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VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri

CHIP REPORT | REPORT #19-06864-183 | JULY 9, 2020

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Figure 1. *Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri*
(Source: https://vaww.va.gov/directory/guide/, accessed on January 27, 2020)

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Harry S. Truman Memorial Veterans' Hospital, which includes multiple outpatient clinics in Missouri. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

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

The unannounced visit was conducted during the week of November 4, 2019, at the Harry S. Truman Memorial Veterans' Hospital and Sedalia VA Clinic. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this medical center's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this medical center and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

Leadership and Organizational Risks

At the time of the OIG's visit, the medical center's leadership team consisted of the Medical Center Director, Chief of Staff, Associate Director for Patient Service (ADPS), Associate Director, and Assistant Director. The Medical Center Director serves as the chairperson of the Joint Leadership Council, which has the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. Patient safety and care are overseen by the Performance Improvement Board which is responsible for tracking and trending quality of care and patient outcomes, and it reports to the Joint Leadership Council.

When the OIG conducted this inspection, the executive team had been working together for two months, although the Chief of Staff had served in the role since 2010 and the Associate Director and Assistant Director had served in their positions since June 2012 and April 2014, respectively.

The OIG noted the medical center averages for specific survey leadership questions were similar to or higher than the VHA average. The same trend was noted for the members of the executive leadership team. In all, employees appeared generally satisfied with facility leaders. The OIG also reviewed responses to relevant survey questions that reflect patients' attitudes about their health care experiences. For this medical center, the patient survey results generally reflected similar or higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

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

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[1]

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

The executive leaders were generally knowledgeable within their scopes of responsibilities about VHA data and/or medical center-level factors contributing to specific poorly-performing SAIL and CLC measures and should continue to take actions to sustain and improve performance.[2]

The OIG noted opportunities for improvement in seven of eight clinical areas reviewed and issued 14 recommendations that are directed to the Medical Center Director, Chief of Staff, and Associate Director for Patient Service. These are briefly described below.

Quality, Safety, and Value

The medical center complied with requirements for establishing a committee responsible for quality, safety, and value oversight functions; reviewing aggregated data; and most patient safety elements. However, the OIG identified opportunities for improvement in utilization management and root cause analysis processes.[3]

Medical Staff Privileging

The medical center met expectations for many of the expected elements of performance, including focused professional practice evaluations. However, the OIG identified deficiencies with ongoing professional practice evaluation and provider exit reviews processes.[4]

Medication Management

The OIG observed compliance with performance indicators for assessment of pain management outcomes and quality, documentation of initial screenings for pain, and evaluation of concurrent therapy with a prescribed benzodiazepine. The medical center also utilized a multidisciplinary pain management committee to oversee and monitor required quality measures. However, the areas for improvement included providers' assessments of aberrant drug related behaviors, provision of urine drug testing, documentation of informed consent, and follow-up after initiation of therapy.

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

[3] 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."

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

Mental Health

The OIG found the medical center complied with requirements related to suicide prevention coordinators, completion of four mental health appointments within the required time frame, follow-up for no-show high-risk appointments, and completion of safety plans. However, the OIG noted concerns with staff completing annual suicide prevention refresher training.

Care Coordination

The medical center generally met expectations for the care coordination elements reviewed. However, the OIG identified noncompliance with completion of LSTD progress notes and establishment of a multidisciplinary committee to review proposed life sustaining treatment plans when necessary.

Women's Health

The OIG found the medical center complied with many of women's health requirements, including care provision and staffing. The OIG noted concerns with the designated Women Veterans Program Manager and the Women Veterans Health Committee.

High-Risk Processes

The medical center met many of the requirements for properly reprocessing reusable medical equipment (RME). However, the OIG identified issues with competency assessments for sterile processing staff.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued 14 recommendations for improvement to the Medical Center Director, Chief of Staff, and ADPS. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this medical center. The intent is for medical center leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems' issues as well as other less-critical findings that, if not addressed, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 69–70, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
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Contents

Abbreviations ii

Report Overview iii

Inspection Results iv

Purpose and Scope 1

Methodology 3

Results and Recommendations 5

Leadership and Organizational Risks 5

Quality, Safety, and Value 21

Recommendation 1 24

Recommendation 2 25

Recommendation 3 26

Medical Staff Privileging 27

Recommendation 4 29

Recommendation 5 30

Environment of Care 31

Medication Management: Long-Term Opioid Therapy for Pain 33

Recommendation 6 35

Recommendation 7 36

Recommendation 8 37

Recommendation 9 38

Mental Health: Suicide Prevention Program 40

Recommendation 10 43

Care Coordination: Life-Sustaining Treatment Decisions 45

Recommendation 11 47

Recommendation 12 48

Women's Health: Comprehensive Care 49

Recommendation 13 51

High-Risk Processes: Reusable Medical Equipment 52

Recommendation 14 54

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings 56

Appendix B: Medical Center Profile 60

Appendix C: VA Outpatient Clinic Profiles 62

Appendix D: Patient Aligned Care Team Compass Metrics 64

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions 66

Appendix F: Community Living Center (CLC) Strategic Analytics for Improvement and Learning (SAIL) Measure Definitions 68

