DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019

Figure 1. *U.S. Department of Veterans Affairs Headquarters, Washington, DC*
(Source: https://www.gsa.gov/, accessed March 13, 2019)

Abbreviations

ADPCS	associate director for patient care services
CBOC	community-based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CPR	cardiopulmonary resuscitation
FPPE	focused professional practice evaluation
FY	fiscal year
LIP	licensed independent practitioner
MST	military sexual trauma
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UCC	urgent care center
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) fiscal year 2019 summary report provides a focused evaluation of the quality of care delivered in 43 inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. The inspections covered 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. Inspections are performed approximately every three years and evaluate specific areas of focus.

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

1. Quality, safety, and value

2. Medical staff privileging

3. Environment of care

4. Medication management (targeting controlled substances inspections)

5. Mental health (focusing on military sexual trauma follow-up and staff training)

6. Geriatric care (spotlighting antidepressant use among the elderly)

7. Women's health (highlighting abnormal cervical pathology results notification and follow-up)

8. High-risk processes (emphasizing operations and management of emergency departments and urgent care centers)

The OIG conducted unannounced site visits at 43 VHA medical centers and outpatient clinics between November 5, 2018, and July 26, 2019. Each site visit involved interviews with facility leaders and staff and reviews of clinical and administrative processes. Although the OIG reviewed a broad spectrum of processes related to the above areas of focus, the sheer complexities of VA facilities limit the inspection teams' abilities to assess all areas of clinical risk. The results in this report are a snapshot of VHA performance within the identified focus areas at the time of the OIG visits during fiscal year 2019. Although it is difficult to quantify the risk of patient harm, the findings in this report may help VHA identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

Leadership and Organizational Risks

The OIG noted positive observations during the review of leadership and organizational risks at the representative sample of 43 VA facilities. First, the OIG found that 88 percent of leadership positions were filled by permanent staff at the time of the inspections. Leaders generally appeared engaged in quality, safety, and value (QSV) activities at their facilities. They reported feeling supported by VISN leaders and program managers and having access to public/private sector expert resources for guidance and assistance with QSV and quality improvement. The executive leaders were also generally knowledgeable about employee and patient satisfaction survey results and related improvement activities. Further, most facility leaders were actively involved in maintaining various accreditations, addressing The Joint Commission (TJC) and OIG recommendations for improvement, and managing organizational risks.

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. The OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[1] The OIG noted opportunities for multiple facilities to improve their SAIL star ratings. Eleven of the surveyed facilities received a "1-" or "2-star" rating as of June 30, 2018. However, there were no remarkable trends observed when comparing facilities' star ratings to complexity levels, number of sentinel events, number of institutional disclosures, or number of OIG CHIP recommendations for improvement.

The OIG noted trends when comparing facilities' complexity levels to the numbers of sentinel events and institutional disclosures—higher occurrence rates were observed for facilities with higher complexities. This observation is not surprising given these facilities' complex clinical programs, volume of high-risk patients, and affiliations with teaching programs. However, there was no corresponding trend for the number of OIG CHIP recommendations—medium and low complexity facilities received notable numbers of OIG recommendations compared to facilities with higher complexities.

The OIG found improvement opportunities in all eight clinical areas reviewed and issued 32 recommendations. These are briefly described below.

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

Quality, Safety, and Value

The OIG found general compliance with many of the selected requirements for patient safety and resuscitation episode reviews. However, the OIG identified weaknesses with the quarterly review of peer review data, peer review of all applicable deaths within 24 hours of admission to the hospital, documentation of at least 75 percent of physician utilization management (UM) advisors' decisions in the National UM Integration database, interdisciplinary review of UM data, root cause analysis processes, and evaluation of each resuscitation episode by cardiopulmonary resuscitation committees.[2]

Medical Staff Privileging

The OIG found general compliance with selected requirements for privileging but identified concerns with professional practice evaluation processes.

Environment of Care

Facilities and community-based outpatient clinics generally met requirements for environment of care rounds and deficiency tracking, general safety, privacy, women veterans programs, hazard vulnerability analyses, and availability of medical equipment and supplies. Locked inpatient mental health units also met overall requirements for environment of care rounds, public area safety, infection prevention, and availability of medical equipment and supplies. However, the OIG identified vulnerabilities related to environmental cleanliness and infection prevention, locked inpatient mental health unit safety, and emergency management.

Medication Management

Most facilities met requirements associated with controlled substance inspectors. However, the OIG found deficiencies with quality management committees' review of monthly and quarterly trend reports, staff restrictions for monthly balance adjustment review, controlled substances area inspections, pharmacy inspections, and facility reviews of override reports.

Military Sexual Trauma

Generally, the OIG found that facilities met requirements for the designation of military sexual trauma (MST) coordinators, establishment and monitoring of informational outreach, tracking of MST-related data, and provision of clinical care. The OIG noted lack of compliance with monitoring of MST-related staff trainings; communication of MST issues, services, and

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[2] 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."

initiatives with facility leaders; and mental health and primary care providers' completion of mandatory MST training within the required time frame.

Geriatric Care

The OIG found general compliance with clinicians' documentation of reasons for medication initiation. However, the OIG identified that many clinicians did not provide adequate patient and/or caregiver education specific to newly prescribed medications, assess patient and/or caregiver understanding of the education provided, or reconcile patients' medications.

Women's Health

The OIG found that facilities generally complied with requirements for the selected staffing elements and provision of care indicators reviewed. However, weaknesses were identified with women veterans health committees and collection and tracking of cervical cancer screening data.

High-Risk Processes

Facilities generally met emergency department/urgent care center requirements for patient flow, medication security and labeling, management of patients with mental health disorders, emergency department participation in local/regional emergency medical services systems, women veteran services, and life support equipment. However, the OIG identified deficiencies with emergency department/urgent care center operating hours, staffing, support services, and general safety.

Conclusion

The OIG conducted detailed inspections at 43 representative facilities across nine key areas (one nonclinical and eight clinical) and noted 10 repeat findings from the *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, for which improvement actions remain in progress; therefore, the OIG made no new recommendations.[3] The OIG subsequently issued 32 recommendations for improvement to the Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders. The results in this report, which were noted from systems issues, should be used by VHA leaders to improve operations and clinical care at the facility level. The recommendations address findings that, if not addressed, may eventually interfere with the delivery of quality health care.

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[3] VA OIG, *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, Report #19-07040-243, October 10, 2019.

Comments

The Executive in Charge, Office of the Under Secretary for Health, agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans (see appendix E, page 97, and the responses within the body of the report for the full text of the executive's comments). The OIG has received evidence of compliance and considers recommendations 21 and 22 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General's (OIG) fiscal year (FY) 2019 comprehensive healthcare inspections was to conduct oversight of healthcare services to veterans. The OIG accomplished this focused evaluation of the quality of care delivered in the inpatient and outpatient settings of a representative sample of 43 facilities by examining a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reported its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions could 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 controlled substances inspections)

6. Mental health (focusing on military sexual trauma follow-up and staff training)

7. Geriatric care (spotlighting antidepressant use among the elderly)

8. Women's health (highlighting abnormal cervical pathology results notification and follow-up)

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

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

9. High-risk processes (emphasizing operations and management of emergency departments urgent care centers)[3]
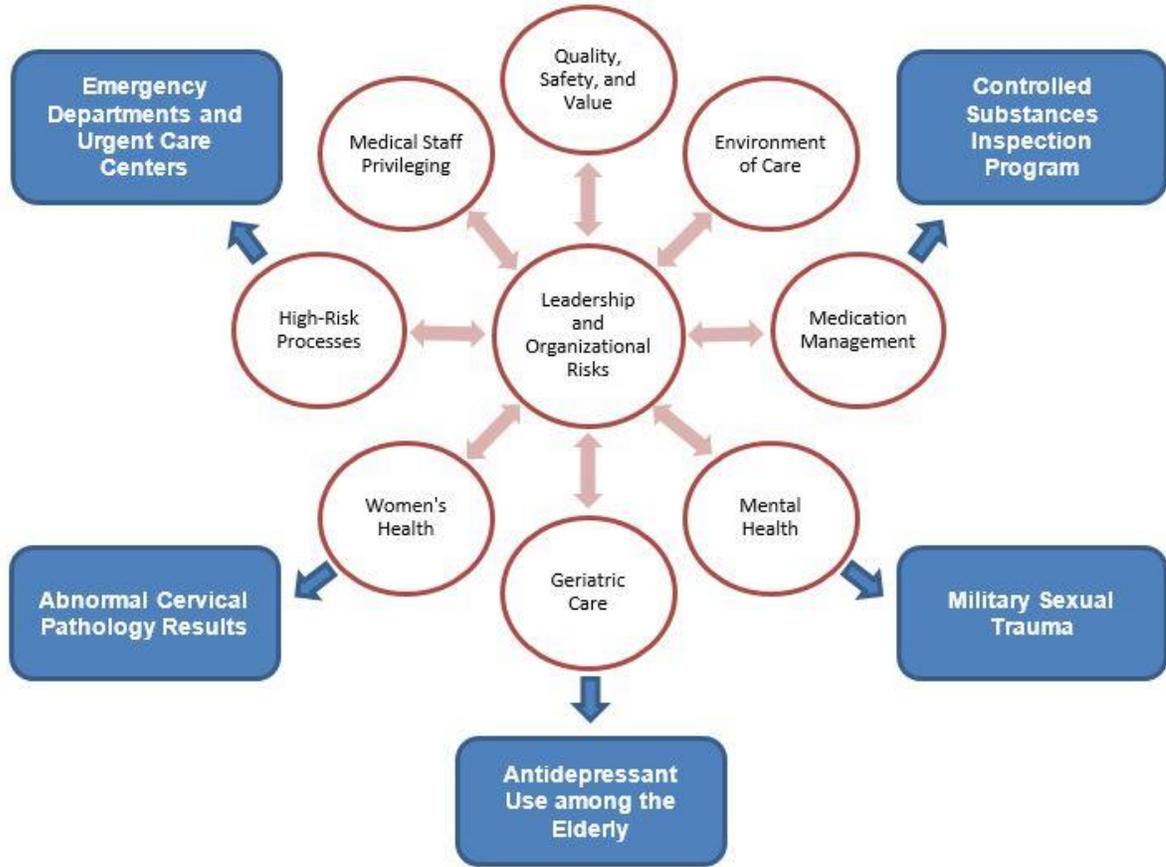

Figure 2. FY 2019 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

[3] See figure 2. Comprehensive Healthcare Inspection Program (CHIP) inspections address these processes during FY 2019 (October 1, 2018, through September 30, 2019); they may differ from prior years' focus areas.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection teams reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports; physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees.[4] The OIG also interviewed members of the executive leadership team at each facility.

The inspections generally examined operations from each randomly selected facility's last routine cyclical OIG inspection. While on site at 15 of the 43 facilities, the OIG referred identified vulnerabilities beyond the scope of the Comprehensive Healthcare Inspection Program (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 target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA completes corrective actions. The comments and action plans submitted by the Executive in Charge, Office of the Under Secretary for Health, in response to the report recommendations appear within each topic area. The OIG accepted the action plans that the VHA 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.

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can affect a facility's ability to provide care in all selected clinical areas of focus.[5] To assess facility-level risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement

2. Employee satisfaction

3. Patient experience

4. Accreditation and/or for-cause surveys and oversight inspections

5. Factors related to possible lapses in care

6. VHA performance data

Executive Leadership Position Stability and Engagement

The OIG performed this review at facilities representing all VISNs and complexity levels (see appendix D, tables D.1 and D.2).[6] Each VA facility organizes its leadership to address the needs and expectations of the local veteran population it serves, and the OIG observed variation in the composition of the executive leadership team at individual facilities. The most common team composition (28 of 43 facilities) included a director, chief of staff, associate director for patient care services (ADPCS), and associate director(s) (primarily nonclinical). The OIG observed that the next most common team composition (8 of 43 facilities) included an additional assistant director (see appendix D, table D.3).

During each comprehensive healthcare inspection, the OIG collected human resource data pertaining to the leadership team that indicated whether the positions were occupied by permanent or interim staff, and the duration of each leader's tenure. For the 190 leadership positions reviewed, 167 positions (88 percent) were permanently assigned while 23 positions (12 percent) were occupied by staff serving in an acting capacity. The 23 positions filled by non-

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

[6] According to VHA Office of Productivity, Efficiency, and Staffing (OPES), "the Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex." Facility groupings are used for various peer grouping purposes, such as operational reporting, performance measurement, and research studies.

permanent staff included 6 facility directors, 6 chiefs of staff, 6 associate directors for patient care services, and 5 associate directors (see appendix D, table D.4).

Among the permanently-assigned leaders, the OIG noted variations in their tenures. Thirty-seven permanently-assigned facility directors served in their positions an average of 3 years; tenure ranged from approximately 1 day to 8.5 years at the time of inspection. The OIG noted that 36 chiefs of staff had also served in their roles an average of 3 years. The newest chief of staff was scheduled to assume the duty approximately 1 week from time of inspection, and the most experienced had served for over 21 years.

