OIG found compliance with many of the performance indicators, including availability of Primary Care Mental Health Integration services, collection and tracking of quality assurance data, and many of the staffing elements reviewed. However, the OIG identified deficiencies with Women's Health Patient Aligned Care Teams, gynecologic care coverage 24/7, CBOC women's health primary care providers, accessibility of emergency contraceptives, and the Women Veterans Health Committee membership.

Specifically, VHA requires comprehensive care for women veterans through the provision of "complete primary care and care coordination at one site" by a Women's Health Patient Aligned Care Team.[139] The OIG found that the Mayfield and Harrisburg VA Clinics did not have a

[139] VHA Directive 1330.01(2).

designated Women's Health Patient Aligned Care Team. The absence of a designated Women's Health Patient Aligned Care Team may result in a lack of comprehensive primary care for women veterans. The Medical Center Director reported that the passage of the VA MISSION Act met the intent of this requirement.[140]

Recommendation 20

20. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that community-based outpatient clinics have a designated Women's Health Patient Aligned Care Team.

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Medical Center Director reviewed and determined that Harrisburg and Mayfield CBOCs were lacking components of a designated Women's Health Patient Aligned Care Team at these locations. A provider was successfully recruited at the Harrisburg CBOC on May 10, 2020. This completes the Women's Health Patient Aligned Care Team. However, recruitment efforts for the Mayfield CBOC continue as this is a challenge due to its rural location. Until a women's health primary care provider can be hired at the Mayfield CBOC, the Marion VA Medical Center will continue to refer women either to the community or to designated women's health providers within the organization according to patient preference and in compliance with VHA guidelines to ensure comprehensive care is delivered.

The Women Veteran Program Manager will monitor monthly the recruitment progress for hiring a women's health primary care provider for the Mayfield CBOC until the position is filled. Recruitment progress will be reported to the Executive Leadership Council which the Medical Center Director chairs.

VHA also requires facilities to ensure "…processes and procedures are in place for 24 hours per day and 7 days per week (24/7) for ED [Emergency Department] and facility call coverage for gynecologic care."[141] The Women Veterans Program Manager did not provide the OIG with a policy or evidence of 24/7 call coverage for gynecology care.[142] The lack of 24/7 gynecological care, such as pregnancy testing and gynecological examinations, may result in women veterans

[140] VA MISSION Act of 2018, Pub.L.No. 115-182, The MISSION Act gives Veterans greater access to health care in VA facilities and the community, expands benefits for caregivers, and improves VA's ability to recruit and retain the best medical providers. https://missionact.va.gov/. (The website was accessed December 16, 2019.)

[141] VHA Directive 1330.01(2).

[142] VHA Directive 1330.01(2).

not receiving timely, comprehensive care. The Medical Center Director believed that offering 24/7 gynecological care in the community via the VA MISSION Act met this requirement.[143]

Recommendation 21

21. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures processes and procedures are in place for gynecological care coverage 24 hours a day/7 days per week.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff reviewed and determined that additional agreements were needed to the support gynecological care coverage for 24 hours a day/7 days per week. The Women Veterans Program Manager has developed a SOP regarding local guidance on the care of the obstetrical and gynecological care of women veterans. The Marion VA Medical Center also follows their local policy on Inter-Facility Patient Transfers which addresses Women Veterans presenting with gynecologic and or obstetrical emergencies. A memorandum of understanding will be developed for gynecological care in collaboration with community partners.

The Chief of Staff will ensure that women veterans are either referred to the community for care or to designated women's health providers in the Marion VA Medical Center according to patient preference and in compliance with VHA guidelines to ensure comprehensive care is delivered. When the SOP has been approved, the Women Veterans Program Manager will present it at the Women Veterans Committee and at the Clinical Executive Board which the Chief of Staff chairs.

Additionally, VHA requires that "all CBOCs must have at least two WH-PCPs [Women's Health Primary Care Providers]."[144] The OIG determined that the Mayfield and Harrisburg VA Clinics did not have a designated women's health primary care provider. The Medical Center Director reported that offering the option to see a primary care provider at the assigned CBOC, or to receive care in the community through the VA MISSION Act, met the intent of this requirement.[145] The human resource specialist also stated the rurality of the CBOCs and competing recruitment efforts by community hospitals affected the medical center's ability to fill provider vacancies.

[143] VA MISSION Act of 2018.

[144] VHA Directive 1330.01(2).