Appendix G: VISN Director Comments 69

Appendix H: Medical Center Director Comments 70

OIG Contact and Staff Acknowledgments 71

Report Distribution 72

Purpose and Scope

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

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

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

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

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

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

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

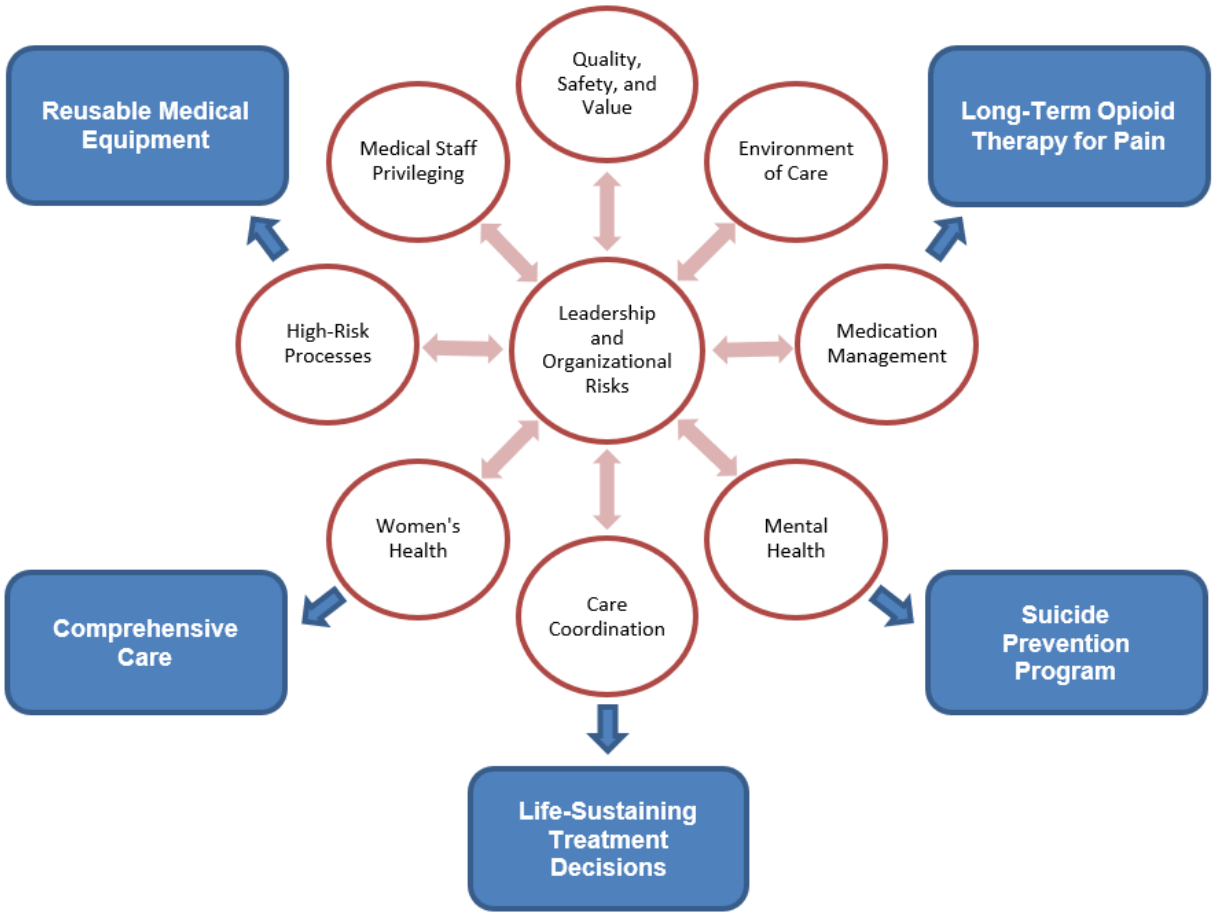

Figure 2. *Fiscal Year (FY) 2020 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

Methodology

The Harry S. Truman Memorial Veterans' Hospital includes multiple outpatient clinics in Missouri. Additional details about the types of care provided by the medical center can be found in Appendixes B and C.

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

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

- Community Living Center (CLC) – 3rd floor
- Emergency department
- Inpatient mental health – Unit 2B
- Intensive care unit – 3rd floor
- Medical inpatient – 4th floor
- Post anesthesia care unit – 3rd floor
- Primary care clinic – White team
- Surgical inpatient – 3rd floor

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

The inspection period examined operations from October 29, 2016, through November 8, 2019, the last day of the unannounced multiday site visit.[5] While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

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

[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.

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

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA medical center. Leadership and organizational risks can impact the medical center's ability to provide care in the clinical focus areas.[6] To assess the medical center's risks, the OIG considered the following indicators:

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

Executive Leadership Position Stability and Engagement

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

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

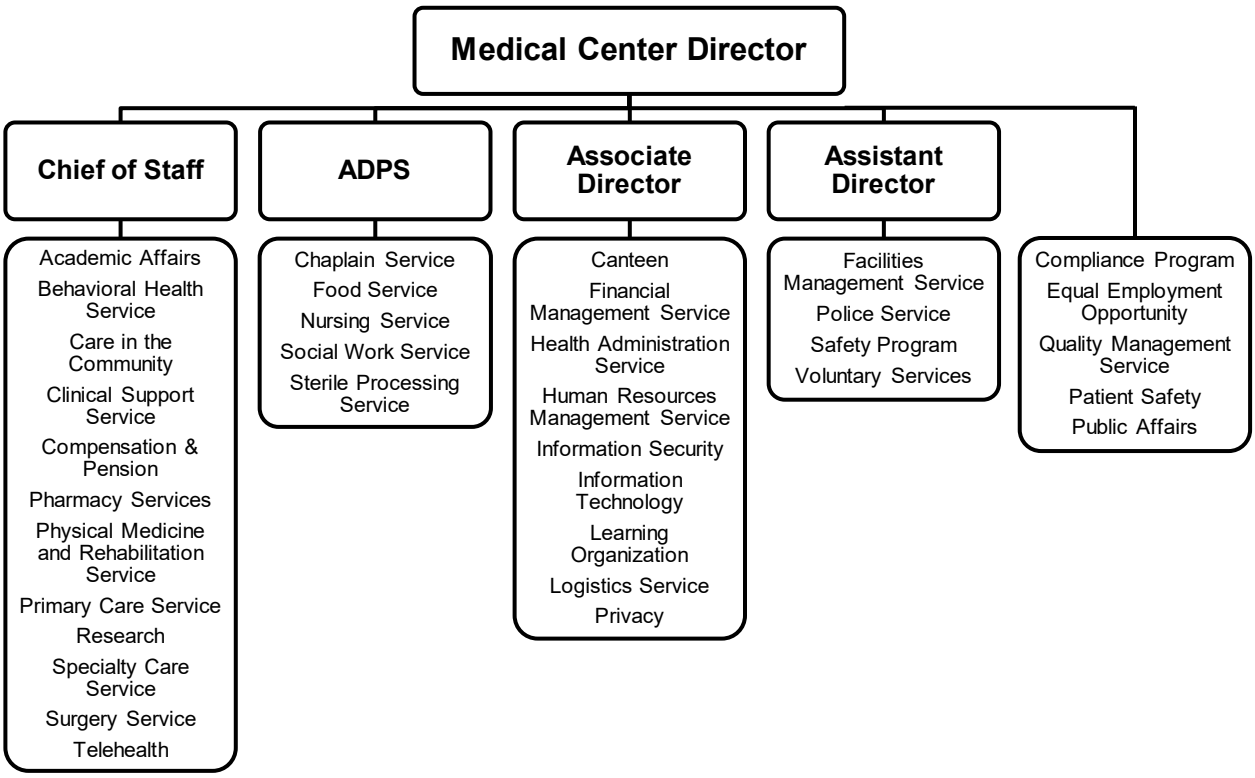

Figure 3. *Medical Center Organizational Chart*
Source: Harry S. Truman Memorial Veterans' Hospital (received November 4, 2019)

At the time of the OIG site visit, the executive team had been working together as a group for two months, although the Chief of Staff had served in the role since 2010 and two other team members had been in their positions for several years (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	September 1, 2019
Chief of Staff	June 20, 2010
Associate Director for Patient Service	July 7, 2019
Associate Director	June 18, 2012
Assistant Director	April 6, 2014

Source: Harry S. Truman Memorial Veterans' Hospital Supervisory Human Resources Specialist (received November 4, 2019)

To help assess the medical center executive leaders' engagement, the OIG interviewed the Medical Center Director, ADPS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance. The Chief of Staff was not available during the week of the inspection.