As with the directors and chiefs of staff, the OIG found a range of tenures for the associate directors for patient care services, deputy directors, associate directors, and assistant directors. The 36 associate directors for patient care services appear to have been the most stable group, having served in their roles an average of 3.9 years. The newest ADPCS was on the job for approximately 7 weeks and the most experienced for almost 13 years at the time of the comprehensive healthcare inspections. The OIG also found that 5 deputy directors, 39 associate directors, and 11 assistant directors had served in their positions an average of 2.0, 2.8, and 3.6 years, respectively. The deputy directors' tenures ranged from approximately 13 weeks to 3.4 years, the associate directors' tenures ranged from approximately 3 weeks to almost 8.6 years, and the assistant directors' tenures ranged from approximately 25 weeks to just over 10 years (see figure 3 and appendix D, tables D.4 and D.5).
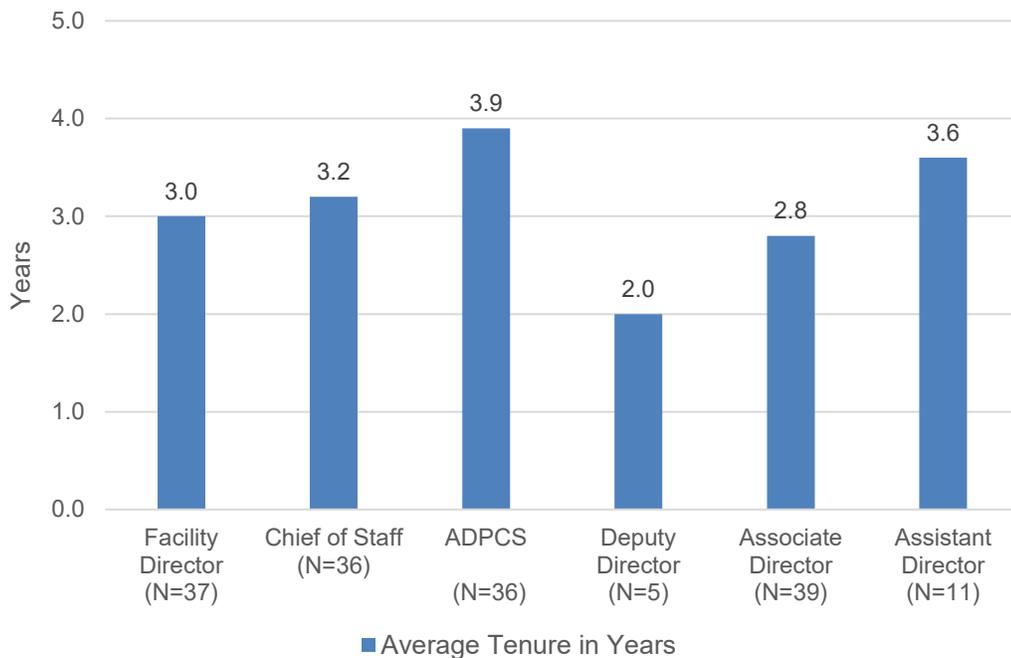

Figure 3. Average Tenure by Typical Leadership Position
Source: VA OIG

During on-site interviews, the OIG assessed facility directors' participation in and engagement with QSV activities; whether they felt supported by VISNs; and whether they had access to external resources for QSV and performance improvement activities. During interviews, facility directors reported spending significant time supporting QSV and improvement activities.[7] When asked about the level of VISN support for quality improvement activities, 38 of 43 facility directors (88 percent) indicated that VISNs provide adequate support.[8] The OIG also noted that 41 of 43 facility directors (95 percent) reported having access to public and/or private sector resources for guidance with quality improvement.[9]

The OIG also assessed the level of engagement of all members of the leadership team with improvement activities involving Strategic Analytics for Improvement and Learning (SAIL), All Employee Survey, and Survey of Healthcare Experiences of Patients data.[10] Interviewed facility leaders were generally able to identify SAIL metrics that contribute to their respective facilities' most recent star rating at the time of the OIG's inspection.[11] Further, when asked about two facility-specific and poorly-performing metrics, leaders were generally able to discuss the cause[12] as well as actions taken or currently underway to improve performance of the metrics.[13]

Regarding survey results relating to the period of October 1, 2017, through September 30, 2018, medical center leaders were generally able to discuss factors contributing to their All Employee Survey scores and actions taken to improve or sustain employee satisfaction and psychological safety.[14] Interviewed facility leaders were also generally able to discuss factors contributing to the observed inpatient, Patient-Centered Medical Home, and Specialty Care Survey of

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[7] Responses included percentages of time, percentage ranges, and numbers of hours per week spent supporting QSV and improvement activities.

[8] Two facility director responses did not clearly address the question, two indicated that VISNs provide inadequate support, and one permanently-assigned facility director was not available for an interview.

[9] One facility director's response indicated no access to public and/or private sector expert resources for guidance in QSV and improvement activities, and one permanently-assigned facility director was not available for an interview.

[10] The OIG assessed facility leaders' responses to specific questions using a scale of 1–5 where a score of 1 indicates the "Interviewee had no answer or could not provide a substantive response," and a score of 5 indicates the "Interviewee provided a thorough response that included in-depth understanding of the metric/question, several facility-based examples to support knowledge, and was able to speak knowledgeably about content/improvement actions/etc."

[11] The average of the scores assigned by the OIG to the interviewed leaders' responses was 3.8.

[12] The averages of the scores assigned by the OIG to the interviewed leaders' responses for factors affecting the two selected SAIL metrics were 3.4 and 3.3.

[13] The averages of the scores assigned by the OIG to the interviewed leaders' responses for actions taken to improve performance of the two selected SAIL metrics were 3.6 and 3.5.

[14] From October 1, 2018, through September 30, 2019, the OIG interviewed leaders and assessed their responses for factors affecting and actions taken to improve performance of selected All Employee Survey questions related to satisfaction with executive leadership, servant leadership, and the workplace. The average of scores assigned by the OIG to the interviewed leaders' responses for factors affecting the All Employee Survey scores were 3.5, 3.4, and 3.4, respectively. The average of scores assigned by the OIG to the interviewed leaders' responses for actions taken to improve performance of the selected All Employee Survey scores were 3.9, 3.6, and 3.7, respectively.

Healthcare Experiences of Patients results and actions taken or currently underway to improve or sustain patient satisfaction.[15]

Accreditation Surveys and Oversight Inspections

The OIG noted that 41 of 43 inspected facilities had received College of American Pathologists surveys since the previous OIG cyclical review.[16] Forty-one facilities also received accreditation from the Commission on Accreditation of Rehabilitation Facilities for at least one rehabilitation program.[17] Additionally, 32 of the 43 facilities had received Long Term Care Institute inspections, and 6 of the 43 facilities had received Paralyzed Veterans of America site surveys.[18]

All recommendations made in previous OIG Combined Assessment Program, Clinical Assessment Program, CHIP, and community-based outpatient clinic (CBOC) inspections of 40 of 43 facilities were closed prior to each respective CHIP site visit.[19] From the time of the previous OIG Combined Assessment Program, Clinical Assessment Program, CHIP, and CBOC reviews, the 43 inspected facilities had undergone 29 OIG hotline inspections that resulted in 114 recommendations. Although 11 of the 114 facility recommendations issued in the hotline reports remained open at the time of the OIG's on-site CHIP inspections, the OIG found that in these instances, insufficient time had passed for the OIG to initiate follow-up, facility leaders were still

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[15] The averages of the scores assigned by the OIG to the interviewed leaders' responses for factors affecting the inpatient "Willingness to Recommend Hospital" question and the selected inpatient, patient-centered medical home, and specialty Survey of Healthcare Experiences of Patients survey questions collectively were 2.7 and 3.5. The averages of the scores assigned by the OIG to the interviewed leaders' responses for actions taken to improve performance of the inpatient "Willingness to Recommend Hospital" question and the selected inpatient, patient-centered medical home, and specialty Survey of Healthcare Experiences of Patients survey questions collectively were 2.9 and 3.7.

[16] 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.

[17] 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."

[18] The Long Term Care Institute, Inc. 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 July 2, 2020.) The Paralyzed Veterans of America performs these annual surveys "to provide the VA Secretary with an assessment of each VA Spinal Cord Injury & Disease (SCI/D) Center's performance." This veteran service organization review does not result in accreditation status.

[19] West Texas VA Health Care System (Big Spring, TX), VA Greater Los Angeles Healthcare System, and Southeast Louisiana Veterans Health Care System (New Orleans, LA) each had one recommendation that remained open at the time of the OIG's on-site inspection.

actively engaged in addressing the recommendations, or sustained improvement was still being monitored.

The OIG also noted that 40 of the inspected facilities received routine, unannounced inspections from The Joint Commission (TJC)—4 of which had been recently inspected or were actively addressing recommendations for improvement. The OIG also noted that 10 medical centers underwent for-cause inspections by TJC since the previous OIG cyclical review.[20]

Factors Related to Possible Lapses in Care

The OIG also reviewed the number of facility-reported sentinel events, institutional disclosures, and large-scale disclosures since the facilities' previous OIG cyclical review. The 43 facilities reported a total of 160 sentinel events (ranging from 0 to 25) with 20 reporting two or more events (see appendix D, table D.7). The facilities also reported a total of 328 institutional disclosures (ranging from 0 to 66; see appendix D, table D.8). Additionally, two facilities reportedly conducted large-scale disclosures.[21]

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" but has limitations for identifying all areas of clinical risk. Despite this, the model presents the data as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[22]

The OIG performed this review at facilities representing the spectrum of SAIL star ratings from "1-star" to "5-star" as of June 30, 2018. Two facilities received a "1-star" rating, 9 received a

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

[21] VA OIG, *Comprehensive Healthcare Inspection Program Review of the Jesse Brown VA Medical Center, Chicago, Illinois*, Report No. 18-04673-138, June 18, 2019; VA OIG, *Comprehensive Healthcare Inspection Program Review of the VA Western New York Healthcare System, Buffalo, New York*, Report No. 18-04666-55, January 7, 2020.

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

"2-star" rating, 13 received a "3-star" rating, 10 received a "4-star" rating, and 8 received a "5- star" rating.[23]

There were no notable trends observed when comparing star ratings to facility complexity, number of sentinel events, number of institutional disclosures, or number of OIG CHIP recommendations for improvement (see appendix D, tables D.9–D.12).

The OIG found limited trends when comparing facilities' complexity designations to the number of sentinel events and institutional disclosures. A higher occurrence rate was observed for facilities with the highest complexity, but there was no corresponding trend for the number of OIG CHIP recommendations—medium and low complexity facilities received notable numbers of OIG recommendations, similar to facilities with higher complexities (see appendix D, tables D.13–D.15).
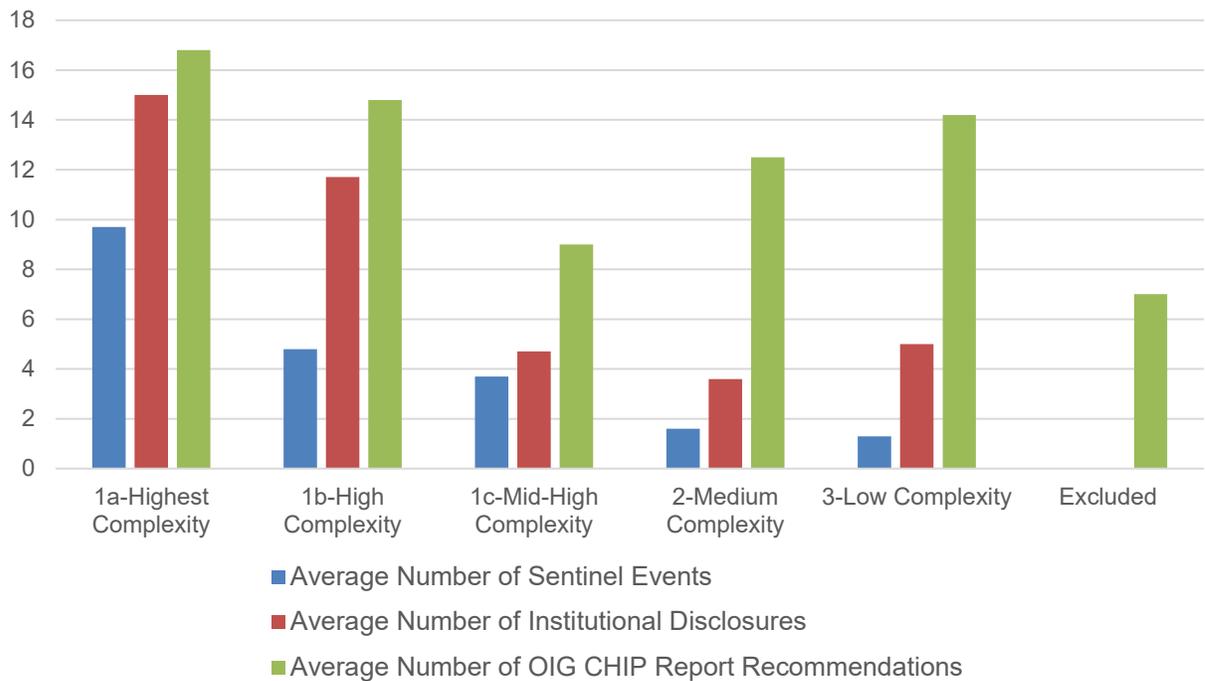
Figure 4. Observed Trends by Facility Complexity[24]
Source: VA OIG

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[23] The VA Manila Outpatient Clinic in Pasay City, Philippines is classified as an "Other Outpatient Services (OOS)" location. VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013, defines as "A site that either provides services to Veterans, but does not generate VHA encounter workload, or does not meet minimum criteria to be classified as a community-based outpatient clinic (CBOC) or Health Care Center (HCC)." According to the VHA Office of Productivity, Efficiency & Staffing, the VA Manila Outpatient Clinic is excluded from the complexity model "per Complexity Model Workgroup Recommendation."

[24] The VA Manila Outpatient Clinic in Pasay City, Philippines is excluded from the complexity model "per Complexity Model Workgroup Recommendation."

Leadership and Organizational Risks Conclusion

The OIG noted many positive observations during the review of leadership and organizational risks at the 43 VA facilities between October 1, 2018, and September 30, 2019. Eighty-eight percent of leadership positions were filled by permanent staff at the time of their respective inspections. Facility directors participated and appeared engaged in supporting QSV activities. The directors also reported feeling generally supported by VISN leaders and program managers and having access to public/private sector expert resources for guidance and assistance with quality improvement activities. Members of the executive leadership team were generally knowledgeable about improvements involving employee and patient satisfaction. Further, most facility leaders demonstrated active involvement in maintaining various accreditations, addressing TJC and OIG recommendations for improvement, and taking actions in response to potential organizational risks.

The OIG found opportunities for multiple facilities to improve their respective SAIL star ratings. Eleven of the surveyed facilities received a "1-" or "2-star" rating as of June 30, 2018. However, there were no remarkable trends observed when comparing facilities' star ratings to complexity ratings, numbers of sentinel events, numbers of institutional disclosures, or numbers of OIG CHIP recommendations for improvement.

Lastly, the OIG noted trends when comparing facility-level complexities to the number of sentinel events and institutional disclosures—higher occurrence rates were observed for facilities with higher complexities. This observation is not surprising given the level of complex clinical programs, high volumes of high-risk patients, and affiliations with teaching programs. However, there was no corresponding trend for the number of OIG CHIP report recommendations—medium and low complexity facilities received notable numbers of OIG recommendations compared to facilities with higher complexities.

This review of leadership and organizational risks was descriptive in nature, and the results should not be generalized across all VHA facilities.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.[25] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[26] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[27]

To determine whether a facility implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV into local activities, the OIG evaluated protected peer reviews of clinical care,[28] utilization management (UM) reviews,[29] patient safety incident reporting with related root cause analyses,[30] and cardiopulmonary resuscitation (CPR) episode reviews.[31]

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[32]

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the

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[25] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

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

[27] VHA Directive 1026.

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

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

[30] 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."

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

[32] VHA Directive 1190.

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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.[33]

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.[34]

VHA also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establish a CPR committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA has also established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.[35]

During each inspection, the OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[36]

- Protected peer reviews

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

  o Implementation of improvement actions recommended by the peer review committees

  o Completion of final reviews within 120 calendar days

  o Quarterly review of each peer review committee's summary analysis by the medical executive committee

  o Peer review of all applicable deaths within 24 hours of admission to the hospital

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[33] VHA Directive 1117(2).

[34] VHA Handbook 1050.01.

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

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

- o Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[37]

- UM

  - o Completion of at least 75 percent of all required inpatient reviews

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

  - o Interdisciplinary review of UM data

- Patient safety

  - o Annual completion of a minimum of eight root cause analyses[38]

  - o Inclusion of required content in root cause analyses (generally)

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

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

  - o Submission of an annual patient safety report to facility leaders

- Resuscitation episode review

  - o Evidence of a committee responsible for reviewing resuscitation episodes

  - o Confirmation of actions taken during resuscitative events being consistent with patients' wishes

  - o Evidence of basic or advanced cardiac life support certification for code team responders

  - o Evaluation of each resuscitation episode by the CPR committees or equivalent

Quality, Safety, and Value Findings and Recommendations

The OIG found general compliance with many of the selected requirements for protected peer reviews, patient safety, and resuscitation episode reviews. However, across the facilities inspected in FY 2019, the OIG identified weaknesses in various key QSV functions:

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[37] VHA Directive 1190.