[145] VA MISSON Act of 2018.

Recommendation 22

22. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that each community-based outpatient clinic has designated women's health primary care providers.

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Chief of Staff reviewed and determined that Harrisburg and Mayfield CBOCs needed a designated women's health primary care provider. A provider was successfully recruited at the Harrisburg CBOC on May 10, 2020. However, recruitment efforts for the Mayfield CBOC continue as this is a challenge due to its rural location. Until a women's health primary care provider can be hired at the Mayfield CBOC, the Medical Center will continue to refer women either to the community or to designated women's health providers in the Marion VA Medical Center according to patient preference and in compliance with VHA guidelines to ensure comprehensive care is delivered.

The Women Veteran Program Manager will monitor monthly the recruitment progress for hiring a women's health primary care provider for the Mayfield CBOC until the position is filled. Recruitment progress will be reported to the Clinical Executive Board which the Chief of Staff chairs.

VHA requires the medical center to provide emergency contraceptives in a timely manner.[146] The Chief of Pharmacy Service did not provide the OIG with evidence that emergency contraceptives were available at the Evansville VA Clinic. Failure to provide timely access to emergency contraceptives may result in the continuation of unwanted pregnancies for women veteran patients. The Chief of Pharmacy Service reported the required emergency contraceptive supply was available at the Evansville VA Clinic but could not provide evidence of this to the OIG team.

Recommendation 23

23. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the availability of timely access to emergency contraceptives at the Evansville VA Clinic.

[146] VHA Directive 1330.01(2).

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff reviewed and determined that the Evansville VA Health Care Center had emergency contraceptives available but did not include them on the Pick-point and Pyxis inventories. Both inventories were updated on May 12, 2020 to include emergency contraceptives.

The Chief of Pharmacy Service will conduct monthly audits to ensure emergency contraceptives are available at the Evansville VA Health Care Center. This will be accomplished by monitoring inventory records each month until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of inventory records that include emergency contraceptives at Evansville Health Care Center and the denominator is the number of inventory records reviewed. The results will be reported to the Clinical Executive Board which the Chief of Staff chairs.

VHA requires that the core membership of the Women Veteran Health Committee includes a Women Veterans Program Manager; a 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."[147] The OIG found the Women Veterans Committee charter did not include the core members from gynecology, pharmacy, or nursing. In addition, the OIG requested meeting minutes from the last two quarters of fiscal year 2019 and received minutes from July 2019 and August 2019 which indicated that the medical and/or surgical subspecialties, social work, emergency department, and executive leadership members did not consistently attend meetings. This could result in a lack of expertise and oversight in the review and analysis of data as the committee plans and carries out improvements for quality and equitable care for women veterans.

The Women's Health Medical Director believed that one person could fulfill three separate roles on the committee; for example, the Women's Health Medical Director could also represent medical-surgical subspecialties and gynecology. The Chief of Pharmacy Service was aware of the requirement but was unable to send a representative due to four vacancies in the department. The Chief of Staff reported the executive leadership representation was delegated to the Women Veterans Program Manager. The Women Veterans Program Manager conveyed that staff from social work and emergency department were assigned but did not attend due to scheduling constraints and clinical care priorities.

[147] VHA Directive 1330.01(2).

Recommendation 24

24. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that required core members are assigned and consistently attend Women Veterans Committee meetings.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Medical Center Director reviewed the core membership for the Women Veterans Committee and determined that core membership requirement was not met. Additionally, core committee members or designees did not consistently attend meetings. The Women Veterans Program Manager will modify the committee charter to include all core members. The Medical Center Director communicated to the chair of the Women Veterans Committee the expectation that members will attend meetings consistently and meeting reminders will be sent to Women Veterans Committee members ahead of scheduled meetings to improve attendance.

The Women Veterans Program Manager will monitor the attendance of the required core members. Attendance will be monitored until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of Women Veterans Committee core members present at the meetings and the denominator is the number of Women Veterans Committee members. Results will be reported to the Executive Leadership Council which the Medical Center Director chairs.

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have a Sterile Processing Services (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment…"[148] The goal of SPS is to "...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[149] 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[150]
- 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[151]

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.[152] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[153]

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,

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

[149] 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.)

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

[151] VHA Directive 1116(2).

[152] 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.