The executive leaders were generally knowledgeable within their scopes of responsibilities about VHA data and system-level factors contributing to specific poorly performing quality of care measures. Leaders were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and patient experiences. These are discussed in greater detail below.

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

These leaders monitor patient safety and care through the Performance Improvement Board which is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes, and it reports to the Joint Leadership Council. See Figure 4.

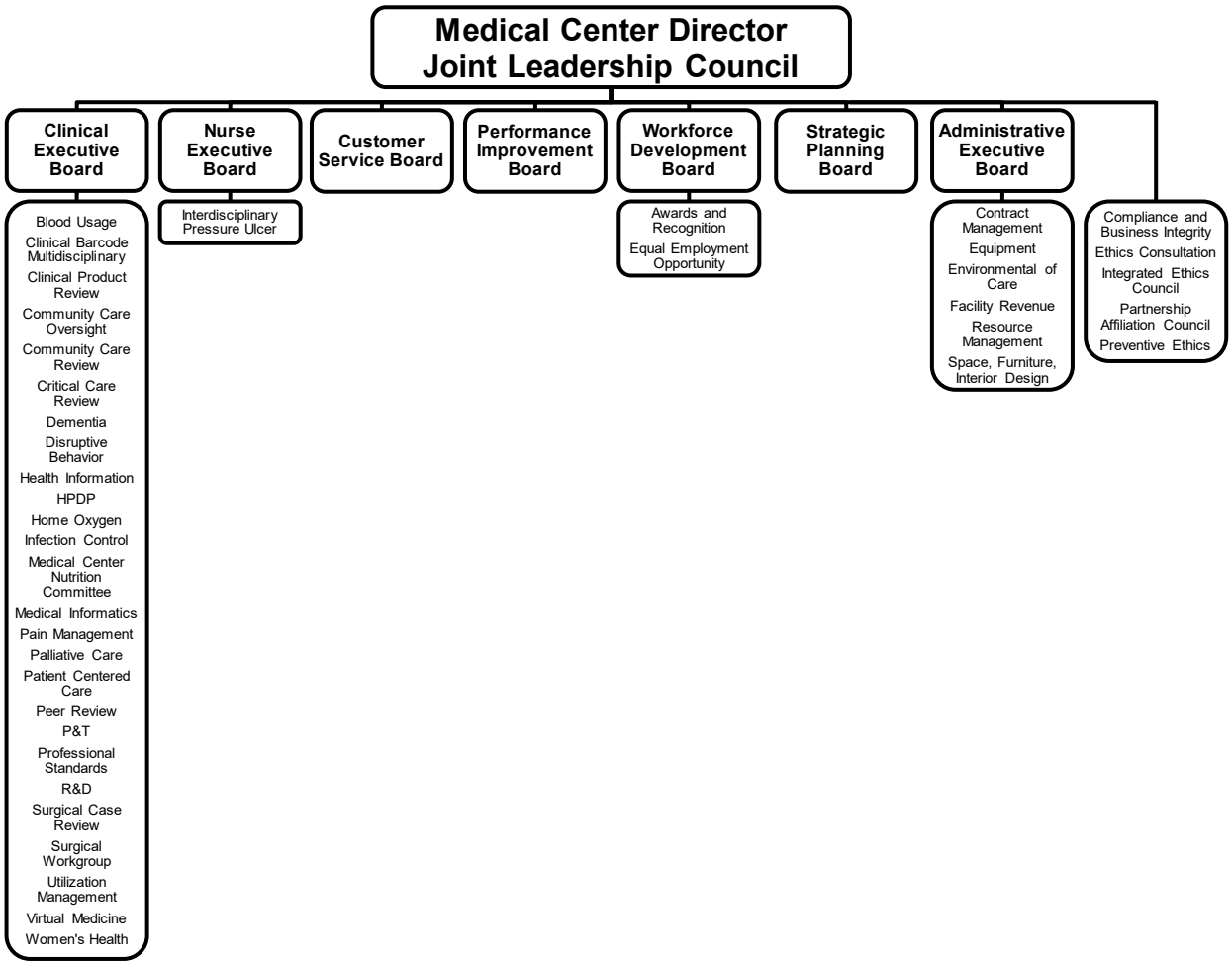

Figure 4. *Medical Center Committee Reporting Structure*
Source: Harry S. Truman Memorial Veteran's Hospital (received November 4, 2019)
HPDP = Health Promotion Disease Prevention
P&T = Pharmacy & Therapeutics
R&D = Research & Development

Employee Satisfaction

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

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of

October 1, 2018, through September 30, 2019.[7] Table 2 provides relevant survey results for VHA, the medical center, and executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center average for the specific survey leadership questions was similar to or higher than the VHA average.[8] The same trend was noted for the members of the executive leadership team. In all, employees appeared generally satisfied with medical center leaders.[9]

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite*[10]	0–100 where higher scores are more favorable	72.6	76.4	94.2	79.2	76.6	73.0	84.0
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.4	3.8	4.8	4.3	3.9	4.2	4.2

[7] Ratings are based on responses by employees who report to or are aligned under the Medical Center Director, Chief of Staff, ADPS, Associate Director, and Assistant Director. It is important to note that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current Medical Center Director and ADPS who assumed their positions just prior to or after the survey was administered.

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

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

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	4.0	4.6	4.4	3.9	4.8	4.5
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	4.0	4.8	4.3	4.0	4.2	4.3

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

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[11] Note that the medical center and leaders' averages for the specific survey questions were similar to or better than the VHA averages. Employees appear to feel safe bringing forth issues and concerns.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	4.0	4.8	4.1	4.0	4.6	4.4

[11] Ratings are based on responses by employees who report to or are aligned under the Medical Center Director, Chief of Staff, ADPS, Associate Director, and Assistant Director. Again, it is important to note that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current Medical Center Director and ADPS who assumed their positions just prior to or after the survey was administered.

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.9	4.6	3.6	3.9	–[12]	4.4
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.4	1.2	1.2	1.2	1.3	0.6	0.2

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

Patient Experience

To assess patient experiences with the medical center, which directly reflect on its leaders, the OIG team reviewed patient experience survey results that relate to the period of October 1, 2018, through June 30, 2019. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for VHA and the medical center.[13]

[12] The All Employee Survey ensures that "Reponses are confidential and data will remain anonymous…In order to maintain confidentiality, no data from groups smaller than five (5) will be released." http://aes.vssc.med.va.gov/SurveyInstruments/Pages/default.aspx. (The website was accessed on March 3, 2020, but is not accessible by the public.)