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

- Medical executive committees' quarterly review of peer review committees' summary analyses

- Peer review of all applicable deaths within 24 hours of admission to the hospital

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

- Interdisciplinary review of UM data

- Annual completion of a minimum of eight root cause analyses

- Inclusion of required processes in root cause analyses

- Evaluation of each resuscitation episode by the respective CPR committee or equivalent

Regarding quarterly reviews, VHA requires that a summary of the peer review committee's work be reviewed quarterly by an executive-level medical committee.[39] The OIG found that 38 of 43 facilities' peer review committees (88 percent) consistently provided summaries of work for medical executive committees to review. The lack of peer review aggregate data available to leadership for analysis could impact improvements in patient care at the five noncompliant facilities. Reported reasons for noncompliance included staffing issues that affected the ability to meet requirements and general lack of oversight.

Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility-level senior leaders, ensures that summaries of the peer review committees' work are reviewed quarterly by medical executive committees.

VHA concurred.

Target date for completion: December 2021

Response: Facilities will submit the Medical Executive Committee (MEC) report and an excerpt of the MEC minutes to the Veterans Integrated Services Network (VISN) liaison, showing that the peer review committee's report was reviewed. Quarterly, the VISN liaison will compile these reports and excerpts into one document. VISN liaisons will review and attest to compliance with VHA Directive 1190, Peer Review for Quality Management. This document and attestation will be submitted to Clinical Risk Management. This will be monitored until there is an aggregate compliance rate of 90% for adherence to policy.

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[39] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

Additionally, VHA requires that peer reviews are completed for all applicable deaths within 24 hours of admission.[40] The OIG noted that 18 of 24 applicable facilities' staff (75 percent) peer reviewed all deaths within 24 hours of admission. This resulted in missed opportunities to identify and address potential improvement needs for clinical practice and organizational performance at the remaining six facilities. Some facility managers reported being unaware of requirements, while others reported staffing issues and a lack of attention to detail as reasons for noncompliance.

Recommendation 2

2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that all applicable deaths within 24 hours of admission are peer reviewed.

VHA concurred.

Target date for completion: December 2021

Response: Facilities will create a log of all applicable deaths within 24 hours of admission. Applicable deaths are defined in VHA Directive 1190, *Peer Review for Quality Management*, Appendix D. This log will include a column identifying if the case was peer reviewed. No Protected Health Information/Personally Identifiable Information will be in this log, nor will there be peer review case identifying information. Quarterly, facilities will report this number to Veterans Integrated Services Network (VISN) liaisons. VISN liaisons will compile these submissions into a single document. VISN liaisons will review and attest to compliance. This document and attestation will be submitted to Clinical Risk Management. This will be monitored until there is an aggregate compliance rate of 90% for adherence to policy.

VHA also requires that physician UM advisors document their decisions in the National UM Integration database regarding appropriateness of patient admissions and continued stays for 75 percent of all inpatient stays.[41] The OIG found that physician UM advisors at 28 applicable facilities (88 percent) documented at least 75 percent of their reviews in the National UM Integration database. This prevented a comprehensive review of UM data at the remaining four applicable facilities to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes. Reasons cited for noncompliance included staff vacancies and competing priorities.

Further, interdisciplinary facility groups that review UM data are to include "representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR

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[40] VHA Directive 1190.

[41] VHA Directive 1117(2).

[Chief Business Office Revenue-Utilization Review]."[42] The OIG found that 9 of 32 applicable facilities (28 percent) had an interdisciplinary group review UM data. The remaining 23 facilities could not provide evidence of any interdisciplinary review of UM data or did not consistently include all required members in their review process. This resulted in a lack of expertise in the interdisciplinary analysis of UM data and program oversight. Facility managers cited staffing vacancies, collateral duties, and lack of awareness of requirements among the reasons for noncompliance.

The documentation of physician UM advisors' decisions in the National UM Integration database and interdisciplinary group review of UM data are repeat findings from the *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, for which improvements actions in response to both recommendations remain in progress; therefore, the OIG made no new recommendations.[43]

For root cause analyses, VHA requires facilities to complete a minimum of eight root cause analyses each fiscal year to help identify and mitigate vulnerabilities in their healthcare systems and to avoid future occurrences. Further, to ensure thoroughness and credibility, VHA requires root cause analysis to include several elements, such as determination of human factors, the processes and systems related to the occurrence, analysis of the underlying systems, consideration of relevant literature, and exclusion of individuals directly involved in the event.[44]

Although the OIG determined that 39 of 43 facilities (91 percent) completed at least four individual root cause analyses, only 38 of them (88 percent) completed four other analyses comprising aggregate, individual, and/or wild card reviews. Additionally, of the 206 root cause analyses reviewed, only 172 (83 percent) included consideration of relevant literature. VHA subsequently clarified the expectations regarding required patient safety reviews and root cause analysis content; therefore, the OIG made no recommendations.[45]

Finally, VHA requires that facilities establish a committee to review each resuscitation episode and that the reviews include an assessment to determine if there were "errors or deficiencies in technique or procedures, lack of availability or malfunction of equipment, clinical or patient care issues," and/or delays in initiating CPR or resuscitation.[46] The OIG found that facilities'

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[42] VHA Directive 1117(2).

[43] VA OIG, *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, Report #19-07040-243, October 10, 2019.

[44] VHA Handbook 1050.01.

[45] Deputy Under Secretary for Health for Organizational Excellence Memorandum, *Annual Minimal Requirements for Facilities to Perform Patient Safety Analyses*, March 17, 2020, and VHA Response to OIG Draft Report, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*, September 23, 2020.

[46] VHA Directive 1177.

CPR committees (or equivalent) reviewed 156 of 229 selected resuscitation episodes (68 percent). For the 156 resuscitation episodes reviewed, facility CPR committees evaluated

- Errors or deficiencies in technique or procedures for 136 episodes (87 percent),

- Lack of availability or malfunction of equipment for 138 episodes (88 percent),

- Clinical or patient care issues for 135 episodes (87 percent), and

- Delays in initiating CPR or resuscitation for 135 episodes (87 percent).

The facilities' inconsistent processes potentially resulted in missed opportunities to identify and address deficiencies that could improve outcomes for cardiopulmonary resuscitation events. Facility managers cited various reasons for noncompliance, including unawareness of requirements, informal and/or undocumented reviews, and lack of attention to detail.

Recommendation 3

3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that cardiopulmonary resuscitation committees review each resuscitative episode under the facilities' responsibility and include required elements in reviews.

VHA concurred.

Target date for completion: March 2021

Response: The Office of Pulmonary, Sleep and Critical Care will request an attestation from each Veterans Integrated Services Network confirming that cardiopulmonary resuscitation committees review each resuscitative event under the facilities' responsibility. As stated in Directive 1177, *Cardiopulmonary Resuscitation*, dated August 28, 2018, and in accordance with The Joint Commission standards the below elements must be included and for any facilities that are non-compliant, an action plan will be required.

Required elements include:

1. Errors of deficiencies in technique or procedures;

2. Lack of availability or malfunction of equipment;

3. Clinical issues; and

4. Patient care issues such as failure to rescue.

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).[47]

Clinical privileges need to be specific and based on the individual'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 re-privileging prior to their expiration.[48]

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 typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges." "The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation[s] (OPPE), [are] essential to confirm the quality of care delivered."[49]

According to TJC, the "FPPE for Cause" should be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care. The "FPPE for Cause" is limited to a particular time frame and customized to the specific provider and related clinical concerns.[50] Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.[51]

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

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

[48] VHA Handbook 1100.19.

[49] VHA Handbook 1100.19.

[50] 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).

[51] VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009.

- 159 solo or few (less than three in a specialty) practitioners hired within 18 months before the site visit or privileged within the prior 12 months[52]

- 332 LIPs hired within 18 months before the site visit

- 738 LIPs re-privileged within 12 months before the visit

- 64 providers who underwent an FPPE for cause within 12 months prior to the visit

The OIG evaluated the following performance indicators:

- Privileging

  - Privileges requested by the provider

    - Facility-specific

    - Service-specific

    - Provider-specific[53]

  - Approval of privileges for a period of less than, or equal to, two years

- FPPEs

  - Criteria defined in advance

  - Use of required criteria in FPPEs for selected specialty LIPs

  - Results and time frames clearly documented

  - Evaluation by another provider with similar training and privileges

  - Executive committee of the medical staff's consideration of FPPE results in its decision to recommend continuing initially-granted privileges

- OPPEs

  - Criteria specific to the service or section

  - Use of required criteria in OPPEs for selected specialty LIPs

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[52] VHA Deputy Under Secretary for Health Operations and Management (DUSHOM) Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being fewer than three providers in the facility that are privileged in a particular specialty.

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

- o Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities

- o Evaluation by another provider with similar training and privileges

- o Executive committee of the medical staff's decision to recommend continuing privileges based on OPPE results

- FPPEs for cause

  - o Clearly defined expectations/outcomes

  - o Time-limited

  - o Provider's ability to practice independently not limited for more than 30 days

  - o Shared with the provider in advance

- Reporting of privileging actions to National Practitioner Data Bank

Medical Staff Privileging Findings and Recommendations

The OIG found general compliance with selected requirements for privileging. However, the OIG identified concerns with FPPE and OPPE processes and FPPEs for cause.

VHA requires that all LIPs new to the facility have FPPE criteria defined in advance.[54] The OIG noted that 251 of 356 LIPs reviewed (71 percent)—including 18 of 24 solo/few providers (75 percent) who underwent FPPE—had criteria defined in advance. This could potentially result in unclear and ill-defined expectations for medical staff performing the evaluation as well as the providers who are being evaluated. Staff reported lack of oversight due to staffing deficiencies, lack of attention to detail, and the belief that verbal communication of criteria met requirements among the reasons for noncompliance.

Recommendation 4

4. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures focused professional practice evaluation criteria are defined in advance.

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[54] VHA Handbook 1100.19.

VHA concurred.

Target date for completion: March 2021

VHA response: The facility annual credentialing and privileging self-assessment tool was revised for fiscal year 2021 to include facility verification of documentation in the Executive Committee of the Medical Staff minutes of service specific Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation indicators and forms have been reviewed and approved on an annual basis, at minimum.

Each facility will be required by their respective Veterans Integrated Services Network (VISN) to complete the facility credentialing and privileging self-assessment by March 31, 2021. Facility leadership must electronically attest to the accuracy of response before it is transmitted electronically to the VISN for review and action as needed. The results will be available to the VISN Chief Medical Officer upon submission of the annual assessment by the facility.

Additionally, VHA has defined minimum specialty criteria for gastroenterology, pathology, nuclear medicine, and radiation oncology professional practice evaluations.[55] The OIG found that 20 of 27 FPPEs (74 percent)[56] and 50 of 68 OPPEs reviewed (74 percent)[57] included the standard elements required by VHA for the specialty. This resulted in insufficient evidence to confirm the quality of care delivered by the remaining providers. Cited reasons for noncompliance included unawareness of requirements, lack of oversight, and lack of attention to detail.

The lack of minimum specialty criteria in gastroenterology, pathology, nuclear medicine, and radiation oncology OPPEs is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*,[58] for which improvement actions remain in progress; therefore, the OIG made no related recommendation.

Recommendation 5

5. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures service chiefs include the minimum specialty criteria for focused professional practice evaluations of gastroenterology, pathology, nuclear medicine, and radiation oncology practitioners.

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

[56] This includes two of five (40 percent) solo/few providers.

[57] This includes 8 of 13 (62 percent) solo/few providers.

[58] VA OIG, *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, Report #19-07040-243, October 10, 2019.

VHA concurred.

Target date for completion: March 2021

VHA response: New mandatory specialty specific indicators are being updated by Department of Veterans Affairs Central Office (VACO) Specialty Program Offices, which will replace the previous required indicators from gastroenterology, pathology, nuclear medicine, and radiation oncology practitioners.

The facility annual credentialing and privileging self-assessment tool was revised for fiscal year 2021 to include facility verification that the mandatory service-specific indicators published by VACO have been incorporated into service level Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation forms and have been reviewed for compliance and approved by the Executive Committee of the Medical Staff.

Each facility will be required by their respective Veterans Integrated Services Network (VISN) to complete the facility credentialing and privileging self-assessment by March 31, 2021. Facility leadership must electronically attest to the accuracy of response before it is transmitted electronically to the VISN for review and action as needed. The results will be available to the VISN Chief Medical Officer upon submission of the annual assessment by the facility.

VHA also requires FPPEs to be time-limited.[59] Time limitations help ensure an efficient process by preventing undefined or indefinite evaluation of providers. The OIG noted 302 of 343 completed FPPEs (88 percent) had time frames that were clearly documented. This could have resulted in an inefficient process for evaluating these LIPs. Reasons for noncompliance included unawareness of the requirement and leadership turnover. This is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*,[60] for which improvements actions remain in progress; therefore, the OIG made no new recommendation.

Additionally, VHA requires that the executive committee of the medical staff recommend continuing LIPs' granted privileges based on FPPE and OPPE results.[61] The OIG found that executive committees of the medical staff documented their recommendations to continue initially-granted privileges based on FPPE results for 284 of 356 LIPs reviewed (80 percent).[62] Further, the OIG found that executive committees of the medical staff documented recommendations to continue privileges based on OPPE results for 675 of 873 LIPs (77 percent).[63] As a result, a significant number of licensed independent practitioners continued

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[59] VHA Handbook 1100.19.

[60] VA OIG, *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*.

[61] VHA Handbook 1100.19.

[62] This includes 18 of 24 solo/few providers (75 percent).

[63] This includes 107 of 135 solo/few providers (79 percent).

to deliver care without thorough evaluations of their practices. Reasons for noncompliance included leadership turnover, insufficient staffing, and lack of attention to detail.

Ensuring that executive committees of the medical staff recommend continuing LIPs' privileges based upon FPPE results is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*,[64] for which improvement actions remain in progress; therefore, the OIG made no related recommendation.

Recommendation 6

6. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures executive committees of the medical staff document the decision to recommend continuing licensed independent practitioners' privileges based on ongoing professional practice evaluation results.

VHA concurred.

Target date for completion: March 2021

VHA response: The facility annual credentialing and privileging self-assessment tool was revised for fiscal year 2021 to include to include facility verification that the Executive Committee of the Medical Staff meeting minutes include consideration of Ongoing Professional Practice Evaluation results in their final recommendation to reprivilege a provider.

Each facility will be required by their respective Veterans Integrated Services Network (VISN) to complete the facility credentialing and privileging self-assessment by March 31, 2021. Facility leadership must electronically attest to the accuracy of response before it is transmitted electronically to the VISN for review and action as needed. The results will be available to the VISN Chief Medical Officer upon submission of the annual assessment by the facility.