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

personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[154]

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.[155]

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

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

  - Eating or drinking in the area prohibited
  - Equipment properly stored
  - Required temperature and humidity maintained
- Completion of staff training, competency, and continuing education
  - Required training completed in a timely manner
  - Competency assessments performed
  - Monthly continuing education received

High-Risk Processes Findings and Recommendations

The medical center met the requirements for monitoring of quality assurance and physical inspections of reprocessing and storage areas. However, the OIG identified deficiencies with administrative processes and staff training and competency.

VHA requires that facilities "…must have standard operating procedures (SOPs) based on manufacturer's guidelines that establishes a documented and systematic approach to critical and semi-critical RME processes."[156] VHA also requires that "…all SOPs are kept up-to-date, reviewed at least every 3 years and updated when there is a change in process or a change in manufacturer's IFU [instructions for use]."[157] The OIG reviewed and found the colonoscope SOP did not align with the IFU. This may have resulted in inadequate disinfection of RME. The SPS Chief stated that the manufacturer advised the use of a different brush than the one indicated on the manufacturer's IFU but could not provide supporting documentation. The SPS Chief also offered that it may have been a typing error on the facility SOP.

Recommendation 25

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

[156] VHA Directive 1116(2).
[157] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Associate Director for Patient Care Services reviewed and determined that Sterile Processing Service SOP did not contain all the required elements. As a result, the Sterile Processing Service SOPs were modified and updated by the Chief of Sterile Processing Service, based on current manufacture guidelines and instructions for use, including the SOP for "Endoscope Olympus Flexible Videoscope" which was revised on November 26, 2019.

The Chief of Sterile Processing Service will ensure that monitoring occurs, and that Sterile Processing Service SOPs align with current manufacturers' guidelines and instructions for use. This will be accomplished by monitoring 5 SOPs each month until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of the Sterile Processing Service SOPs reviewed that contain current manufacturers' guidelines and instructions for use and the denominator is five of the number of Sterile Processing Service SOPs reviewed. Results will be reported to the Executive Leadership Council of which the Associate Director for Patient Care Services is a member.

To promote patient safety and sustainable processes, VHA requires that all facilities deploy the CensiTrac® Instrument Tracking System.[158] The OIG did not find evidence of all instruments being tracked through the CensiTrac® Instrument Tracking System. Not using CensiTrac® may result in potential veteran and staff harm through noncompliant record control processes. The SPS Chief reported that infrequently used and single instruments were not entered into CensiTrac® until the instruments were requested for use and sent for reprocessing. The RME Coordinator stated that several instrument sets had not been used since implementation of CensiTrac® and therefore were not entered. The SPS Chief stated that CensiTrac® was only being partially implemented because supporting the operating rooms took precedence over ensuring that large volumes of items were entered into the system.

Recommendation 26

26. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that all equipment is entered into the CensiTrac® Instrument Tracking System.

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

Medical center concurred.

Target date for completion: November 30, 2020

Medical center response: The Associate Director for Patient Care Services reviewed and determined that the CensiTrac® had not been fully implemented. The Chief of Sterile Processing Service fully implemented the CensiTrac® system by completing an inventory of all instruments to ensure they were logged on April 04, 2020. Going forward, all new instruments will be logged into the CensiTrac® system before they are put into service.

The Chief of Sterile Processing Service will conduct monthly monitoring of all new instruments logged into CensiTrac®. This will be accomplished by monitoring 5 or 100 percent if < 5 new instruments each month. Aggregated quarterly data will be monitored until 90 percent compliance has been reached for two consecutive quarters. The numerator is the number of new instruments logged into CensiTrac® and the denominator is the number of new instruments. Results will be reported to the Executive Leadership Council of which the Associate Director of Patient Care Services is a member.

VHA requires that the SPS Chief performs an annual risk analysis and reports the results to the VISN SPS Management Board.[159] The OIG found that the SPS Chief performed a risk analysis but did not report the results to the VISN SPS Management Board. Failure to report the risk analysis could result in a lack of identification of potential problems or process failures. The SPS Chief thought the risk analysis results had been reported.

Recommendation 27

27. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that the Sterile Processing Services Chief consistently performs an annual risk analysis and reports the analysis to the VISN Sterile Processing Services Management Board.

[159] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Associate Director for Patient Care Services reviewed and determined the facility Sterile Processing Service annual risk assessment was completed. However, there was no evidence in the VISN Sterile Processing Service Management Board minutes that the annual risk assessment was received or reviewed.

The Chief of Sterile Processing Service will ensure that monitoring occurs, the annual risk analysis is conducted, and is reported to the VISN Sterile Processing Services Management Board. Results will be reported to the Executive Leadership Council of which the Associate Director of Patient Care Services is a member.