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

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

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.1	79.0
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	89.5
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	77.0	83.9
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	78.0	86.2

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

In 2015, women represented 9.4 percent of the total veteran population in the United States, and it is projected that women will represent 16.3 percent of living veterans by 2043. Further, from 2005 to 2015, the number of women veterans using VA health care increased by 46.4 percent, from almost 240,000 to 455,875.[14] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

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

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients' experiences by gender (see Tables 5–7) including those for Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG noted that the results for male respondents were generally similar to or more favorable than the corresponding VHA averages. The same trend was generally noted for the Patient-Centered Medical Home and Specialty Care results for female respondents; inpatient averages were not available for comparison.

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

Questions	Scoring	VHA[15]		Medical Center[16]	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.3	83.6	82.0	–[17]
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.7	83.0	88.6	–
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	68.5	62.0	78.7	–

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

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

[16] The medical center averages are based on 266–278 male and two or three female respondents, depending on the question.

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

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

Questions	Scoring	VHA[18]		Medical Center[19]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.8	43.2	56.7	40.7
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.8	49.5	61.4	60.3
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.0	64.8	78.6	85.4

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

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

[19] The medical center averages are based on 882–1,965 male and 33–91 female respondents, depending on the question.

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

Questions	Scoring	VHA[20]		Medical Center[21]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.3	44.4	58.8	78.7
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	53.9	66.1	67.3
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	69.9	69.4	78.6	79.3

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

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[22] Table 8 summarizes the relevant medical center inspections most recently performed by the OIG and The Joint Commission (TJC).[23] Of note, at the time of the OIG visit, the medical center had closed all

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

[21] The medical center averages are based on 388–1,356 male and 16 or 47 female respondents, depending on the question.

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

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

recommendations for improvement issued since the previous comprehensive healthcare inspection conducted in October 2016.

At the time of the site visit, the OIG also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[24] The Long Term Care Institute also conducted an inspection of the medical center's CLC on September 24, 2019; ten recommendations remained open at the time of the OIG's site visit.[25]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Clinical Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, MO,* Report No. 16-00550-145, March 8, 2017)	October 2016	13	0
TJC Hospital Accreditation	June 2019	38	0
TJC Behavioral Health Care Accreditation		2	0
TJC Home Care Accreditation		6	0

Source: OIG and TJC (Inspection/survey results verified with the Chief of Quality Management on November 4, 2019)

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

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental

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

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

conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms.

Table 9 lists the reported patient safety events from October 28, 2016 (the prior comprehensive OIG inspection), through November 8, 2019.[26] The Chief of Quality Management provided details of the sentinel events and institutional disclosure. One patient event was listed as an institutional disclosure and a sentinel event. Two events occurred while the patients received care from community providers. Reportedly, none of the incidents resulted in deaths.

Table 9. Summary of Selected Organizational Risk Factors (October 28, 2016, through November 8, 2019)

Factor	Number of Occurrences
Sentinel Events[27]	5
Institutional Disclosures[28]	1
Large-Scale Disclosures[29]	0

Source: Harry S. Truman Memorial Veterans' Hospital's Chief of Quality Management (received November 4, 2019)

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted

[26] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Harry S. Truman Memorial Veterans' Hospital is a mid-high complexity (1c) affiliated system as described in Appendix B.)

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

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

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

limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[30]

Figures 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2019. Of note, Figure 5 uses blue and green data points to indicate high performance for the Harry S. Truman Memorial Veterans' Hospital (for example, in the areas of best place to work, rating (of) hospital, rating (of) primary care (PC) provider, and specialty care (SC) survey access). Metrics that need improvement are denoted in orange and red (for example, mental health (MH) experience (exp) of care, registered nurse (RN) turnover, and ambulatory care sensitive condition (ACSC) hospitalization).[31]

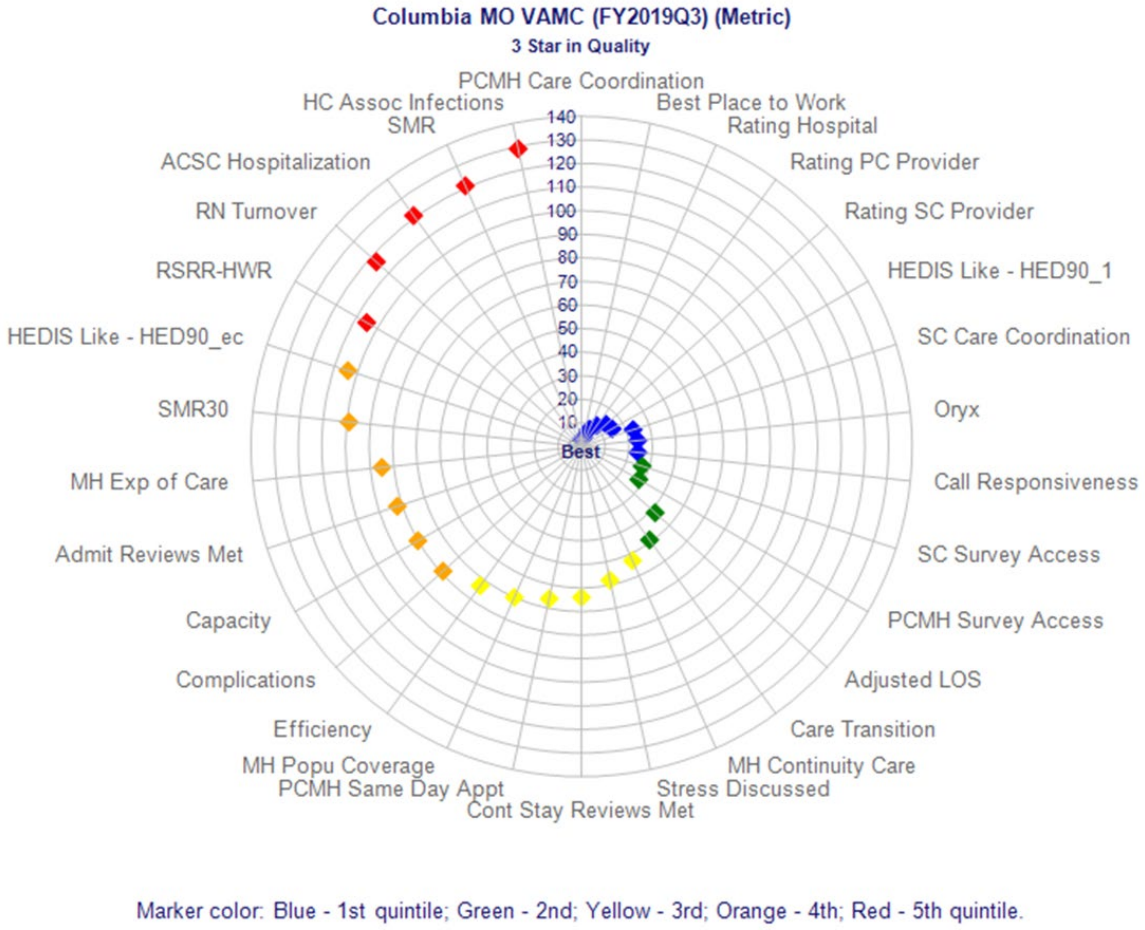

Figure 5. *System Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)*
Source: VHA Support Service Center