VHA requires OPPEs to include service- or section-specific criteria.[65] The OIG found that OPPE criteria were specific to the service/section for 709 of 873 LIPs (81 percent).[66] This resulted in insufficient evidence to confirm the quality of care delivered by 19 percent of providers reviewed. Reasons for noncompliance included unawareness of requirements and leadership turnover. This is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*,[67] for which improvements actions remain in progress; therefore, the OIG made no new recommendation.

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[64] VA OIG, *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*.

[65] VHA Handbook 1100.19.

[66] This included 93 of 135 solo/few providers (69 percent).

[67] VA OIG, *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*.

VHA requires service chiefs to base their privileging determinations, in part, on the results of OPPE activities.[68] The process involves evaluating providers' privilege-specific competence and may include periodic chart review, direct observation, diagnostic and treatment technique monitoring, or discussion with other individuals involved in patient care.[69] The OIG found that service chiefs determined to continue the current privileges of 752 of the 873 LIPs reviewed (86 percent) based, in part, on the results of OPPE activities.[70] This allowed the remaining providers to continue delivering care without a thorough evaluation of their practice. Reasons for noncompliance included leadership turnover and lack of oversight.

Recommendation 7

7. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that service chiefs' privileging determinations are based, in part, on ongoing professional practice evaluation activities.

VHA concurred.

Target date for completion: March 2021

VHA response: VetPro (VAs credentialing and privileging software) will be modified to include a required field that provides documentation by the service chief to notate the overall findings of the Ongoing Professional Practice Evaluation review.

VHA requires "another provider with similar training and privileges [to] evaluate the privilege-specific competence of the practitioner and document evidence of competently performing the requested privileges of the facility."[71] The OIG noted that 90 of 114 completed OPPEs for solo/few LIPs (79 percent) were based on an evaluation by another provider with similar training and privileges. As a result, 21 percent of solo/few LIPs reviewed continued to deliver care without a thorough evaluation of their practice. Reasons for noncompliance included difficulty finding providers to conduct reviews and misinterpretation of requirements.

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[68] VHA Handbook 1100.19.

[69] VHA Handbook 1100.19.

[70] This included those for 114 of 135 solo/few providers (84 percent).

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

Recommendation 8

8. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that ongoing professional practice evaluations use assessments by providers with similar training and privileges.

VHA concurred.

Target date for completion: March 2021

VHA response: The facility credentialing and privileging self-assessment tool was revised for fiscal year 2021 to include facility verification that the Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation reviews were completed by providers with similar training and privileges.

Each facility will be required by their respective Veterans Integrated Services Network (VISN) to complete the facility credentialing and privileging self-assessment by March 31, 2021. Facility leadership must electronically attest to the accuracy of response before it is transmitted electronically to the VISN for review and action as needed. The results will be available to the VISN Chief Medical Officer upon submission of the annual assessment by the facility.

VHA requires FPPEs for cause to be time-limited, have clearly defined expectations and outcomes, and be shared with the provider in advance.[72] The OIG found that 47 of 64 FPPEs for cause (73 percent) included clearly defined expectations and outcomes, 49 of 64 (77 percent) were time-limited, and 45 of 64 (70 percent) were shared with LIPs in advance. Failure to clearly define expectations for all FPPEs for cause can hinder the effective evaluations of providers. Reasons for noncompliance included lack of understanding of documentation requirements, lack of attention to detail, and lack of training.

Recommendation 9

9. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures facility clinical managers clearly define and share in advance the expectations, outcomes, and time frames for focused professional practice evaluations for cause with licensed independent practitioners.

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[72] 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).

VHA concurred.

Target date for completion: March 2021

VHA response: The facility credentialing and privileging self-assessment tool was revised for fiscal year 2021 to include facility verification that the Focused Professional Practice Evaluation (FPPE) For Cause monitors, benchmarks for success, period of monitoring and method of monitoring are shared with the providers prior to initiation of FPPE For Cause.

Each facility will be required by their respective Veterans Integrated Services Network (VISN) to complete the facility credentialing and privileging self-assessment by March 31, 2021. Facility leadership must electronically attest to the accuracy of response before it is transmitted electronically to the VISN for review and action as needed. The results will be available to the VISN Chief Medical Officer upon submission of the annual assessment by the facility.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[73]

The purpose of this facet of the OIG inspection was to determine whether facilities maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether facilities met requirements in selected areas that are often associated with higher risks of harm to patients, such as in locked inpatient mental health units. The inspection team also looked at facilities' compliance with emergency management processes.[74]

VHA requires its facilities to have the "capacity for [providing] mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting." However, for facilities that do not have inpatient mental health services, that "capacity" could mean facilitating care at a nearby VA or non-VA facility.[75]

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities' efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to health care and other essential services.[76] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[77] Occupational Safety and Health Administration,[78] and National Fire Protection Association

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

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

[75] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

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

[77] VHA Directive 1028, *Electrical Power Distribution Systems*, July 25, 2014.

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

standards.[79] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[80]

In all, OIG teams inspected 457 areas—430 patient care areas and 27 locked inpatient mental health units. The team also inspected 43 community-based outpatient clinics.[81] The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility and community-based outpatient clinic
    - General safety
    - Environmental cleanliness and infection prevention
    - General privacy
    - Women veterans program
    - Availability of medical equipment and supplies
- Locked inpatient mental health unit
    - Mental health environment of care rounds
    - Nursing station security
    - Public area and general unit safety
    - Patient room safety
    - Infection prevention
    - Availability of medical equipment and supplies
- Emergency management
    - Hazards vulnerability analysis
    - Emergency operations plan
    - Emergency power testing and availability

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

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

[81] The Manila Outpatient Clinic was assessed as a community-based outpatient clinic.

Environment of Care Findings and Recommendations

Facilities and community-based outpatient clinics generally met requirements for environment of care rounds and deficiency tracking, general safety, privacy, women veterans programs, and availability of medical equipment and supplies. Locked inpatient mental health units met general requirements for environment of care rounds, public area safety, infection prevention, and availability of medical equipment and supplies. Emergency management requirements for hazards vulnerability analysis were met by most facilities. The OIG identified vulnerabilities in environmental cleanliness and infection prevention, locked inpatient mental health unit safety, and emergency management.

VHA requires hospitals to "identify environmental deficiencies, hazards, and unsafe practices" and TJC requires hospitals to keep "furnishings and equipment safe and in good repair."[82] The OIG noted that furnishings and equipment were in good repair at most locations—381 of 430 patient care areas (89 percent) inspected at main facilities and 38 of 43 community-based outpatient clinics (88 percent). For the noncompliant locations, examples of furnishings and equipment in disrepair included wheelchairs and waiting room chairs used by veterans.

Additionally, TJC requires that areas used by patients are clean and that facilities acts to minimize or eliminate identified safety risks in the environment.[83] The OIG found that 36 of 43 community-based outpatient clinic floors (84 percent) and 22 of 27 inpatient mental health patient care areas (81 percent) inspected were clean on inspection. Dirty floors may be indicative of broader unsanitary conditions that could jeopardize the safety and physical well-being of patients, staff, and visitors. Reasons for noncompliance included staff shortages and difficulties in hiring and retaining housekeeping staff.

Poor environmental cleanliness and safety is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, for which improvement actions remain in progress; therefore, the OIG made no new recommendation.[84]

VHA requires that VA police test and document response time to panic alarms in locked inpatient mental health units.[85] The OIG found evidence of panic alarm testing for 23 of 27 locked units (85 percent). Of the 23 locked units with evidence of panic alarm testing, only

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[82] Department of Veterans Affairs, Veterans Health Administration Environmental Programs Service, *Environment of Care Assessment and Compliance Rounding Process Guide*, 08.03.2014; TJC. Environment of Care standard EC.02.06.01, EP 26.

[83] TJC. Environment of Care standard EC.02.06.01, EP 20; TJC. Environment of Care standard 02.01.01, EP 3.

[84] VA OIG, *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, Report #19-07040-243, October 10, 2019.

[85] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration Facilities*, September 27, 2012; VA National Center for Patient Safety, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, September 16, 2019.

20 (87 percent) of the units' testing documentation included VA police response times. Inadequate testing and related panic alarm processes may increase risks to patients, visitors, and staff since timely, coordinated police intervention is critical to minimize the risk of harm. Reasons for noncompliance included unawareness of the requirement to annotate officer response time and staff vacancies.

Panic alarm testing and documentation of VA police response times is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*,[86] for which improvement actions remain in progress; therefore, the OIG made no new recommendation.

VHA requires that inpatient mental health seclusion rooms be designed to prevent patient injury. This includes floors which should "have some cushioning."[87] The OIG noted that seclusion room floors in only 18 of 22 locked inpatient mental health units (82 percent) provided cushioning. Inadequate floor cushioning in the remaining four units can result in harm to patients. Reasons for noncompliance included lack of VHA guidance—specifically, lack of construction specifications and only a vague reference to cushioned flooring in the Mental Health Design Guide.[88]

The installation of floor cushioning in locked mental health unit seclusion rooms is a repeat finding from the *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*,[89] for which improvement actions remain in progress; therefore, the OIG made no new recommendation.

For emergency management, VHA and TJC require facilities to have a comprehensive emergency management plan that includes a documented inventory of resources and assets that may be needed during emergencies.[90] This inventory must be evaluated by the Emergency Management Committee and approved by the executive leadership team annually. In 37 of 43 facilities (86 percent), the OIG found evidence of the required inventory. Failure to conduct an annual inventory of emergency supplies and equipment as noted in the six noncompliant facilities could result in critical shortages and other related supply issues during emergency contingency operations. Reasons for noncompliance included staffing vacancies and a lack of understanding of the requirement.

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[86] VA OIG, *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, Report #19-07040-243, October 10, 2019.

[87] *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, September 16, 2016.

[88] Department of Veterans Affairs, *Mental Health Facilities Design Guide*, December 2010, rev 12/01/2017.

[89] VA OIG, *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*.

[90] VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017; TJC Emergency Management standard EM.03.01.01, EP3.

Recommendation 10

10. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that inventories of resources and assets that may be needed during an emergency are documented and reviewed annually.

VHA concurred.

Target date for completion: January 2021

VHA response: In accordance with the August 7, 2019, memorandum from the Deputy Under Secretary for Health for Operations and Management, all VHA medical facilities uploaded their Emergency Operations Plans (EOPs), Hazards Vulnerability Assessments, resource and assets inventories, exercise documentation and After-Action Reports into the VHA Performance Improvement System, by November 1, 2019. The Office of Emergency Management (OEM) staff assisted facilities with this process providing technical support and training, in addition to the webinars that were conducted in October 2019.

The VHA Emergency Management Coordination Cell has been activated at Level I (24/7 coverage) continuously since December 28, 2019, in response to the Puerto Rico earthquake and the Coronavirus Disease of 2019 (COVID-19) Pandemic. This unprecedented activation has required the full-time response of OEM staff and the subsequent suspension of assessments and other non-COVID activities. All Veterans Integrated Services Networks (VISNs) and VHA medical facilities have activated their EOPs due to the COVID-19 pandemic.

A February 18, 2020, the Deputy Under Secretary for Health for Operations and Management memorandum required all VHA medical facilities to conduct a tabletop exercise by March 6, 2020, to review plans, policies and procedures for responding to COVID-19 and identify additional areas for improvement. OEM developed the situation manual and additional exercise materials. Area Emergency Managers assisted with the conduct of these exercises.

On March 23, 2020, VHA published the COVID-19 Response Plan as an Incident-Specific Annex to the VHA High Consequence Infection Base Plan that provided enhanced planning guidance for Veterans Integrated Services Networks (VISN) and VA Medical Centers. VHA has developed a disaster response pandemic plan to provide additional guidance for responding to other events (e.g., hurricane, earthquake, wildfire) within a COVID environment.

VA, VHA, and OEM are in an unprecedented COVID-19 pandemic and a 2020 hurricane season. OEM currently has all personnel deployed to cover the states where there are active mission assignments responding to COVID and intra-VA Hurricane Laura recovery and Sally preparedness efforts. The 2020 hurricane season has been and continues to be historic in every way. OEM has all assigned staff working or deployed to current life-threatening emergencies that have taken precedence. OEM understands the need to complete the reviews.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.[91] Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.[92]

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.[93]

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

- Controlled substances coordinator reports

  - Monthly summary of findings to facility directors

  - Quarterly trend reports to facility directors

  - Quality management committees' review of monthly and quarterly trend reports

  - Actions taken to resolve identified problems

- Pharmacy operations

  - Staff restrictions for monthly reviews of balance adjustments[94]

- Requirements for controlled substances inspectors

  - No conflicts of interest

  - Appointed in writing by facility directors for a term not to exceed three years

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

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

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

[94] *Controlled Substances (CS) Inspector's User Manual*, Version 3, March 1997, revised June 2018.

- o Hiatus of one year between any reappointment

- o Completion of required annual competency assessments

- Controlled substances area inspections

  - o Completion of monthly inspections

  - o Rotations of controlled substances inspectors

  - o Patterns of inspections

  - o Completion of inspections on day initiated

  - o Reconciliation of dispensing between pharmacies and each dispensing area

  - o Verification of controlled substances orders

  - o Performance of routine controlled substances inspections

- Pharmacy inspections

  - o Monthly physical counts of the controlled substances in pharmacies

  - o Completion of inspections on day initiated

  - o Security and verification of drugs held for destruction[95]

  - o Accountability for all prescription pads in pharmacies

  - o Verification of hard copy controlled substances prescriptions

  - o Verification of 72-hour inventories of the main pharmacy vault[96]

  - o Quarterly inspections of emergency drugs

  - o Monthly checks of locks and verification of lock numbers

- Facility reviews of override reports[97]

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

[96] VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (This handbook was rescinded on May 1, 2019, and replaced by VHA Directive 1108.01, *Controlled Substances Management*, May 1, 2019.)

[97] Miller K, Shah M, Hitchcock L, et al. "Evaluation of Medications Removed from Automated Dispensing Machines Using the Override Function Leading to Multiple System Changes." In: Henriksen K, Battles JB, Keyes MA, Grady ML, eds. *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 4: Technology and Medication Safety)*. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008.

Medication Management Findings and Recommendations

Most facilities met requirements associated with controlled substance inspectors. However, the OIG found deficiencies with quality management committees' review of monthly and quarterly trend reports, staff restrictions for monthly balance adjustment review, controlled substances area inspections, pharmacy inspections, and facility reviews of override reports.

VHA requires that monthly and quarterly controlled substances inspection program reports are reviewed for adherence with program requirements; this must be performed at least quarterly by the committee responsible for quality oversight. Additionally, VHA expects the committee to identify and track corrective actions until completion.[98] The OIG found 38 of 43 responsible facility committees (88 percent) reviewed program reports at least quarterly. Lack of consistent inspection report oversight for all facilities' controlled substances inspection programs could result in failure to identify trends and detect diversion. Reasons for noncompliance included a lack of effective oversight and attention to detail when documenting committees' discussions.

Recommendation 11

11. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that monthly and quarterly controlled substances inspection reports are reviewed at least quarterly by the facility committees responsible for quality oversight.