VHA requires annual airflow system inspections to maintain a controlled environment.[160] The OIG found that the scope inspection room, housed within the SPS preparation/assembly room, did not have an annual airflow check. Failure to evaluate the heating, ventilation, and air-conditioning system may result in an increased opportunity for healthcare-associated infections.[161] The SPS Chief and RME Coordinator reported the door in the scope inspection room was always kept open and that this met the requirement for one airflow check for both rooms.

Recommendation 28

28. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that annual airflow testing is conducted in all areas where reusable medical equipment is reprocessed.

[160] VHA Directive 1116(2).

[161] Centers for Disease Control and Prevention, *Guidelines for Environmental Infection Control in Health-Care Facilities, July 2019*. https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf. (The website was accessed on February 6, 2020.)

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Associate Director for Patient Care Services reviewed and reinforced staff accountability for consistently monitoring and documenting annual airflow tests.

The Chief of Sterile Processing Service will ensure that monitoring occurs, and that annual air flow testing is conducted in all areas where reusable medical equipment is reprocessed. Monitoring will continue until annual air flow testing is demonstrated. Annual testing results will be reported to the Executive Leadership Council of which the Associate Director of Patient Care Services is a member.

VHA requires that competencies be conducted and documented listing all critical action steps, validation methods, and the validators' initials.[162] The OIG team reviewed one competency for the Olympus Flexible Videoscope CF-HQ190L and one competency for the Olympus Evis Exera III Bronchovideoscope BF-H190 for five selected SPS staff (10 competencies total). The OIG found the competencies lacked critical action steps and validator initials for five SPS employees. Failure to properly complete the required competency assessments could result in improper reprocessing of RME and place patients and employees at risk of microbial contamination and exposure to chemical and material hazards.[163] The SPS Chief was unaware that the assessments were improperly completed and stated the competency process as well as the documentation forms are being revised.

Recommendation 29

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

[162] VHA DUSHOM Memorandum, *Competency Assessment for Employees Reprocessing Critical and Semi-critical Reusable Medical Equipment*, April 11, 2017.

[163] Centers for Disease Control and Prevention, *Guidelines for Environmental Infection Control in Health-Care Facilities, July 2019.* https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf. (The website was accessed on August 15, 2019.)

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Associate Director for Patient Care Services reviewed and determined that the existing Sterile Processing Service competency forms should be modified to include critical action steps and validator initials. The Chief of Sterile Processing Service completed edits to the existing competency forms on November 19, 2019.

The Chief of Sterile Processing Service will perform a random monthly audit of 10 competencies to ensure that critical action steps and validator initials are included in the competency assessment. Monitoring will continue until 90 percent compliance is demonstrated for two consecutive quarters. The numerator is the number of competencies reviewed with all required elements including critical action steps and validator initials and the denominator is 10 Sterile Processing Service competencies reviewed. Results will be reported to the Executive Leadership Council of which the Associate Director for Patient Care Services is a member.

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 (medical center or system) • VHA performance data for CLCs	Twenty-nine 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, ADPCS, and Associate Director for Operations. 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	• Action items are implemented when problems or opportunities for improvement are identified and documented in Executive Leadership Council minutes.	• Physician UM advisors consistently document their decisions in the National Utilization Management Integration database. • All required representatives consistently 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	• Reprivileging decisions are based on service-specific OPPE data. • Providers with similar training and privileges complete OPPEs of licensed independent practitioners. • Licensed healthcare professional's first- or second-line supervisor completes and signs the exit review forms within seven calendar days of the professional's departure from the medical center.	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Medical center
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Accommodation and privacy for women veterans
	  ○ Logistics
	• Inpatient mental health unit
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Accommodation for women veterans
	  ○ Logistics
	• Community-based outpatient clinic
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Privacy for women veterans
	  ○ Logistics
		• Staff secure protected health information within laboratory transport containers.	• Medical center managers repair or remove damaged wheelchairs from service.