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

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

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

Veterans Health Administration Performance Data for Community Living Centers

The "CLC SAIL" Value Model is a tool to summarize and compare the performance of CLCs in the VA. The model leverages much of the same data used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource to review quality measures and health inspection results.[32]

Figure 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2019. Figure 6 uses blue and green data points to indicate high performance for the Harry S. Truman Memorial Veterans' Hospital CLC (for example, in the areas of physical restraints–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), and newly received antipsychotic (antipsych) meds (SS). Metrics that need improvement are denoted in orange and red (for example, urinary tract infection (LS), catheter in bladder (LS), help with activities of daily living (ADL) (LS), and falls with major injury (LS).[33]

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

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

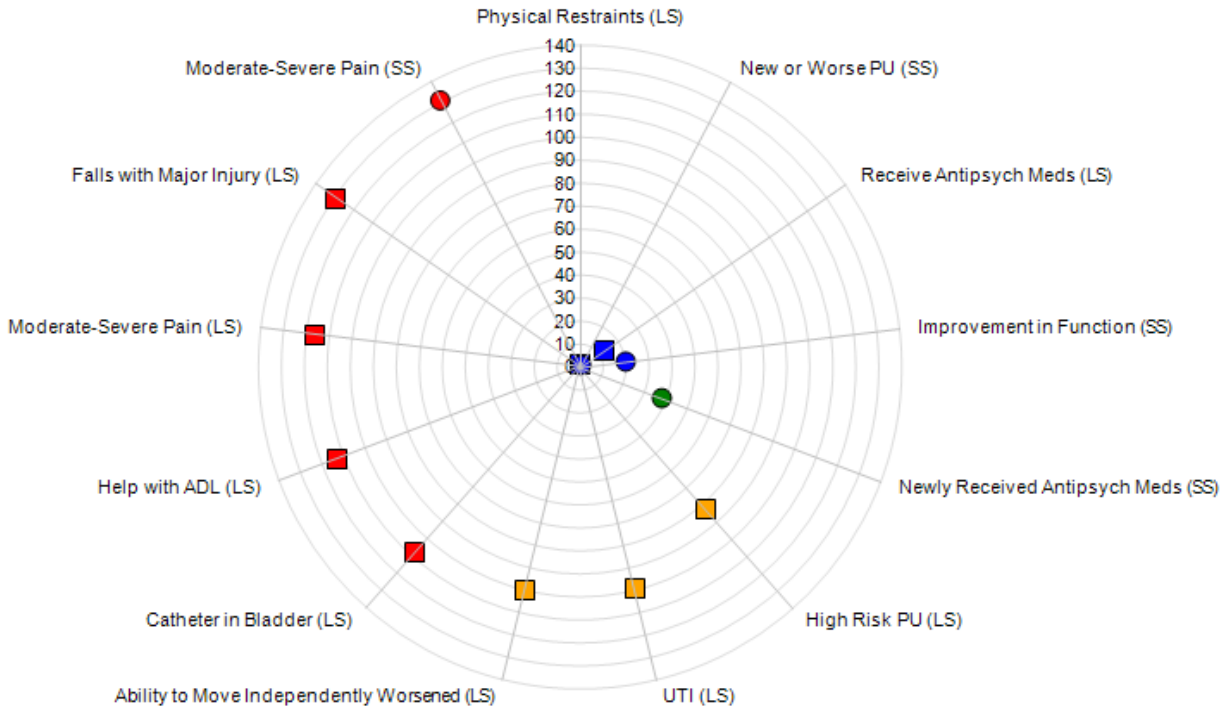

Figure 6. *Harry S. Truman Memorial Veterans' Hospital CLC Quality Measure Rankings (as of June 30, 2019)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

Leadership and Organizational Risks Conclusion

The medical center's recently established executive leadership team appeared stable, with all positions permanently filled at the time of the OIG's visit. Survey results on employee satisfaction with medical center executive leaders were generally better than VHA averages. Survey data revealed that patients' satisfaction with overall experiences was above VHA averages, and both male and female veteran satisfaction scores were generally similar to or better than VHA patients nationally. Medical center executive leaders appeared actively engaged with employees and patients and were working to sustain and further improve engagement and satisfaction. The executive leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes. The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. The executive leadership team was generally knowledgeable within their scopes of responsibility about VHA data and/or medical center-level factors contributing to specific poorly performing SAIL and CLC quality measures and should continue to take actions to sustain and improve performance.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.[34] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and to maintain Joint Commission accreditation.[35] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[36]

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

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

The OIG reviewers also assessed the medical center's processes for conducting protected peer reviews of clinical care.[37] Protected peer reviews, when conducted systematically and credibly, reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[38] The OIG team examined the completion of the following elements:

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

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

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

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

[38] VHA Directive 1190.

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[39]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee
- Quarterly review of Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Next, the inspection team assessed the medical center's utilization management (UM) program, a key component of VHA's framework for quality, safety, and value, which provides vital tools for managing the quality and the efficient use of resources.[40] It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[41] Inspectors reviewed several aspects of the UM program:

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

Finally, the OIG reviewers assessed the medical center's reports of patient safety incidents with related root cause analyses.[42] Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly

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[39] VHA Directive 1190.

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

[41] VHA Directive 1117(2).

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

communicate potential and actual causes of harm to patients throughout the medical center.[43] The medical center was assessed for its performance on several dimensions:

- Annual completion of a minimum of eight root cause analyses[44]
- Inclusion of required content in root cause analyses
- Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
- Provision of feedback about root cause analysis actions to reporting employees
- Submission of annual patient safety report to medical center leaders

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents.[45]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for establishing a committee responsible for QSV oversight functions and its review of aggregated data as well as most patient safety elements reviewed. However, the OIG identified significant weaknesses in various key QSV functions:

- Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
- Interdisciplinary review of UM data
- Inclusion of required content in root cause analyses

VHA requires that physician UM advisors document, at minimum, 75 percent of their decisions in the National UM Integration database regarding the appropriateness of patient admissions and continued stays.[46] The OIG found that physician UM advisors completed 16 percent of referred reviews from April 1, 2019, through September 30, 2019. Incomplete reviews resulted in a lack of information available at the national level and for facility-level reviews by an interdisciplinary group to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes. The Deputy Chief of Staff indicated cases were reviewed as required but

[43] VHA Handbook 1050.01.