> VHA concurred.
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> Target date for completion: March 2021
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> VHA response: The Office of Pharmacy Benefits Management Services in coordination with the Office of the Assistant Under Secretary for Health (AUSH) for Quality and Patient Safety and the Veterans Integrated Services Network (VISN) Quality Management Officer with Network Pharmacy Benefits Executive and the Office of the AUSH for Operations will develop a chartered team to identify a consistent and sustainable plan and process for ensuring facilities' controlled substance inspectors have completed all required components for the monthly physical inspections. Each VISN will provide an attestation of compliance and any facility that has shown to be non-compliant, an action plan will be developed and submitted for review and resolution.

Despite VHA's requirement that pharmacy staff assigned to review controlled substances inventory balance adjustments are not the same staff who perform and document the adjustments,[99] the OIG found that 34 of 43 pharmacy staff (79 percent) who were assigned to

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[98] VHA Directive 1108.2(1).
[99] VHA Directive 1108.2(1).

monitor adjustments also had electronic access to perform balance adjustments to the pharmacy vault inventory. The 21 percent of facilities with pharmacy staff who monitored balance adjustments while having access to perform balance adjustments are less able to prevent diversion. Reasons for noncompliance included lack of oversight, staff turnover, and lack of awareness of the requirement.

Recommendation 12

12. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that electronic access for monitoring and performing controlled substances balance adjustments is limited to appropriate staff.

VHA concurred.

Target date for completion: March 2021

VHA response: The Office of Pharmacy Benefits Management Services in coordination with the Office of the Assistant Under Secretary for Health (AUSH) for Quality and Patient Safety and the Veterans Integrated Services Network (VISN) Quality Management Officer with Network Pharmacy Benefits Executive and the Office of the AUSH for Operations will develop a chartered team to identify a consistent and sustainable plan and process for ensuring facilities' controlled substance inspectors have completed all required components for the monthly physical inspections. Each VISN will provide an attestation of compliance and any facility that has shown to be non-compliant, an action plan will be developed and submitted for review and resolution.

VHA requires that inspectors conduct monthly inspections of nonpharmacy controlled substances storage areas and complete these inventories on the day they are initiated. Monthly inspections must also include (1) reconciliation of one random day's stocking/refilling from the pharmacy to every automated dispensing unit, (2) one random day's return of stock to pharmacy from every automated dispensing unit, and (3) verification that there is evidence of a written or electronic controlled substances order in the patient record for five randomly selected dispensing activities.[100]

For the 351 monthly inspections reviewed, the OIG found that

- 313 (89 percent) were conducted and completed on the day of initiation,
- 261 (74 percent) included reconciliation of one day dispensing from the pharmacy to the automated dispensing cabinet,

[100] VHA Directive 1108.2(1).

- 236 (67 percent) involved one day's return of stock to the pharmacy from every automated dispensing cabinet, and

- 268 (76 percent) included verification of five random dispensing activities.

This resulted in missed opportunities to identify discrepancies and potential drug diversion activities. Reasons for noncompliance included lack of attention to detail, lack of oversight, and unawareness of requirements.

Ensuring that controlled substances inspectors reconcile one day's dispensing from pharmacy and one day's return to pharmacy for every automated dispensing cabinet during monthly controlled substances area inspections are repeat findings from the *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*,[101] for which improvement actions remain in progress; therefore, the OIG made no related recommendations.

Recommendation 13

13. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that controlled substances inspectors complete monthly physical inspections of controlled substances storage areas on the day initiated.

VHA concurred.

Target date for completion: March 2021

VHA response: The Office of Pharmacy Benefits Management Services in coordination with the Office of the Assistant Under Secretary for Health (AUSH) for Quality and Patient Safety and the Veterans Integrated Services Network (VISN) Quality Management Officer with Network Pharmacy Benefits Executive and the Office of the AUSH for Operations will develop a chartered team to identify a consistent and sustainable plan and process for ensuring facilities' controlled substance inspectors have completed all required components for the monthly physical inspections. Each VISN will provide an attestation of compliance and any facility that has shown to be non-compliant, an action plan will be developed and submitted for review and resolution.

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[101] VA OIG, *Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018*, Report #19-07040-243, October 10, 2019.

Recommendation 14

14. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that controlled substances inspectors verify controlled substance orders for five randomly selected dispensing activities.

VHA concurred.

Target date for completion: March 2021

VHA response: The Office of Pharmacy Benefits Management Services in coordination with the Office of the Assistant Under Secretary for Health (AUSH) for Quality and Patient Safety and the Veterans Integrated Services Network (VISN) Quality Management Officer with Network Pharmacy Benefits Executive and the Office of the AUSH for Operations will develop a chartered team to identify a consistent and sustainable plan and process for ensuring facilities' controlled substance inspectors have completed all required components for the monthly physical inspections. Each VISN will provide an attestation of compliance and any facility that has shown to be non-compliant, an action plan will be developed and submitted for review and resolution.

VHA requires monthly pharmacy inspections to verify (1) that drugs held for destruction are secured and documented, (2) there is a corresponding sealed evidence bag containing the drug(s) held for destruction as listed on the "Destructions File Holding Report," (3) the prescription pad inventory count on the day of the monthly pharmacy inspection, and (4) there is evidence of a written signature (non-electronically prescribed) for controlled substances prescriptions for the previous month.[102]

During on-site inspections, OIG inspectors reviewed the documentation of pharmacy inspections for the two previously completed quarters and found that

- 71 of 80 (89 percent) included verification that drugs held for destruction were secured and documented,

- 70 of 79 (89 percent) had evidence inspectors verified that a corresponding sealed evidence bag contained the drug(s) held for destruction as listed on the "Destructions File Holding Report,"

- 65 of 73 (89 percent) had evidence—where prescription pads were stored—that controlled substances inspectors verified prescription pad counts each month, and

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[102] VHA Directive 1108.2(1).

- 57 of 71 (80 percent), included evidence—where controlled substances prescriptions were filled—of verified hard copy prescriptions for 50 controlled substances orders.

Facilities that fail to perform required activities may be vulnerable to loss, theft, and/or diversion of controlled substances. Reasons for noncompliance included lack of oversight and attention to detail.

Recommendation 15

15. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that controlled substances inspectors verify that drugs listed on the "Destructions File Holding Report" are secured and documented and that there is a corresponding sealed evidence bag for each medication during monthly inspections.

VHA concurred.

Target date for completion: March 2021

VHA response: The Office of Pharmacy Benefits Management Services in coordination with the Office of the Assistant Under Secretary for Health (AUSH) for Quality and Patient Safety and the Veterans Integrated Services Network (VISN) Quality Management Officer with Network Pharmacy Benefits Executive and the Office of the AUSH for Operations will develop a chartered team to identify a consistent and sustainable plan and process for ensuring facilities' controlled substance inspectors have completed all required components for the monthly physical inspections. Each VISN will provide an attestation of compliance and any facility that has shown to be non-compliant, an action plan will be developed and submitted for review and resolution.

Recommendation 16

16. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that controlled substances inspectors verify the inventory count for prescription pads on the day of monthly pharmacy inspections.

VHA concurred.

Target date for completion: March 2021

VHA response: The Office of Pharmacy Benefits Management Services in coordination with the Office of the Assistant Under Secretary for Health (AUSH) for Quality and Patient Safety and the Veterans Integrated Services Network (VISN) Quality Management Officer with Network Pharmacy Benefits Executive and the Office of the AUSH for Operations will develop a chartered team to identify a consistent and sustainable plan and process for ensuring facilities' controlled substance inspectors have completed all required components for the monthly physical inspections. Each VISN will provide an attestation of compliance and any facility that has shown to be non-compliant, an action plan will be developed and submitted for review and resolution.

Recommendation 17

17. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that controlled substances inspectors verify written controlled substances prescriptions during monthly area inspections.

VHA concurred.

Target date for completion: March 2021

VHA response: The Office of Pharmacy Benefits Management Services in coordination with the Office of the Assistant Under Secretary for Health (AUSH) for Quality and Patient Safety and the Veterans Integrated Services Network (VISN) Quality Management Officer with Network Pharmacy Benefits Executive and the Office of the AUSH for Operations will develop a chartered team to identify a consistent and sustainable plan and process for ensuring facilities' controlled substance inspectors have completed all required components for the monthly physical inspections. Each VISN will provide an attestation of compliance and any facility that has shown to be non-compliant, an action plan will be developed and submitted for review and resolution.

VHA requires that controlled substances inspectors verify and document that 72-hour pharmacy inventory checks have been completed.[103] The OIG found that 78 of 93 pharmacy inspections reviewed (84 percent) had evidence that 72-hour inventory counts for facilities' main vaults were verified. Facilities that fail to verify physical inventories could potentially delay identification of

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[103] VHA Directive 1108.2(1); VHA Handbook 1108.01.

missing stock and increase the likelihood of drug diversions. Reasons for noncompliance included lack of oversight, inattention to detail, and inadequate staffing.

Recommendation 18

18. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that controlled substances inspectors verify pharmacy vault inventory at the required frequency.

VHA concurred.

Target date for completion: March 2021

VHA response: The Office of Pharmacy Benefits Management Services in coordination with the Office of the Assistant Under Secretary for Health (AUSH) for Quality and Patient Safety and the Veterans Integrated Services Network (VISN) Quality Management Officer with Network Pharmacy Benefits Executive and the Office of the AUSH for Operations will develop a chartered team to identify a consistent and sustainable plan and process for ensuring facilities' controlled substance inspectors have completed all required components for the monthly physical inspections. Each VISN will provide an attestation of compliance and any facility that has shown to be non-compliant, an action plan will be developed and submitted for review and resolution.

VHA requires monthly inspections of the emergency drug cache.[104] Once each quarter, the locks securing medications in the drug cache must be broken and the controlled substances physically counted. In the two months of the quarter when a physical inventory is not performed, the locks must be inspected for evidence of tampering. The OIG found that 39 of 44 (89 percent) drug cache inspections included checks for evidence of tampering and verification of lock numbers. Inconsistent monthly inspections can result in missed opportunities for VHA facilities to identify potential drug diversion. Reasons for noncompliance included lack of oversight and effective controls and unawareness of required documentation.

Recommendation 19

19. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that controlled substances inspectors complete emergency drug cache inspections that include checks for lock tampering and verification of lock numbers.

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[104] VHA Directive 1108.2(1).

VHA concurred.

Target date for completion: March 2021

VHA response: The Office of Pharmacy Benefits Management Services in coordination with the Office of the Assistant Under Secretary for Health (AUSH) for Quality and Patient Safety and the Veterans Integrated Services Network (VISN) Quality Management Officer with Network Pharmacy Benefits Executive and the Office of the AUSH for Operations will develop a chartered team to identify a consistent and sustainable plan and process for ensuring facilities' controlled substance inspectors have completed all required components for the monthly physical inspections. Each VISN will provide an attestation of compliance and any facility that has shown to be non-compliant, an action plan will be developed and submitted for review and resolution.

TJC requires that "when automatic dispensing cabinets (ADCs) are used, the hospital has a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews."[105] The OIG found that 31 of 43 facilities (72 percent) reviewed override reports. Again, inconsistencies in performing the required reviews can potentially lead to diversion of controlled substances and patient safety risks. Reasons for noncompliance included lack of oversight and unawareness of requirements.

Recommendation 20

20. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that clinical managers implement processes for reviewing automated drug dispensing cabinet override reports.

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[105] TJC. Medication Management standard MM.08.01.01, EP16.

VHA concurred.

Target date for completion: March 2021

VHA response: The Office of Pharmacy Benefits Management Services in coordination with the Office of the Assistant Under Secretary for Health (AUSH) for Quality and Patient Safety and the Veterans Integrated Services Network (VISN) Quality Management Officer with Network Pharmacy Benefits Executive and the Office of the AUSH for Operations will develop a chartered team to identify a consistent and sustainable plan and process for ensuring facilities' controlled substance inspectors have completed all required components for the monthly physical inspections. Each VISN will provide an attestation of compliance and any facility that has shown to be non-compliant, an action plan will be developed and submitted for review and resolution.

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

The Department of Veterans Affairs uses the term "military sexual trauma" (MST) to refer to a "psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training."[106] MST is an experience, not a diagnosis or a mental health condition. Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.[107]

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.[108] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[109]

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system.[110] Those who screen positive must have access to appropriate MST-related care.[111] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.[112]

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.[113] All mental health and primary care providers must complete MST mandatory

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

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

[108] VHA Directive 1115.

[109] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008, amended November 16, 2015.

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

[111] VHA Directive 1115.

[112] VHA Handbook 1160.01.

[113] VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[114]

To determine whether facilities complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 1903 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Designated facility MST coordinators

  o Establish and monitor MST-related staff training

  o Establish and monitor informational outreach

  o Communicate MST-related issues, services, and initiatives with local leaders

- Evidence of MST-related data tracking

- Provision of clinical care

  o Referral of patients with positive MST screens to MST-related care

  o Initial evaluation within 24 hours of referral for mental health services

  o Comprehensive diagnostic and treatment planning evaluation within 30 days of referral for mental health services

- Completion of MST mandatory training requirement for mental health and primary care providers

Mental Health Findings and Recommendations

Generally, the OIG found that facilities met expectations consistent with requirements for designation of MST coordinators, informational outreach, MST-related data tracking, and provision of clinical care. The OIG identified noncompliance with MST-related staff trainings; communication of MST issues, services, and initiatives with facility leaders; and mental health and primary care providers completion of MST mandatory training within the required time frame.

VHA requires that facility MST coordinators establish and monitor MST-related staff training.[115] The OIG determined that 38 out of 43 facility MST coordinators (88 percent)

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[114] VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017, amended May 8, 2020; Acting Deputy Under Secretary for Health for Operations and Management, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers,* February 2, 2016.

[115] VHA Directive 1115.

established and monitored MST training for facility staff. Consistent treatment for veterans with MST care needs may have been deficient in the facilities where MST coordinators did not establish and maintain required training for their staff. Facility MST coordinators generally reported unawareness of the requirement.

Recommendation 21

21. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures military sexual trauma coordinators establish and monitor related training.[116]

VHA concurred.

Target date for completion: Completed

VHA response: It is critical that all staff involved in assisting Military Sexual Trauma (MST) survivors receive appropriate training on MST-related issues. VHA's mandatory training requirement for all mental health and primary care providers is an essential means by which this training occurs. MST Coordinators' activities to monitor and ensure appropriate implementation of this requirement (see response to Recommendation 23) are directly in service of their duties to direct and provide MST-related education at their facilities. MST Coordinators also engage in other local education activities such as providing supplemental trainings on MST screening or clinical care issues to clinical providers; educating frontline clerks, eligibility staff, and other administrative personnel on MST-related sensitivity and eligibility issues, best practices in assisting MST survivors, and their role and contact information as MST Coordinator; and conducting education and awareness-raising events during Sexual Assault Awareness Month and other times of the year.