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	• Clinicians complete pain screening for all patients prior to initiating long-term opioid therapy. • Providers complete a behavior risk assessment that includes a history of substance abuse, psychological disease, and aberrant drug-related behaviors on patients prior to initiating long-term opioid therapy. • Providers consistently conduct urine drug testing as required for patients on long-term opioid therapy. • Providers consistently obtain and document informed consent for patients who are initiated on long-term opioid therapy. • Providers follow up with patients within required time frame after initiating long-term opioid therapy. • Providers' follow-up of patients receiving long-term opioid therapy includes assessment of adherence to pain management plan of care. • Providers' follow up of patients receiving long-term opioid therapy includes effectiveness of intervention(s) provided.	• The medical center's Pain Committee monitors the 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 medical center suicide prevention coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements	• Safety plans include all required elements.	• Clinical and non-clinical staff receive annual suicide prevention refresher training.
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• Practitioners enter life-sustaining treatment notes that include all required elements in patients' electronic health records as required.	• None.
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• Community-based outpatient clinics have a designated Women's Health Patient Aligned Care Team. • Processes and procedures are in place for gynecological care coverage 24 hours a day/7 days per week. • Each community-based outpatient clinic has designated women's health primary care providers. • Emergency contraceptives are available to all women veteran patients in a timely manner at the Evansville VA Clinic.	• Required core members are assigned and consistently attend Women Veterans Committee meetings.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Data monitoring • Physical inspection • Staff training	• Standard operating procedures align with manufacturers' guidelines and instructions for use. • All equipment is entered into the CensiTrac® Instrument Tracking System. • Annual airflow testing is conducted in all areas where reusable medical equipment is reprocessed. • Sterile Processing Services managers properly complete competency assessments for staff reprocessing reusable medical equipment.	• The Sterile Processing Services Chief consistently performs an annual risk analysis and reports the analysis to the VISN Sterile Processing Services Management Board.

Appendix B: Medical Center Profile

The table below provides general background information for this medium complexity (2) medical center reporting to VISN 15.[1]

Table B.1. Profile for Marion VA Medical Center (675)
(October 1, 2016, through September 30, 2019)

Profile Element	Medical center Data FY 2017[2]	Medical center Data FY 2018[3]	Medical center Data FY 2019[4]
Total medical care budget in dollars	$293,645,168	$332,084,563	$344,061,606
Number of:			
• Unique patients	43,758	43,220	45,269
• Outpatient visits	477,323	479,970	475,921
• Unique employees[5]	955	1084	1204
Type and number of operating beds:			
• Community living center	54	54	54
• Domiciliary	9	9	20
• Medicine	33	33	33
• Surgery	6	6	6
Average daily census:			
• Community living center	31	27	27
• Domiciliary	9	9	12
• Medicine	17	15	14
• Surgery	0	0	0

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] The VHA medical centers are classified according to a medical center complexity model; a designation of "2" indicates a medical center with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs."

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

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

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

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

Appendix C: VA Outpatient Clinic Profiles[1]

The VA outpatient clinics in communities within the catchment area of the 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
Mount Vernon, IL	657GK	4,538	2,496	n/a	EKG	Nutrition Social Work Weight management

[1] Includes all outpatient clinics in the community that were in operation as of August 27, 2019. The OIG omitted (657QC) Enterprise Way, 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.