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

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

[46] VHA Directive 1117(2).

decisions were not documented in the National UM Integration database. The Deputy Chief of Staff also stated that documenting retrospective reviews was an unnecessary administrative exercise that required unavailable staffing resources.

Recommendation 1

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

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. The Chief of Staff expanded the number of Physician Utilization Management (UM) Advisors from one to four to include two hospitalists and two surgeons. The current Physician UM Advisor conducted training for the additional physicians on December 5, 2019. All four physicians were granted access as a Physician UM Advisor in the National UM Integration database at that time and have been reviewing cases as assigned.

The Chief, Quality Management will monitor for Physician UM Advisors' compliance with documenting decisions in the National UM Integration database. Data, pulled directly from National UM Integration database, will be reported to Performance Improvement Board monthly until a target of 75 percent, or the current VHA target*, is met. Results of the monitor will be aggregated into a quarterly report and monitoring will continue until the target has been achieved for two quarters. The sample size will be 100 percent of acute admissions referred to Physician UM Advisors. The numerator will be the number of admissions reviewed by the Physician UM Advisor and the denominator will be the number of admissions referred to them.

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

VHA requires that an interdisciplinary group review UM data.[47] This group must include, but is not limited to, "representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR [chief business office revenue-utilization review]."[48] The OIG found that from December 18, 2018, through September 24, 2019, the UM Committee lacked representation from social work and mental health. As a result, the UM Committee performed

[47] VHA Directive 1117(2).

[48] VHA Directive 1117(2).

reviews and analyses without the perspectives of key colleagues. The Chief of Quality Management reported social work clinical responsibilities and a mental health vacancy as reasons for lack of representation.

Recommendation 2

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

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. Utilization Management Committee attendance by the Social Work representative was identified and addressed by the Chief, Quality Management prior to the OIG CHIP review. The Social Work representative has attended the last two quarters and will send an alternate when member is not available. A new Mental Health representative (to replace the retired member) was appointed December 17, 2019 and took part in the last two quarters meetings.

The Chief, Quality Management will review Utilization Management Committee attendance for two quarters to ensure 90 percent compliance by all required interdisciplinary representatives/alternates. The numerator will be attendance of required members at meetings and the denominator will be number of meetings. The data will be reported quarterly to the Clinical Executive Board which the Chief of Staff chairs.

To ensure credibility, VHA requires root cause analyses to include several factors, such as participation by leaders, analysis of the underlying systems to determine where redesigns might reduce risk, consideration of relevant literature, and identification of at least one root cause with a corresponding action and outcome measure.[49] Of the five individual root cause analyses reviewed, the OIG found that three did not include a consideration of relevant literature. This likely affected the evaluation of patient safety events and could have limited the reviewers' ability to identify vulnerabilities and implement process improvements to prevent future patient harm. The Patient Safety Manager reported that the requirement was met because the issues/processes under review were specific to the medical center; therefore, no additional relevant literature was needed.

[49] VHA Handbook 1050.01.

Recommendation 3

3. The Medical Center Director determines reasons for noncompliance and ensures that root cause analyses include all required review elements.

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. Root Cause Analysis Just-in-Time training was updated to include adding references to "WebSPOT" software application in the VHA Patient Safety Information System. This includes, at a minimum, entering author's last name, first initial, name of article, name of the reference, reference issue and date; relevant literature to support evidence-based action items. This was completed January 1, 2020.

The Patient Safety Manager will review "WebSPOT" documentation during first 6 months of Fiscal Year 2020 to ensure 90 percent compliance with documenting relevant literature. The numerator will be the number of root cause analysis cases with appropriate documentation and the denominator will be the overall number of root case analysis cases completed. The data will be reported quarterly to the Medical Center Joint Leadership Council which the Medical Center Director chairs.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[50]

Clinical privileges need to be specific and based on the individual practitioner's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[51]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance." The FPPE process occurs when a provider is hired at the facility and granted initial privileges and before any new clinical privileges are granted. Additionally, VA facilities must continuously monitor the performance of their providers. VHA requirements state that "the on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered."[52] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[53]
  - Clear documentation of the results and time frames
  - Evaluation by another provider with similar training and privileges
- OPPEs
  - Application of criteria specific to the service or section
  - Use of minimum criteria for selected specialty LIPs[54]
  - Evaluation by another provider with similar training and privileges

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

[51] VHA Handbook 1100.19.

[52] VHA Handbook 1100.19.

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

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

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

Further, VA must put processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former licensed practitioner's clinical practice, VA has an obligation to notify state licensing boards (SLBs) and to subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[55] Further, "VA medical facility Directors must designate an individual, and backup, to be responsible for the SLB reporting process. This individual will be the subject matter expert (SME) for the facility…and ensure oversight of the exit review process, including receipt, review, and maintenance of the Provider Exit Review Forms."[56] The OIG reviewers assessed whether the medical center's staff

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

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

- Three solo/few practitioners who underwent initial or reprivileging during the previous 12 months[57]
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs privileged within 12 months before the visit
- Twenty LIPs who left the medical center in 12 months before the visit

Medical Staff Privileging Findings and Recommendations

The medical center was compliant with many of the expected elements of performance, including FPPE and administrative processes. The inspection team identified deficiencies with the OPPE and provider exit review processes.

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

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

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

VHA requires that LIPs are evaluated on an ongoing basis by providers with similar training and privileges."[58] The OIG found one of three solo practitioner's profiles with OPPE activities lacked evidence that a provider with similar training and privileges completed the evaluations. This resulted in the LIP practicing without a thorough evaluation of the competencies, which could negatively impact quality of care and patient safety. Despite awareness of the requirement, the Chief of Staff reported that the evaluation was inadvertently overlooked.

Recommendation 4

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

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. Medical Staff Credentialing supervisor has notified all service chiefs and clinical supervisors of requirement and will review the signatures of the licensed independent practitioners on the actual review sheets to ensure it has been completed by a same specialty provider, before the Focused/Ongoing Professional Practice Evaluation gets sent to the Clinical Executive Board which is chaired by the Chief of Staff.

Medical Staff Credentialing supervisor will review all completed evaluations monthly and submit to Clinical Executive Board which the Chief of Staff chairs until 90 percent compliance is maintained for six months. The numerator will be the number of reviews completed by same specialty and the denominator will be the total number of reviews sent.