OIG found that 88% of MST Coordinators it assessed had established and were monitoring MST-related training for facility staff. While it is important to continually pursue improvement in this area, VHA believes that this percentage likely underestimates the actual number of MST Coordinators engaging in required educational activities. MST Coordinators have access to national data resources which provide them with data on mandatory training completion and may not have established procedures for systematic, formal documentation of additional training efforts, as this is not required by policy. Additionally, much training by MST Coordinators occurs through informal, 1:1 communication with individual staff members as they work to assist individual Veterans. These efforts may be particularly difficult to document after the fact. Since the OIG Comprehensive Healthcare Inspection Program (CHIP) review, many MST Coordinators have commented to the staff of VHA's national MST Support Team, that they are

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[116] The OIG reviewed VHA's response, determined that sufficient actions have been taken, and closed this recommendation prior to publication.

now sensitized to the benefits of establishing more formal documentation systems that can better capture the wide range of educational efforts they engage in.

In addition, several VHA efforts will help ensure universal compliance with MST Coordinators' education-related responsibilities.

Specifically, in the context of an operational memo disseminated to Veterans Integrated Services Network leadership, facility MST Coordinators and MST VISN Points of Contact on June 24, 2020 (see response to Recommendation 22), MST Coordinators and others were provided with an updated version of an educational MST Coordinator position guidance document. The document is also routinely provided to all new MST Coordinators when they enter the position and is available on demand on VA's intranet MST Resource Homepage. The document describes core position duties and highlights the type of educational activities that MST Coordinators should be engaging in to meet the requirements of VHA Directive 1115.

The national MST Support Team provides a range of training opportunities and resources to assist MST Coordinators in fulfilling their responsibilities. One key training is an annual virtual MST Conference which features a half day of sessions dedicated to topics specific to MST Coordinators. This year's conference, held June 24–25, 2020, included an MST Coordinator Best Practices Roundtable which focused in part on how to address OIG CHIP review findings.

Recurring national educational and evaluation efforts provide naturally occurring prompts to MST Coordinators to engage in local education efforts. For example, the MST Support Team develops and disseminates new resources annually in advance of Sexual Assault Awareness Month (April) and encourages MST Coordinators to disseminate these resources and generally capitalize on April to host local education and awareness-raising efforts. Also, every 6 months, the MST Support Team conducts a systematic national review of MST Coordinator accessibility, which involves contacting every health care system to survey the experiences a Veteran would likely have in attempting to reach an MST Coordinator by telephone. This campaign has prompted facilities to develop systems and training efforts to ensure frontline staff have information and training specific to MST; MST Coordinators also conduct test training calls themselves throughout the year and engage in special training efforts in advance of national test calls. VHA has completed the actions for this recommendation and requests OIG to consider closure.

VHA requires MST coordinators to communicate MST-related issues, services, and initiatives to facility leaders.[117] The OIG determined that 34 out of 43 facility MST coordinators (79 percent) communicated MST-related issues to leaders. The absence of necessary communication at 21 percent of the facilities reviewed may hinder the accomplishment of project goals and hamper leaders' ability to identify and address improvement opportunities. MST coordinators reported

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[117] VHA Directive 1115.

unawareness of the requirement, lack of oversight, and position vacancies among the reasons for noncompliance.

Recommendation 22

22. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures military sexual trauma coordinators communicate related issues, services, and initiatives to facility leaders.[118]

VHA concurred.

Target date for completion: Completed

VHA response: VHA Directive 1115, specifies that Military Sexual Trauma (MST) Coordinators must, while respecting the appropriate chain of command, communicate with local leadership and ensure they are aware of the current status of MST services and initiatives at the facility. OIG's review highlighted the potential for different interpretations of this policy language and VHA appreciates the opportunity the Comprehensive Healthcare Inspection Program (CHIP) findings have provided to disseminate clarification and elaborated guidance to facilities.

On June 24, 2020, an operational memo was disseminated to Veterans Integrated Services Network (VISN) leadership, facility MST Coordinators, and VISN MST Points of Contact which requested that all facilities and VISNs, regardless of whether they received an OIG visit, take action to address three common areas of noncompliance identified during the 2019 OIG CHIP reviews and other oversight activities. (Although developed earlier than June, the release of this memo was intentionally delayed to allow facilities to focus on adapting operations to COVID-19). One action item in the memo specifically focused on ensuring there is an adequate structure or process for the facility MST Coordinator to communicate with service-level and executive leadership. The memo outlined policy requirements, provided best practice guidance, and asked facilities to closely review how their current practices align with these and to make changes as needed.

The MST Support Team has also updated key educational resources on the MST Coordinator position, such as its MST Coordinator position guidance document, to include the more detailed guidance issued in the memo as to what constitutes an appropriate minimum level of communication with leadership. This document was referenced in the operational memorandum, dated June 24, 2020, and is routinely provided to all new MST Coordinators when they enter the position. This memorandum is archived on VA's intranet MST resource homepage. In addition, the topic of communication with leadership and on responding to OIG CHIP findings in this area

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[118] The OIG reviewed VHA's response, determined that sufficient actions have been taken, and closed this recommendation prior to publication.

was a key focus of the MST Coordinator Best Practices Roundtable held as part of the MST Support Team's virtual MST conference, which was held in June 24–25, 2020. VHA has completed the actions for this recommendation and requests OIG to consider closure.

VHA also requires that all primary care and mental health providers complete mandatory MST training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[119] The OIG found that 266 of 465 applicable providers hired after July 1, 2012 (57 percent), completed the training within the required time frame. Lack of timely training for the remaining providers could potentially prevent consistent levels of counseling, clinical care, and service to veterans who have experienced MST. Coordinators cited poor oversight and the belief that the facility met the requirement as some of the reasons for noncompliance.

Recommendation 23

23. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures mental health and primary care providers complete mandatory military sexual trauma training within the required time frame.

VHA concurred.

Target date for completion: June 2021

VHA response: Ensuring clinical staff are well-prepared to treat Military Sexual Trauma (MST) survivors is a key priority for VHA, and its mandatory training requirement for all mental health and primary care providers is central to these efforts. To date, VHA's monitoring efforts specific to this requirement have focused on whether providers are currently compliant (have been assigned the training and have either completed it or have more time before their due date for completion) or noncompliant. This is in part due to the data historically available to VHA's national MST Support Team, which focused on compliance and noncompliance as just described. This evaluation approach also has the benefit of promoting a continued focus on ensuring completion even once a provider's 90-day window for initially completing the training had passed.

Using this evaluation approach, VA data has consistently shown national compliance rates in the high 90s percentage and as of July 2, 2020 (the most recent data available), 98% of current primary care providers and 99% of current mental health providers were in compliance. Based

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[119] VHA Memorandum, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers (VAIQ 7663786)*, February 2, 2016, refers to specific MST training requirements for providers assuming their position before or after July 1, 2012.

on national guidance, MST Coordinators and facilities have largely relied on this data to evaluate compliance with the mandatory training policy.

VHA has taken action to promote improved timeliness. VHA's national MST Support Team has secured access to a new data resource that provides not only the national and facility summary-level information about current compliance previously available but also information about individual staff and their training due dates. The MST Support Team is currently exploring the best way to use these data, but it provides the opportunity to create additional monitoring and notification resources to assist MST Coordinators and facilities in ensuring timely completion of the training requirement.

On June 24, 2020, an operational memorandum was disseminated to Veterans Integrated Services Network (VISN) leadership, facility MST Coordinators, and VISN MST Points of Contact which requested that all facilities and VISNs, take action to address three common areas of noncompliance identified during the fiscal year 2019 OIG Comprehensive Healthcare Inspection Program (CHIP) reviews (although developed earlier than June, the release of this memorandum was intentionally delayed to allow facilities to focus on adapting operations to COVID-19). The memo restated the mandatory training requirements for mental health and primary care providers. The memorandum outlined policy requirements, provided best practice guidance, and asked facilities to closely review how their current practices align with these and to make changes as needed. The memorandum provided instructions for running reports to obtain information about individual staff, due dates, and compliance status.

Also, a new automated notification has been added in VA's Talent Management System to alert users who are within 15 days of becoming delinquent on the training requirement. This earlier notification will provide an additional prompt to providers to complete the training requirement while still in the required timeframe. Supervisors will also be notified through VA's Talent Management System of the approaching deadline.

The MST Coordinator Best Practices Roundtable was hosted during the June 24–25, 2020, MST Support Team's virtual MST conference. VHA is exploring how to adapt inclusive data monitoring metrics for training completion timeliness, which will be incorporated into ongoing data and evaluation efforts.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."[120] The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.[121]

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepression drugs, psychotherapy, or a combination of both."[122]

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.[123] The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."[124] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[125] Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.[126] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves remission. Monitoring includes assessment of symptoms, adherence to medication and

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

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

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

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

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

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

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

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psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.[127]

To determine whether facilities complied with requirements concerning the use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 1,510 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[128] The OIG evaluated the following performance indicators:

- Justification for medication initiation

- Evidence of patient and/or caregiver education specific to the medication prescribed

- Clinician evaluation of patient and/or caregiver understanding of the education provided

- Medication reconciliation

Geriatric Care Findings and Recommendations

The OIG found general compliance with clinicians documenting reasons for medication initiation. However, the OIG identified that clinicians did not always provide adequate patient and/or caregiver education specific to newly prescribed medications, assess patient and/or caregiver understanding of the education provided, or reconcile patients' medications.

Specifically, TJC requires that clinicians educate patients and families about safe and effective use of medications and evaluate patient/caregiver understanding of the education provided.[129] The OIG estimated that clinicians provided education to 60 percent of patients, based on the electronic records reviewed. In addition, the OIG estimated that clinicians assessed understanding of education provided to 78 percent of patients. The provision of clear, understandable medication education by all clinicians is critical to ensure that patients have the information they need to manage their health at home. Reasons for noncompliance cited by facility managers and clinicians included competing priorities and lack of attention to detail when documenting elements of patient care visits.

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[127] *VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder*.

[128] The seven selected antidepressant medications are amitriptyline, clomipramine, desipramine, doxepin (>6mg/day), imipramine, nortriptyline, and paroxetine.

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

Recommendation 24

24. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that clinicians provide and document education on newly prescribed medications and assess patient/caregiver understanding of the information provided.

VHA concurred.

Target date for completion: May 2021

VHA response: VHA agrees that developing and implementing standards to ensure improvement in the documentation of newly prescribed medications is a vital component in the care of the Veteran population and the whole health process and patient safety. The National Integrated Clinical Communities will develop a team of subject matter experts that includes individuals from the national program offices, Veterans Integrated Services Network (VISN) and facility leadership, to evaluate and establish a standardized compliance mechanism. This effort will include required education documentation on newly prescribed medications and the assessment of patient/caregiver understanding, enabling successful at-home medication compliance. At the completion, a report will be developed and shared with VISN and facility leadership for implementation.

According to TJC, the required process of medication reconciliation is when "a clinician compares the medications a patient should be taking (and is actually taking) to the new medications that are ordered for the patient and resolve[s] any discrepancies."[130] TJC also requires patients' medical records to contain information that reflects care, treatment, and services provided. Furthermore, VHA requires that clinicians review and reconcile medications relevant to the episode of care.[131] The OIG estimated that clinicians performed medication reconciliation for 74 percent of patients. Failure to maintain and communicate accurate patient medication information to and reconcile medications with all patients may increase the risk of duplications, omissions, and interactions in patients' actual drug regimens. Facility managers cited the lack of a consistent process for documenting medication reconciliation among the reasons for noncompliance.

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[130] TJC. National Patient Safety Goal standard NPSG.03.06.01.
[131] VHA Directive 1164.

Recommendation 25

25. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that clinicians review and reconcile patients' medications and maintain and communicate accurate medication information in electronic health records.

VHA concurred.

Target date for completion: May 2021

VHA response: VHA agrees that developing and implementing standards to ensure compliance in the medication reconciliation process is a vital component in the care of the Veteran population and patient safety. The National Integrated Clinical Communities will develop a team of subject matter experts that includes individuals from the national program offices, Veterans Integrated Services Network (VISN) and facility leadership to evaluate and improve the compliance in the review and reconciliation process and documentation (communication) of medication information in the electronic health record. At the completion a report will be developed and shared with VISN and facility leadership for implementation.

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

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.[132] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[133] In addition to HPV infection, other risk factors for cervical cancer include smoking, HIV infection, use of oral contraceptives for five or more years, and having given birth to three or more children.[134] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[135]

VA is authorized to provide "gender-specific services, such as Papanicolaou tests (Pap smears)," to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.[136]

VHA requires that each facility have a "full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health care." VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women's health program. Each facility must also have a "Women Veterans Health Committee (WVHC), comprised of appropriate facility leadership and program directors, which develops and implements a Women's Health Program strategic plan." The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.[137]

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

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

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

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

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

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

[137] VHA Directive 1330.01(2).

results to patients must be documented. Facilities must ensure that appropriate follow-up care is provided to patients with abnormal results.[138]

To determine whether facilities complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, OIG inspection teams reviewed relevant documents and interviewed selected employees and managers. The teams also reviewed the electronic health records of 934 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators across each facility:

- Appointment of a women veterans program manager

- Appointment of a women's health medical director or clinical champion

- Women Veterans Health Committee

   o Core membership

   o Quarterly meetings

   o Reports to clinical executive leaders

- Collection and tracking of cervical cancer screening data

   o Notification of patients due for screening

   o Completed screenings

   o Results reporting

   o Follow-up care

- Communication of abnormal results to patients within required time frame

- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women's Health Findings and Recommendations[139]

The OIG found that facilities generally complied with requirements for the selected staffing elements and provision of care indicators reviewed. However, weaknesses were identified with women veterans health committees and facilities' collection and tracking of cervical cancer screening data.

VHA requires that the core membership of women veterans health committees include a women veterans program manager; a women's health medical director; and "representatives from

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[138] VHA Directive 1330.01(2).

[139] This review was not performed at the VA Manila Outpatient Clinic because of an insufficient number of veterans identified during the study period.

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." VHA also requires women veterans health committees to meet at least quarterly and report to executive leadership with signed minutes.[140]

The OIG found deficient representation from the following required core members when reviewing committee meeting minutes from the two previously completed quarters:

- Mental health—33 of 40 (83 percent)

- Medical and/or surgical subspecialties—26 of 40 (70 percent)

- Gynecology—22 of 28 (79 percent)

- Pharmacy—27 of 40 (68 percent)

- Emergency department—18 of 25 (72 percent)

- Radiology—28 of 40 (70 percent)

- Laboratory—19 of 40 (48 percent)

- Quality management—28 of 40 (70 percent)

- Business office/non-VA care—25 of 40 (63 percent)

- Executive leadership—24 of 40 (60 percent)

Additionally, the OIG found that 35 of 40 women veterans health committees (88 percent) met quarterly, and 31 of 40 (78 percent) reported to leadership. As a result, the women veterans programs lacked the expertise, guidance, and oversight to ensure high-quality, comprehensive, and equitable care for women veterans. Leadership turnover, scheduling conflicts, and ineffective oversight were cited among reasons for noncompliance.

Recommendation 26

26. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensure that women veterans health committees include required core members, meet at least quarterly, and report to leadership.

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[140] VHA Directive 1330.01(2).

VHA concurred.

Target date for completion: October 2020

VHA response: The Women Veterans Health Committee is a vital committee within the health care system to ensure the needs of women Veterans are identified, monitored and tracked. Representatives from core departments are critical for a fully functioning committee.