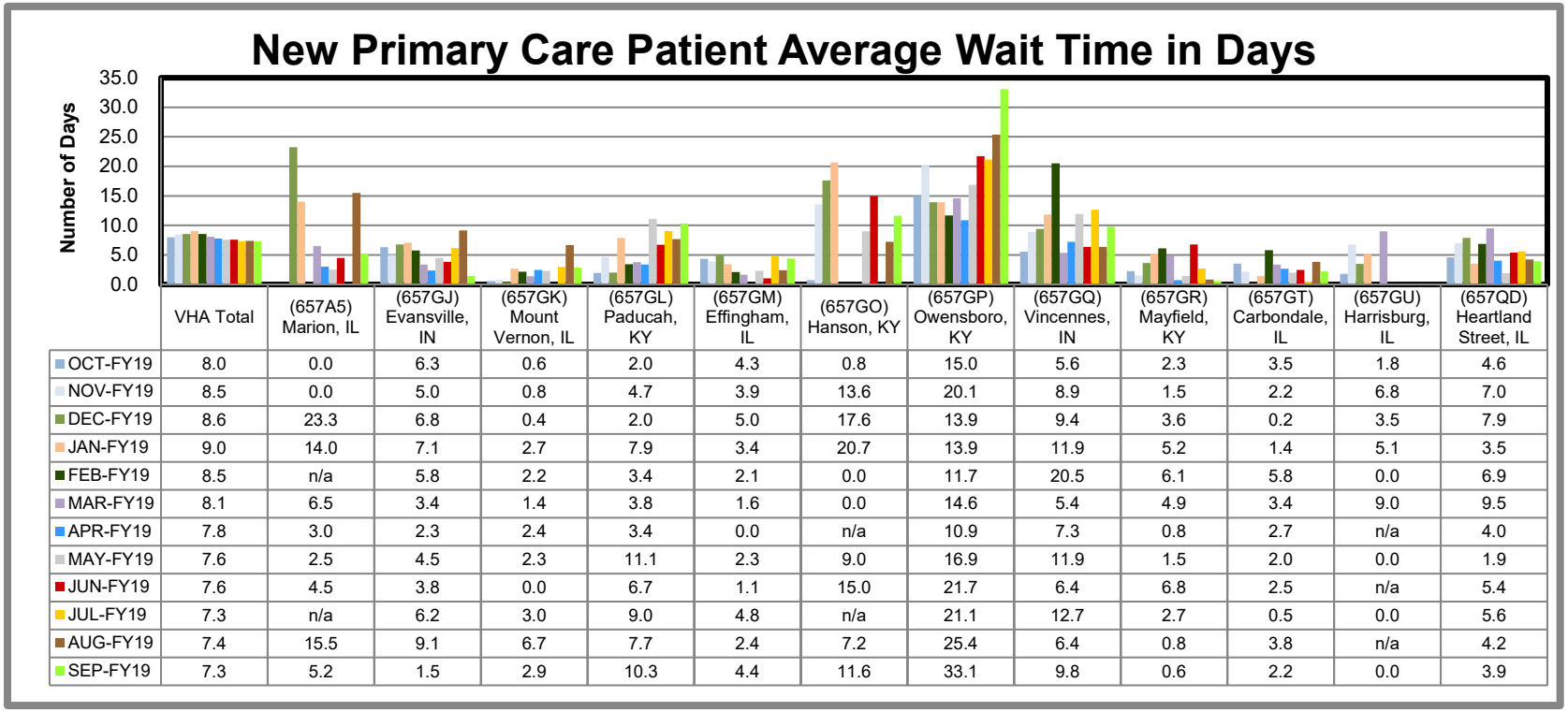
[5] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Evansville, IN	657GJ	22,336	16,802	Anesthesia Cardiology Dermatology Eye Gastroenterology General surgery Hematology/ Oncology Infectious disease Nephrology Orthopedics Otolaryngology Podiatry Poly-trauma Pulmonary/ Respiratory disease Rehab physician Spinal cord injury Urology	EKG Laboratory & Pathology Radiology	Dental Nutrition Social Work Weight management
Paducah, KY	657GL	9,490	4,898	Dermatology	EKG	Nutrition Social Work Weight management
Effingham, IL	657GM	6,086	2,249	Dermatology	EKG	Nutrition Weight management
Hanson, KY	657GO	2,478	170	n/a	EKG	Nutrition Weight management
Owensboro, KY	657GP	6,579	4,592	Dermatology	EKG	Nutrition Social Work Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Vincennes, IN	657GQ	3,610	1,844	n/a	EKG	Nutrition Social Work Weight management
Mayfield, KY	657GR	5,630	3,210	Dermatology	EKG	Nutrition Weight management
Carbondale, IL	657GT	6,283	1,787	Dermatology	EKG	Nutrition Social Work Weight management
Harrisburg, IL	657GU	3,182	952	Dermatology	EKG	Nutrition Weight management
Marion, IL	657QD	10,441	971	GYN	EKG	Nutrition 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]