VHA requires that "Provider Exit Review forms must be completed within 7 calendar days of the departure of a licensed health care professional…" from a medical center to ensure timely reporting to the state licensing boards of practitioners who fail to meet professional practice standards for delivering patient care.[59] For the 20 providers who departed the medical center in the previous 12 months, the OIG found that 16 providers' exit forms were not completed within seven calendar days. This could have potentially resulted in delayed reporting to state licensing boards about the healthcare professionals who provided substandard care. The Chief of Quality Management indicated awareness of the seven day reporting requirement; however, the Deputy Chief of Staff stated that he was only aware of the need to complete the exit forms, not of the timing restriction.

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

[59] VHA Notice 2018-05, *Amendment to VHA Handbook 1100.18.*

Recommendation 5

5. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that service chiefs complete provider exit review forms within seven calendar days of licensed health care professionals' departure from the medical center.

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. Medical Staff Credentialing supervisor educated service chiefs regarding the requirement. The supervisor and credentialing staff will monitor Human Resources Gains & Losses (G&L) report weekly for term dates and immediately send exit review to losing service. The Exit Review form has been modified to include a footer for including the date sent from Chief of Staff office and date received from service.

Medical Staff Credentialing supervisor will review monthly and submit to Clinical Executive Board which the Chief of Staff chairs until 90 percent compliance is maintained for six months. The denominator is the number of forms sent out and the numerator is the number returned within the seven-day requirement.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct Comprehensive Environment of Care Inspection Rounds and to resolve issues in a timely manner. The goal of the Comprehensive Environment of Care Program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[60]

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

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

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

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

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

- CLC – 3rd floor
- Emergency department
- Inpatient mental health – Unit 2B
- Intensive care unit – 3rd floor
- Medical inpatient – 4th floor
- Post anesthesia care unit – 3rd floor
- Primary care clinic – White team
- Surgical inpatient – 3rd floor

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

Environment of Care Findings and Recommendations

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

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[61] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[62] Long-term opioid use is of particular concern in the veteran population where there is a high incidence of posttraumatic stress disorder, major depressive disorder, alcohol use, substance abuse, and suicide attempts.[63] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[64]

VHA requires routine assessments of pain and the completion of an opioid risk assessment before initiating patients on long-term opioid therapy and recommends against the therapy for patients with untreated substance use disorders. VHA also recommends avoiding drugs capable of inducing fatal interactions, such as opioids with benzodiazepines.[65] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[66] To achieve VHA's vision of providing patient-driven healthcare, practitioners are also required to obtain informed consent from patients and to provide education about the risks, benefits, and alternatives prior to initiating long-term opioid therapy.[67] VHA recommends evaluating patients receiving continued opioid therapy for improvement of pain and opioid-related adverse events at least every three months and more frequently as doses increase.[68]

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

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

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

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

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

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

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

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

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

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

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

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures include, but are not limited to, adherence to published clinical practice guidelines, timeliness of treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment, patient satisfaction, and quality of life.[69] The OIG examined the following indicators for program oversight and evaluation:

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

The OIG interviewed key employees and managers and reviewed relevant documents and the electronic health records of 15 selected outpatients who had newly-dispensed (no VA dispensing in previous six months) long-term opioids for pain, daily or intermittently for 90 or more calendar days through VA from July 1, 2018, through June 30, 2019. The team considered whether providers acted in accordance with guidelines for the provision of pain management and the medical center's oversight process for evaluating pain management outcomes and quality.

Medication Management Findings and Recommendations

The OIG found the medical center complied with performance indicators for assessment of pain management outcomes and quality, documentation of initial screenings for pain, and evaluation of concurrent therapy with a prescribed benzodiazepine. The medical center also utilized a multidisciplinary pain management committee to oversee and monitor required quality measures. However, the OIG found deficiencies with providers'

- Assessment of aberrant behavior risk,
- Completion of urine drug testing,
- Completion and proper documentation informed consent, and
- Follow-up with patients after therapy initiation.

VA/DoD clinical practice guidelines recommend completion of a behavior risk assessment, including history of substance abuse, psychological factors, and aberrant drug-related

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

behaviors,[70] prior to initiating opioid therapy.[71] The OIG determined that providers completed an aberrant behavior risk assessment in 87 percent of the patients at the facility, based on electronic health records reviewed.[72] This may have resulted in providers prescribing opioids for patients at high risk for misuse. The Chief of Primary Care reported that ordering providers did not consider a veteran "new" to opioid therapy if previously prescribed long-term opioid therapy at a non-VA medical center; therefore, providers did not believe assessment of aberrant behavior was necessary. However, OIG noted that when prescriptions are initiated through a non-VA medical center, it is presumed that the VA provider examines the patient and assesses the appropriateness of the opioid therapy before the prescription is reissued.

Recommendation 6

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

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

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

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

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. An updated medical record template is being completed by the Pain Pharmacist and the Chief of Primary Care that will require a "Stratification Tool for Opioid Risk Management" or "STORM " note for new starts of long-term opioids > 5 days' supply per policy/law, substance use disorder history assessment, social history documented in notes of new long-term opioid starts and aberrant behavior assessment for new long-term opioid starts.

Pain Management Committee members will complete a review of ten medical records per month until six months of 90 percent compliance with the mandated fields and report monthly to Clinical Executive Board which the Chief of Staff chairs. The numerator will be the number of records with all required documentation completed and the denominator will be number of records reviewed.

VA/DoD clinical practice guidelines recommend that providers "obtain UDT [urine drug test] prior to initiating or continuing long-term opioid therapy and periodically thereafter."[73] The OIG found that clinicians conducted initial urine drug screening in 80 percent of the patients reviewed.[74] This resulted in providers' inability to identify patients who had potentially active substance use disorders, to determine potential diversion, and to ensure patients adhered to the prescribed medication regimen. The Chief of Primary Care stated that most patients reviewed were new to receiving opioid therapy from the VA but were not new to opioid therapy; therefore, providers did not follow through with urine drug testing.

Recommendation 7

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

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

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

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. An updated clinical reminder order check was developed as part of a Health-care Failure Modes Effect Analysis (had been completed prior to OIG visit) and was implemented October 10, 2019. The Licensed Practical Nurse opioid refill note (in in the Computerized Patient Record System) was updated and it will alert the provider when a urine drug screen is needed. An updated medical record template is being completed by the Pain Pharmacist and Chief Primary Care for new long-term opioid starts and will require urine drug screen's at baseline for new long-term opioid starts and in the Emergency Department with all opioid prescriptions.