Women's Health (WH) will request an attestation from each Veterans Integrated Services Network (VISN) that facility women Veterans health committees include required core members, meet at least quarterly, and report to leadership. For any facilities that are non-compliant an action plan will be required. WH will assign to the VISN Lead Women Veteran Program Manager to review compliance at each site and provide updates to WH annually.

VHA requires that facilities have a process to track cervical cancer screening data, including notification of patients due for screening, completion of screening, results reporting, and follow-up care.[141] The OIG found that 34 of 42 facilities (81 percent) collected and tracked quality assurance data related to cervical cancer screenings, of which 29 of 34 (85 percent) had a systematic process for tracking notification of patients due for screening and follow-up care. Lack of a consistent systematic process at all facilities may delay VHA's efforts with timely cervical cancer diagnosis and intervention. New staff's knowledge gaps and failure to designate an individual responsible for tracking data were among the reasons cited for noncompliance.

Recommendation 27

27. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that clinical managers implement quality assurance processes that include tracking of cervical cancer screening notification and follow-up care.

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[141] VHA Directive 1330.01(2).

VHA concurred.

Target date for completion: October 2020

VHA response: Women's Health (WH) will provide guidance through a memorandum to the field to reinforce that each facility is required to have a process in place to ensure tracking and timely follow-up of findings from cervical cancer screening. All health care systems must have in place standard operating procedures that specify the tracking process and assign cervical cancer screening care coordination duties to specific individuals. The memorandum will include an attestation request from each Veterans Integrated Services Network (VISN) that clinical managers have implemented a quality assurance process that includes tracking of cervical cancer screening notification and follow-up care. For any facilities that are non-compliant an action plan will be required. WH will assign to the VISN Lead Women Veteran Program Manager to review compliance at each site and provide updates to WH annually.

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

VHA defines an emergency department as a "unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations." An urgent care center (UCC) "provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries."[142] A variety of emergency services may exist, dependent on "capability, capacity, and function of the local VA medical facility;" however, emergency care must be uniformly available in all VHA emergency departments and UCCs.[143]

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide "unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week." VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that "evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care."[144]

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can "undermine the timeliness of care and, ultimately, patient safety." Effective management processes that "support patient flow [in the emergency department or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care."[145]

The VHA National Director of Emergency Medicine developed the Emergency Medicine Improvement initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software tracking program to document and manage the flow of patients.[146]

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

[143] VHA Directive 1101.05(2).

[144] VHA Directive 1101.05(2).

[145] TJC. Leadership standard LD.04.03.11.

[146] VHA Directive 1101.05(2); The Emergency Medicine Management Tool uses data collected from Emergency Department Integration Software to generate productivity metrics. They are key tools in accomplishing Emergency Medicine Improvement initiative goals.

VA emergency departments and UCCs must also be designed to promote a safe environment of care.[147] Managers must ensure medications are securely stored,[148] a psychiatric intervention room is available,[149] and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also requires emergency departments to have communication systems available to accept requests by local emergency medical services for transporting unstable patients to VA emergency departments.[150]

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

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

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[147] VHA Directive 1101.05(2).

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

[149] A psychiatric intervention room is where individuals experiencing a behavioral health crisis, including serious disturbances, agitation, or intoxication may be taken immediately on arrival; VHA Directive 1101.05(2).

[150] VHA Directive 1101.05(2).

- o Licensed independent mental health provider available as required for the facility's complexity level

    - o Telephone message system during non-operational hours

    - o Inpatient provider available for patients requiring admission

- Patient flow

    - o Emergency Department Integration Software tracking program

    - o Emergency department patient flow evaluation

    - o Diversion policy

    - o Designated bed flow coordinator

- General safety

    - o Directional signage to after-hours emergency care

    - o Fast tracks[151]

- Medication security and labeling

- Management of patients with mental health disorders

- Emergency department participation in local/regional emergency medical services system, if applicable

- Women veteran services

    - o Capability and equipment for gynecologic examinations

- Life support equipment

High-Risk Processes Findings and Recommendations

Facilities generally met emergency department/UCC requirements for patient flow, medication security and labeling, management of patients with mental health disorders, emergency department participation in local/regional emergency medical services systems, women veteran services, and life support equipment. However, the OIG identified deficiencies with emergency department/UCC operating hours, staffing, support services, and general safety.

VHA requires that VA medical facilities operating a UCC 24 hours a day, 7 days a week, must request and receive approval for a "waiver from the National Director of Emergency

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[151] The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated; VHA Directive 1101.05(2).

Medicine to ensure safe patient care with proper staffing and support."[152] The OIG found that 7 of 11 applicable facilities (64 percent) had a UCC operating as required. The lack of an approved waiver for the remaining facilities hindered VHA leaders' ability to ensure that all facilities provided safe UCC care during all hours of operation. Reasons for noncompliance included a lack of follow-up after submission of a waiver request to the respective VISN leaders and the need to address stakeholders' concerns prior to changing the UCC's hours of operation.

Recommendation 28

28. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that urgent care centers operating 24 hours a day, 7 days a week have an approved waiver from the National Director of Emergency Medicine.

VHA concurred.

Target date for completion: October 2020

VHA response: Emergency Medicine (EM) program office validates operating hours of all Urgent Care Centers (UCCs) annually. The EM program office will be incorporating a request for this information on the emergency medicine site directory as part of a mandated update process. All emergency departments and UCCs are required to validate information on this site quarterly. The next update to include operating hours information will occur October 2020.

The EM program office will work in collaboration with our Veterans Integrated Services Network Emergency Medicine Chief Consultants to obtain updated and accurate information from all UCCs. This information will be collected at a shared location and include current operating hours, and waiver status. Sites operating 24/7 that need an updated waiver will be required to provide an updated waiver within 30 days receipt of the request.

VHA requires that an emergency department/UCC has appropriately educated and qualified emergency care professionals physically present during all hours of operation. This includes a licensed physician and a minimum of two registered nurses.[153] Although the OIG found that 31 of 33 emergency departments/UCCs (94 percent) were staffed with at least one licensed privileged physician, the physician was present at all times in only 26 of 31 of the staffed areas (84 percent). Further, only 25 of 33 emergency departments/UCCs (76 percent) had at least two registered nurses on duty during all hours of operation. Insufficient minimum clinical staffing at these deficient facilities could result in potentially unsafe situations in the event of a

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[152] VHA Directive 1101.05(2).
[153] VHA Directive 1101.05(2).

medical emergency. Reasons for noncompliance included staffing challenges and the belief that a low emergency department/UCC census did not support the staffing requirements.

Recommendation 29

29. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that emergency departments and urgent care centers are staffed with a minimum of two registered nurses during all hours of operation.

VHA concurred.

Target date for completion: October 2020

VHA response: The Emergency Medicine program office will send a memorandum to the Veterans Integrated Services Network (VISN) Directors and Chief Medical Officers to require an attestation ensuring staffing compliance of two registered nurses during all hours of operation, as stated in the Emergency Medicine Directive 1101_05(2). If compliance is not met, an action plan and timeline to comply will be required.

VHA requires that emergency departments/UCCs have a written staffing contingency plan, including a backup call schedule to address situations when additional providers are needed.[154] The OIG found that only 23 of 33 emergency departments/UCCs (67 percent) had a provider backup call schedule. For the remainder of the facilities, the ability to provide uninterrupted and timely patient care cannot be assured. Reasons for noncompliance included unawareness of the requirement, staffing issues, and informal processes in lieu of a defined backup call schedule.

Recommendation 30

30. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensure clinical managers maintain a backup call schedule for emergency department and urgent care center providers.

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[154] VHA Directive 1101.05(2).

VHA concurred.

Target date for completion: October 2020

VHA response: The Emergency Medicine program office will send a memorandum to the Veterans Integrated Services Network Directors and Chief Medical Officers to require an attestation to ensure facility implementation of a written provider staffing contingency plan and back-up call schedule, as stated in the Emergency Medicine Directive 1101_05(2). If compliance is not met, an action plan and timeline to comply will be required.

VHA states that support services must be available when the emergency department/UCC is open "to ensure that necessary and appropriate care can be consistently delivered to patients in a timely fashion."[155] The OIG found that only 29 of 33 emergency departments/UCCs (88 percent) had access to support services during business hours, off hours, on the weekends, and during holidays. Further, the OIG found that just 26 of 32 emergency departments/UCCs (81 percent) had access to social workers during business hours, off hours, on the weekends, and during holidays. Failure to provide support services during all hours of operation could negatively impact patient care at noncompliant facilities. Reasons for noncompliance included lack of awareness of the requirement and the belief that a low volume of patients seen during some hours did not justify the cost of additional staff.

Recommendation 31

31. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that support services, including social work, are available to emergency departments and urgent care centers during all hours of operation.

VHA concurred.

Target date for completion: October 2020

VHA response: The Emergency Medicine program office, in collaboration with the National Director of Social Work and the National Social Work program office, will send a memorandum to the Veterans Integrated Services Network Directors and Chief Medical Officers to require an attestation to ensure onsite or on call 24 hours a day, 7 days a week, social work services, as stated in the Emergency Medicine Directive 1101_05(2). If compliance is not met, an action plan and timeline to comply will be required.

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[155] VHA Directive 1101.05(2).

VHA also requires that facilities have appropriate signage directing patients to the emergency department/UCC.[156] The OIG found that 28 of 33 facilities (85 percent) had directional signage to the emergency department/UCC. Lack of signage at 15 percent of facilities reviewed may result in patients not being able to locate the emergency department/UCC and potentially delay needed emergent or urgent care. Reasons for noncompliance included unawareness of the deficiency.

Recommendation 32

32. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that facilities use appropriate signage to direct patients to emergency departments and urgent care centers.

VHA concurred.

Target date for completion: December 2020

VHA response: The Emergency Medicine program office has sent a memorandum to the Veterans Integrated Services Network Directors (VISN) and Chief Medical Officers to require an attestation ensuring an assessment on the Emergency Department and/or Urgent Care Center external and internal wayfinding signage was conducted to assess the appropriate signage is present. If improvements in wayfinding are identified, the facility will attest to an action plan with a timeline for completion. The VISNs will monitor facility ongoing compliance with the Emergency Department and the Urgent Care Center way finding signage.

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[156] VHA Directive 1101.5(2).

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

Healthcare Processes	Requirements	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation and/or for-cause surveys and oversight inspections • Factors related to possible lapses in care • VHA performance data	Thirty-two OIG recommendations in the areas of quality, safety, and value; medical staff privileging; environment of care; controlled substances inspections; military sexual trauma follow-up and training; geriatric care; women's health; and operations and management of emergency departments and urgent care centers are attributable to VHA facility leaders. See details below.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• All applicable deaths within 24 hours of admission are peer reviewed. • CPR committees review each resuscitative episode under the facilities' responsibility and include required elements in the reviews.	• Summaries of the peer review committees' work are reviewed quarterly by medical executive committees.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• Service chiefs include the minimum applicable specialty criteria for FPPEs of gastroenterology, pathology, nuclear medicine, and radiation oncology practitioners. • Executive committees of the medical staff document the decision to recommend continuing LIPs' privileges based on OPPE results. • Service chiefs' privileging determinations are based, in part, on OPPE activities. • OPPEs use assessments by providers with similar training and privileges. • Clinical managers clearly define and share in advance the expectations, outcomes, and time frames for FPPEs for cause with LIPs.	• FPPE criteria are defined in advance.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent facility
	   o General safety
	   o Environmental cleanliness and infection prevention
	   o General privacy
	   o Women veterans program
	   o Availability of medical equipment and supplies
	
	• Community-based outpatient clinic
	   o General safety
	   o Environmental cleanliness and infection prevention
	   o General privacy
	   o Women veterans program
	   o Availability of medical equipment and supplies
	
	• Locked inpatient mental health unit
	   o Mental health environment of care rounds
	   o Nursing station security
	   o Public area and general unit safety
	   o Patient room safety
	   o Infection prevention
	   o Availability of medical equipment and supplies
	
	• Emergency management
	   o Hazard vulnerability analysis
	   o Emergency operations plan
	   o Emergency power testing and availability
		• Inventories of resources and assets that may be needed during an emergency are documented and reviewed annually.	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• None	• Monthly and quarterly controlled substances inspection reports are reviewed at least quarterly by the facility committees responsible for quality oversight. • Electronic access for monitoring and performing controlled substances balance adjustments is limited to appropriate staff. • Controlled substances inspectors complete monthly physical inspections of controlled substances storage areas on the day initiated. • Controlled substances inspectors verify controlled substance orders for five randomly selected dispensing activities. • Controlled substances inspectors verify that drugs listed on the "Destructions File Holding Report" are secured and documented and that there is a corresponding sealed evidence bag containing drug(s) for each medication during monthly inspections. • Controlled substances inspectors verify the inventory count for prescription pads on the day of monthly pharmacy inspections.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
			• Controlled substances inspectors verify written controlled substances prescriptions during monthly area inspections. • Controlled substances inspectors verify pharmacy vault inventory at the required frequency. • Controlled substances inspectors complete emergency drug cache inspections that include checks for lock tampering and verification of lock numbers. • Clinical managers implement processes for reviewing automated drug dispensing cabinet override reports.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers	• None	• MST coordinators establish and monitor related training. • MST coordinators communicate related issues, services, and initiatives to facility leaders. • Mental health and primary care providers complete mandatory MST training in the required time frame.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Geriatric Care: Antidepressant Use among the Elderly	• Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation	• Clinicians provide and document education on newly prescribed medications and assess patient/caregiver understanding of the information provided. • Clinicians review and reconcile patients' medications and maintain and communicate accurate medication information in electronic health records.	• None
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data • Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated	• None	• Women veterans health committees include required core members, meet at least quarterly, and report to leadership. • Clinical managers implement quality assurance processes that include tracking of cervical cancer screening notification and follow-up care.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Operations and Management of Emergency Departments and UCCs	• General • Staffing for emergency department/UCC • Support services for emergency department/UCC • Patient flow • General safety • Medication security and labeling • Management of patients with mental health disorders • Emergency department participation in local/regional system • Women veteran services • Life support equipment	• UCCs operating 24 hours a day, 7 days a week have an approved waiver from the National Director of Emergency Medicine. • Emergency departments and UCCs are staffed with a minimum of two registered nurses during all hours of operation. • Support services, including social work, are available to emergency departments and UCCs during all hours of operation.	• Clinical managers maintain a backup call schedule for emergency department and UCC providers. • Facilities use appropriate signage to direct patients to emergency departments and UCCs.