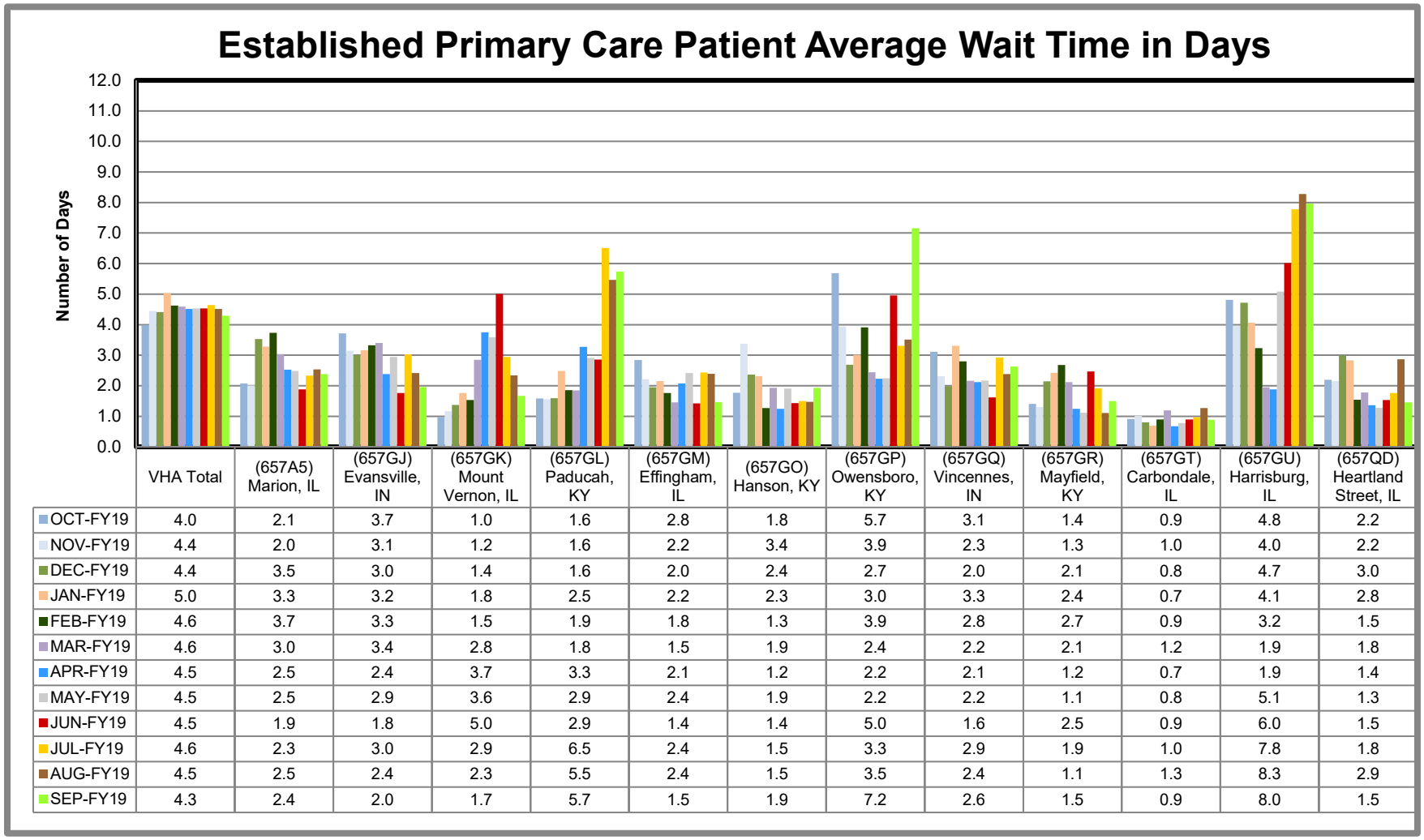
	VHA Total	(657A5) Marion, IL	(657GJ) Evansville, IN	(657GK) Mount Vernon, IL	(657GL) Paducah, KY	(657GM) Effingham, IL	(657GO) Hanson, KY	(657GP) Owensboro, KY	(657GQ) Vincennes, IN	(657GR) Mayfield, KY	(657GT) Carbondale, IL	(657GU) Harrisburg, IL	(657QD) Heartland Street, IL
OCT-FY19	8.0	0.0	6.3	0.6	2.0	4.3	0.8	15.0	5.6	2.3	3.5	1.8	4.6
NOV-FY19	8.5	0.0	5.0	0.8	4.7	3.9	13.6	20.1	8.9	1.5	2.2	6.8	7.0
DEC-FY19	8.6	23.3	6.8	0.4	2.0	5.0	17.6	13.9	9.4	3.6	0.2	3.5	7.9
JAN-FY19	9.0	14.0	7.1	2.7	7.9	3.4	20.7	13.9	11.9	5.2	1.4	5.1	3.5
FEB-FY19	8.5	n/a	5.8	2.2	3.4	2.1	0.0	11.7	20.5	6.1	5.8	0.0	6.9
MAR-FY19	8.1	6.5	3.4	1.4	3.8	1.6	0.0	14.6	5.4	4.9	3.4	9.0	9.5
APR-FY19	7.8	3.0	2.3	2.4	3.4	0.0	n/a	10.9	7.3	0.8	2.7	n/a	4.0
MAY-FY19	7.6	2.5	4.5	2.3	11.1	2.3	9.0	16.9	11.9	1.5	2.0	0.0	1.9
JUN-FY19	7.6	4.5	3.8	0.0	6.7	1.1	15.0	21.7	6.4	6.8	2.5	n/a	5.4
JUL-FY19	7.3	n/a	6.2	3.0	9.0	4.8	n/a	21.1	12.7	2.7	0.5	0.0	5.6
AUG-FY19	7.4	15.5	9.1	6.7	7.7	2.4	7.2	25.4	6.4	0.8	3.8	n/a	4.2
SEP-FY19	7.3	5.2	1.5	2.9	10.3	4.4	11.6	33.1	9.8	0.6	2.2	0.0	3.9