Appendix B: Parent Facilities Inspected

Table B.1. Parent Facilities Inspected
(October 1, 2018, through September 30, 2019)

Names	City
Amarillo VA Health Care System	Amarillo, TX
Alaska VA Healthcare System	Anchorage, AK
Charlie Norwood VA Medical Center	Augusta, GA
VA Maryland Health Care System	Baltimore, MD
Edith Nourse Rogers Memorial Veterans Hospital	Bedford, MA
West Texas VA Health Care System	Big Spring, TX
Western New York Healthcare System	Buffalo, NY
VA Butler Health Care Center	Butler, PA
Canandaigua VA Medical Center	Canandaigua, NY
Cheyenne VA Medical Center	Cheyenne, WY
Jesse Brown VA Medical Center	Chicago, IL
Louis Stokes Cleveland VA Medical Center	Cleveland, OH
Coatesville VA Medical Center	Coatesville, PA
Chalmers P. Wylie Ambulatory Care Center	Columbus, OH
Carl Vinson VA Medical Center	Dublin, GA
El Paso VA Health Care System	El Paso, TX
Fargo VA Health Care System	Fargo, ND
Central California VA Health Care System	Fresno, CA
North Florida/South Georgia Veterans Health System	Gainesville, FL
VA Texas Valley Coastal Bend Health Care System	Harlingen, TX
Edward Hines, Jr. VA Hospital	Hines, IL
VA Pacific Islands Health Care System	Honolulu, HI
Richard L. Roudebush VA Medical Center	Indianapolis, IN
Oscar G. Johnson VA Medical Center	Iron Mountain, MI
Kansas City VA Medical Center	Kansas City, MO
VA Central Massachusetts Healthcare System	Leeds, MA
VA Greater Los Angeles Healthcare System	Los Angeles, CA
Manchester VA Medical Center	Manchester, NH
James H. Quillen VA Medical Center	Mountain Home, TN
Eastern Oklahoma VA Health Care System	Muskogee, OK

Names	City
Southeast Louisiana Veterans Health Care System	New Orleans, LA
VA Manila Outpatient Clinic	Pasay City, Philippines
Corporal Michael J. Crescenz VA Medical Center	Philadelphia, PA
Northern Arizona VA Health Care System	Prescott, AZ
Hunter Holmes McGuire VA Medical Center	Richmond, VA
Sheridan VA Medical Center	Sheridan, WY
Sioux Falls VA Health Care System	Sioux Falls, SD
St. Cloud VA Health Care System	St. Cloud, MN
James A. Haley Veterans' Hospital	Tampa, FL
Tuscaloosa VA Medical Center	Tuscaloosa, AL
Jonathan M. Wainwright Memorial VA Medical Center	Walla Walla, WA
VA Connecticut Healthcare System	West Haven, CT
VA Southern Oregon Rehabilitation Center and Clinics	White City, OR

Source: OIG

Appendix C: VA Outpatient Clinics Inspected

**Table C.1. VA Outpatient Clinics Inspected
(October 1, 2018, through September 30, 2019)**

Outpatient Clinic Name and Location	Parent Facility City
Clovis VA Clinic	Amarillo, TX
Juneau VA Clinic	Anchorage, AK
Statesboro VA Clinic	Augusta, GA
Glen Burnie VA Clinic	Baltimore, MD
Lynn VA Clinic	Bedford, MA
Abilene VA Clinic	Big Spring, TX
Dunkirk VA Clinic	Buffalo, NY
Armstrong County VA Clinic	Butler, PA
Rochester VA Clinic	Canandaigua, NY
Rawlins VA Clinic	Cheyenne, WY
Adam Benjamin Jr., VA Outpatient Clinic	Chicago, IL
Sandusky VA Clinic	Cleveland, OH
Spring City VA Clinic	Coatesville, PA
Newark VA Clinic	Columbus, OH
Perry VA Clinic	Dublin, GA
Las Cruces VA Clinic	El Paso, TX
Minot VA Clinic	Fargo, ND
Oakhurst VA Clinic	Fresno, CA
The Villages VA Clinic	Gainesville, FL
South Enterprize VA Clinic	Harlingen, TX
LaSalle VA Clinic	Hines, IL
Leeward Oahu VA Clinic	Honolulu, HI
Indianapolis-West VA Clinic	Indianapolis, IN
Hancock VA Clinic	Iron Mountain, MI
Warrensburg VA Clinic	Kansas City, MO
Fitchburg VA Clinic	Leeds, MA
San Luis Obispo VA Clinic	Los Angeles, CA
Somersworth VA Outpatient Clinic	Manchester, NH
Marion VA Clinic	Mountain Home, TN
McCurtain County VA Clinic	Muskogee, OK

Outpatient Clinic Name and Location	Parent Facility City
Franklin VA Clinic	New Orleans, LA
Burlington VA Clinic	Philadelphia, PA
Anthem VA Clinic	Prescott, AZ
Fredericksburg 2 VA Clinic	Richmond, VA
Rock Springs VA Clinic	Sheridan, WY
Watertown VA Clinic	Sioux Falls, SD
Max J. Beilke Department of Veterans Affairs Outpatient Clinic	St. Cloud, MN
Lakeland VA Clinic	Tampa, FL
Selma VA Clinic	Tuscaloosa, AL
Lewiston VA Clinic	Walla Walla, WA
Newington outpatient clinic	West Haven, CT
Grants Pass VA Clinic	White City, OR

Source: OIG

Appendix D: Leadership and Organizational Risk Summary Results

Table D.1. Inspected Facilities by VISN

VISN	Number of Facilities Inspected
VISN 1: VA New England Healthcare System	4
VISN 2: New York/New Jersey VA Health Care Network	2
VISN 4: VA Healthcare – VISN 4	3
VISN 5: VA Capitol Health Care Network	1
VISN 6: VA Mid-Atlantic Health Care Network	1
VISN 7: VA Southeast Network	3
VISN 8: VA Sunshine Healthcare Network	2
VISN 9: VA MidSouth Healthcare Network	1
VISN 10: VA Healthcare System	3
VISN 12: VA Great Lakes Health Care System	3
VISN 15: VA Heartland Network	1
VISN 16: South Central VA Health Care Network	1
VISN 17: VA Heart of Texas Health Care Network	4
VISN 19: Rocky Mountain Network	3
VISN 20: Northwest Network	3
VISN 21: Sierra Pacific Network	3
VISN 22: Desert Pacific Healthcare Network	2
VISN 23: VA Midwest Health Care Network	3

Source: VA OIG

Table D.2. Inspected Facilities by Complexity[1]

Facility Complexity	Number of Facilities Inspected
1a-Highest Complexity[2]	9
1b-High Complexity[3]	6
1c-Mid-High Complexity[4]	3
2-Medium Complexity[5]	8
3-Low Complexity[6]	16
Excluded[7]	1

Source: VA OIG

[1] Results as of the CHIP inspection.

[2] VHA Office of Productivity, Efficiency, & Staffing (OPES) Facility Complexity Level Model Fact Sheet "Facilities with high volume, high risk patients, most complex clinical programs, and large research and teaching programs."

[3] VHA Office of Productivity, Efficiency, & Staffing (OPES) Facility Complexity Level Model Fact Sheet "Facilities with medium-high volume, high risk patients, many complex clinical programs, and medium-large research and teaching programs."

[4] VHA Office of Productivity, Efficiency, & Staffing (OPES) Facility Complexity Level Model Fact Sheet "Facilities with medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs."

[5] VHA Office of Productivity, Efficiency, & Staffing (OPES) Facility Complexity Level Model Fact Sheet "Facilities with medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs."

[6] VHA Office of Productivity, Efficiency, & Staffing (OPES) Facility Complexity Level Model Fact Sheet "Facilities with low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs."

[7] The VA Manila Outpatient Clinic in Pasay City, Philippines, is classified as an "Other Outpatient Services (OOS)" location. VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013, defines this term as "a site that either provides services to Veterans, but does not generate VHA encounter workload, or does not meet minimum criteria to be classified as a community-based outpatient clinic (CBOC) or Health Care Center (HCC)." According to the VHA Office of Productivity, Efficiency & Staffing, the VA Manila Outpatient Clinic is excluded from the complexity model "per Complexity Model Workgroup Recommendation."

Table D.3. Composition of Leadership Teams[8]

Composition	Number of Leadership Teams
Director and Chief Medical Officer	1
Facility Director, Chief of Staff, ADPCS, and Associate Director(s)	28
Facility Director, Chief of Staff, ADPCS, Associate Director(s), and Assistant Director	8
Facility Director, Chief of Staff, ADPCS, Executive Directors, and Associate Directors	1
Facility Director, Chief of Staff, ADPCS, Deputy Director, and Associate Director	2
Facility Director, Chief of Staff, ADPCS, Deputy Director, and Assistant Director	1
Facility Director, Chief of Staff, ADPCS, Deputy Director, Associate Director, and Assistant Director	2

Source: VA OIG

Table D.4. Permanence of Facility Leaders[9]

Position	Yes	Percent Yes	No	Percent No	Total
Facility Director	37	86	6	14	43
Chief of Staff	36	86	6	14	42
Chief Medical Officer	1	100	0	0	1
ADPCS	36	86	6	14	42
Deputy Director	5	100	0	0	5
Executive Director	2	100	0	0	2
Associate Director	39	89	5	11	44
Assistant Director	11	100	0	0	11
Overall	**167**	**88**	**23**	**12**	**190**

Source: VA OIG

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[8] Results as of the CHIP inspection.

[9] Results as of the CHIP inspection.

Table D.5. Average Tenure of Permanent Leaders[10]

Position	Number of Staff	Average Tenure (Years)	Minimum Tenure Observed (Weeks)	Maximum Tenure Observed (Years)
Facility Director	37	3.0	0.1	8.5
Chief of Staff	36	3.2	0.0	21.2
Chief Medical Officer	1	4.0	n/a	n/a
ADPCS	36	3.9	7.1	12.9
Deputy Director	5	2.0	13.1	3.4
Executive Director	2	1.1	55.1	1.2
Associate Director	39	2.8	3.1	8.6
Assistant Director	11	3.6	25.1	10.2
Overall	**167**	**2.8**	**0.0**	**21.2**

Source: VA OIG
n/a = not applicable

Table D.6. Distribution of Permanent Leaders' Tenure[11]

Position	<6 Months	6 months–1 year	1–2 years	2–5 years	>5 years	Total
Director	2	4	7	18	6	37
Chief of Staff	9	4	6	10	7	36
Chief Medical Officer	0	0	0	1	0	1
ADPCS	2	4	6	14	10	36
Deputy Director	1	1	0	3	0	5
Executive Director	0	0	2	0	0	2
Associate Director	4	6	11	10	8	39
Assistant Director	1	1	1	5	3	11
Overall	**19**	**20**	**33**	**61**	**34**	**167**

Source: VA OIG
n/a = not applicable

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[10] Results as of the CHIP inspection.

[11] Results as of the CHIP inspection.

Table D.7. Occurrence of Sentinel Events across Facilities

Number of Reported Sentinel Events	Number of Facilities	Total Sentinel Events
0	17	0
1	6	6
2	3	6
3	3	9
4	3	12
5	2	10
6	1	6
7	1	7
9	1	9
10	1	10
13	3	39
21	1	21
25	1	25
Overall	**43**	**160**

Source: VA OIG

Table D.8. Occurrence of Institutional Disclosures across Facilities

Number of Reported Institutional Disclosures	Number of Facilities	Total Institutional Disclosures
0	3	0
1	5	5
2	4	8
3	4	12
4	4	16
5	4	20
6	4	24
7	1	7
8	4	32
9	1	9
10	1	10
12	1	12
14	1	14
15	1	15
16	2	32
18	1	18
28	1	28
66	1	66
Overall	**43**	**328**

Source: VA OIG

Table D.9. Facility Complexity by VHA SAIL Star Rating

SAIL Star Rating	Facility Complexity	Number of Facilities
1	1a-Highest	0
	1b-High	0
	1c-Mid-High	0
	2-Medium	1
	3-Low	1
2	1a-Highest	1
	1b-High	1
	1c-Mid-High	2
	2-Medium	1
	3-Low	4
3	1a-Highest	4
	1b-High	4
	1c-Mid-High	0
	2-Medium	1
	3-Low	4
4	1a-Highest	2
	1b-High	1
	1c-Mid-High	1
	2-Medium	5
	3-Low	1
5	1a-Highest	2
	1b-High	0
	1c-Mid-High	0
	2-Medium	0
	3-Low	6
Excluded	Excluded	1
Overall		**43**

Source: VA OIG
n/a = not applicable

Table D.10. Sentinel Events by VHA SAIL Star Rating

SAIL Star Rating	Number of Sentinel Events	Number of Facilities	Average Number of Sentinel Events
1	3	2	1.5
2	20	9	2.2
3	84	13	6.5
4	40	10	4.0
5	13	8	1.6
Excluded	0	1	0.0
Overall	**160**	**43**	**3.7**

Source: VA OIG

Table D.11. Institutional Disclosures by VHA SAIL Star Rating

SAIL Star Rating	Number of Institutional Disclosures	Number of Facilities	Average Number of Institutional Disclosures
1	3	2	1.5
2	58	9	6.4
3	165	13	12.7
4	42	10	4.2
5	60	8	7.5
Excluded	0	1	0.0
Overall	**328**	**43**	**7.6**

Source: VA OIG

Table D.12. OIG CHIP Report Recommendations by VHA SAIL Star Rating

SAIL Star Rating	Number of CHIP Report Recommendations	Number of Facilities	Average Number of CHIP Report Recommendations
1	20	2	10.0
2	137	9	15.2
3	197	13	15.2
4	132	10	13.2
5	108	8	13.5
Excluded	7	1	7.0
Overall	**601**	**43**	**14.0**

Source: VA OIG

Table D.13. Sentinel Events by Facility Complexity[12]

Facility Complexity	Number of Sentinel Events	Number of Facilities	Average Number of Sentinel Events
1a-Highest Complexity	87	9	9.7
1b-High Complexity	29	6	4.8
1c-Mid-High Complexity	11	3	3.7
2-Medium Complexity	13	8	1.6
3-Low Complexity	20	16	1.3
Excluded	0	1	0.0
Overall	**160**	**43**	**3.7**

Source: VA OIG

Table D.14. Institutional Disclosures by Facility Complexity[13]

Facility Complexity	Number of Institutional Disclosures	Number of Facilities	Average Number of Institutional Disclosures
1a-Highest Complexity	135	9	15.0
1b-High Complexity	70	6	11.7
1c-Mid-High Complexity	14	3	4.7
2-Medium Complexity	29	8	3.6
3-Low Complexity	80	16	5.0
Excluded	0	1	0.0
Overall	**328**	**43**	**7.6**

Source: VA OIG

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[12] Results as of the CHIP inspection.

[13] Results as of the CHIP inspection.

Table D.15. OIG CHIP Report Recommendations by Facility Complexity[14]

Facility Complexity	Number of CHIP Report Recommendations	Number of Facilities	Average Number of CHIP Report Recommendations
1a-Highest Complexity	151	9	16.8
1b-High Complexity	89	6	14.8
1c-Mid-High Complexity	27	3	9.0
2-Medium Complexity	100	8	12.5
3-Low Complexity	227	16	14.2
Excluded	7	1	7.0
Overall	**601**	**43**	**14.0**

Source: VA OIG

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[14] Results as of the CHIP inspection.

Appendix E: Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: September 23, 2020

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019 (Project No. 2020-01994-HI-1028) (VIEWS # 03370587)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the OIG draft report, Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019.

2. I concur with recommendations 1–32. The applicable information is provided in the attached action plan.

3. If you have any questions, please contact the GAO OIG Accountability Liaison Office at VHA10BGOALAction@va.gov.

(Original signed by:)

Richard A. Stone, M.D.

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