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (657QC) Marion, IL, as no data were reported. The OIG has on file the medical center's explanation for the increased wait times for the (657GP) Owensboro, KY, CBOC.

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

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



	VHA Total	(657A5) Marion, IL	(657GJ) Evansville, IN	(657GK) Mount Vernon, IL	(657GL) Paducah, KY	(657GM) Effingham, IL	(657GO) Hanson, KY	(657GP) Owensboro, KY	(657GQ) Vincennes, IN	(657GR) Mayfield, KY	(657GT) Carbondale, IL	(657GU) Harrisburg, IL	(657QD) Heartland Street, IL
OCT-FY19	4.0	2.1	3.7	1.0	1.6	2.8	1.8	5.7	3.1	1.4	0.9	4.8	2.2
NOV-FY19	4.4	2.0	3.1	1.2	1.6	2.2	3.4	3.9	2.3	1.3	1.0	4.0	2.2
DEC-FY19	4.4	3.5	3.0	1.4	1.6	2.0	2.4	2.7	2.0	2.1	0.8	4.7	3.0
JAN-FY19	5.0	3.3	3.2	1.8	2.5	2.2	2.3	3.0	3.3	2.4	0.7	4.1	2.8
FEB-FY19	4.6	3.7	3.3	1.5	1.9	1.8	1.3	3.9	2.8	2.7	0.9	3.2	1.5
MAR-FY19	4.6	3.0	3.4	2.8	1.8	1.5	1.9	2.4	2.2	2.1	1.2	1.9	1.8
APR-FY19	4.5	2.5	2.4	3.7	3.3	2.1	1.2	2.2	2.1	1.2	0.7	1.9	1.4
MAY-FY19	4.5	2.5	2.9	3.6	2.9	2.4	1.9	2.2	2.2	1.1	0.8	5.1	1.3
JUN-FY19	4.5	1.9	1.8	5.0	2.9	1.4	1.4	5.0	1.6	2.5	0.9	6.0	1.5
JUL-FY19	4.6	2.3	3.0	2.9	6.5	2.4	1.5	3.3	2.9	1.9	1.0	7.8	1.8
AUG-FY19	4.5	2.5	2.4	2.3	5.5	2.4	1.5	3.5	2.4	1.1	1.3	8.3	2.9
SEP-FY19	4.3	2.4	2.0	1.7	5.7	1.5	1.9	7.2	2.6	1.5	0.9	8.0	1.5

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (657QC) Marion, IL, as no data 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

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

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

Source: VHA Support Service Center

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

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

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

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 1, 2020

From: Director, VA Heartland Network (10N15)

Subj: Comprehensive Healthcare Inspection of the Marion VA Medical Center in Illinois

To: Director, Office of Healthcare Inspections (54CH06)

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

Attached is the facilities response to the Comprehensive Healthcare Inspection of the Marion VA Medical Center, Illinois draft report.

I have reviewed and concur with the facility's response to the findings, recommendations, and submitted action plans.

(Original signed by:)

William P. Patterson, M.D., MSS
Network Director
VA Heartland Network (VISN 15)

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: May 27, 2020

From: Director, Marion VA Medical Center (657A5/00)

Subj: Comprehensive Healthcare Inspection of the Marion VA Medical Center in Illinois

To: Director, VA Heartland Network (10N15)

I have reviewed the findings within the report of the Comprehensive Healthcare Inspection of the Marion VA Health Care System. I agree with all the findings of the review.

Corrective action plans have been established with planned completion dates outlined in this report.

(Original signed by:)

Jo-Ann Ginsberg, RN, MSN
Medical Center Director

OIG Contact and Staff Acknowledgments

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