Pain Management Committee members will complete a review of ten medical records per month until six months of 90 percent compliance with the mandated fields and report monthly to Clinical Executive Board which the Chief of Staff chairs. The numerator will be the number of records with all required documentation completed and the denominator will be number of records reviewed.

VHA requires providers to obtain and document informed consent for therapeutic treatments that have a significant risk of complication or morbidity, including long-term opioid therapy, prior to initiation. VHA also recommends that the informed consent conversation cover the risks and benefits of opioid therapy, as well as alternative therapies.[75] The OIG determined that clinicians documented informed consent prior to initiating long-term opioid therapy in 80 percent of the patients at the medical center, based on electronic health records reviewed.[76] The remaining patients, therefore, may have been receiving treatment without knowledge of the risks associated with long-term opioid therapy, including opioid dependence, tolerance, addiction, and intentional or unintentional fatal overdose. The Chief of Primary Care reported that most patients reviewed were newly receiving opioid therapy from the VA but were not new to opioid therapy; therefore, providers did not follow through to complete or document informed consent.

Recommendation 8

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

[75] VHA Directive 1005(1), *Informed Consent for Long-Term Opioid Therapy for Pain*, May 6, 2014, amended November 13, 2018.

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

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. An updated medical record template is being completed by the Pain Pharmacist and Chief Primary Care that will require informed consents and risks/benefits of opioid therapy are addressed.

Pain Management Committee members will complete a review of ten medical records per month until six months of 90 percent compliance with the mandated fields and report monthly to Clinical Executive Board which the Chief of Staff chairs. The numerator will be the number of records with all required documentation completed and the denominator will be number of records reviewed.

VA/DoD clinical practice guidelines recommend providers follow up with patients within three months after initiating long-term opioid therapy.[77] The OIG found that clinicians provided patient follow-ups within three months after initiating long-term opioid therapy in 67 percent of the patients reviewed.[78] For the remaining patients, failure to conduct follow-ups can result in missed opportunities to assess those patients' adherence to the therapy plan, effectiveness of treatment, and risks of continued opioid therapy.[79] The Chief of Primary Care stated, that patients on chronic opioid therapy receive six month follow-up visits; however, because of the timeframe reviewed some visits may not have occurred yet.

Recommendation 9

9. The Chief of Staff determines reasons for noncompliance and ensures healthcare providers follow up with patients within the required timeframe after initiating long-term opioid therapy.

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

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

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

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. An updated medical record template is being completed by the Pain Pharmacist and Chief Primary Care that will require 1-month follow-up with provider upon new opioid starts even if the patient is on an opioid through community provider and will continue required six-month follow-up for all patients on chronic opioids.

Pain Management Committee members will complete a review of ten medical records per month until six months of 90 percent compliance with the mandated fields and report monthly to Clinical Executive Board which the Chief of Staff chairs. The numerator will be the number of records with all required documentation completed and the denominator will be number of records reviewed.

Mental Health: Suicide Prevention Program

In 2017, suicide was the 10th leading cause of death, with approximately 47,000 lives lost across the United States.[80] The suicide rate was 1.5 times greater for veterans than for non-veteran adults and estimated to represent approximately 22 percent of all suicide deaths in the United States.[81] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[82]

VHA has identified suicide prevention as a top priority and implemented various evidence-based approaches to reduce the veteran suicide rate. In addition to expanded mental health services and community outreach, VHA has developed comprehensive screening and assessment processes to identify at-risk patients.[83]

VHA requires that each medical center and very large CBOC have a full-time suicide prevention coordinator (SPC) to track and follow up with high-risk veterans, develop a process for responding to referrals from hotlines such as the Veteran Crisis Line, and conduct community outreach activities.[84] The OIG examined various requirements related to SPCs:

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

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

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

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

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

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

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

in his or her electronic health record "as soon as possible but no later than 1 business day after such determination by the SPC."[85] According to VHA, "Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death…The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions."[86] The HRS PRF is reviewed at least every 90 days and depending on changes to the suicide risk status, will remain active or be removed.[87] Additionally, VHA requires designated high-risk patients to have a completed suicide safety plan and four face-to-face visits with an acceptable provider within the first 30 days of designation.[88]

The OIG noted that from July 1, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA required that "Any patient determined to be High Risk for Suicide [by the licensed independent provider] must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination."[89] However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management changed the requirement for the HRS PRF placement to be "as soon as possible but no later than 1 business day after determination by the SPC."[90] VHA further provided additional clarifying information:

- The "SPC exclusively controls the HRS-PRF and must limit their use to patients who meet the criteria of being placed on the facility high-risk suicide list."
- "The time frame of placing the flag begins once the SPC makes the determination that an HRS-PRF is warranted."
- The SPC's determination process "may be beyond 24 hours after a referral, due to case consultation and review."[91]

The OIG is concerned that the updated requirement may result in delayed placement of HRS PRFs for at-risk patients. Without defined time frames for SPC determination that the HRS PRF is warranted, patients identified as at-risk for suicide could have PRFs placed in his or her chart

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

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

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

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

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

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

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

several days after referral. For example, the current requirement would allow for a patient to be identified as high risk for suicide and referred to the SPC on Monday, the SPC to assess the patient for risk and determine the need for an HRS PRF on the following Friday, and the SPC to place an HRS PRF on the subsequent Monday (a week after referral).

On March 27, 2020, VHA also updated existing policy requirements to allow the review of HRS PRFs to "occur no earlier than 10 days before and no later than 10 days after the 90-day due date."[92]

Inspectors examined the completion of several requirements:

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

All VHA employees must complete suicide risk and intervention training within 90 days of entering their position. Clinical staff (including physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and Vet Center counselors) must complete Suicide Risk Management Training for Clinicians, and nonclinical staff must complete Operation S.A.V.E. training.[93] VHA also requires that all staff receive annual refresher training.[94] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[95]

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

- Relevant documents;

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

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

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

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

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

Mental Health Findings and Recommendations

The OIG found the medical center complied with requirements related to SPCs, completion of four mental health appointments within the required time frame, follow-up for no-show high-risk appointments, and completion of safety plans.

However, the OIG noted concerns with reviewing HRS PRFs within the required time frame. VHA required that all patients with an HRS PRF be reevaluated at least every 90 days, and there is documented justification for continuing or discontinuing the flag.[96] The OIG estimated that 43 percent of patients with an HRS PRF were reevaluated at least every 90 days.[97] However, based upon the updated requirement that HRS PRFs be reviewed up to 10 days prior to or after the due date for reevaluation, the OIG found that 46 of 47 patients were reviewed within required time frames (observed range was 0–99 days).[98]

Additionally, the OIG noted concerns with completion of suicide prevention training. VHA requires that all employees complete suicide risk and intervention training within 90 days of entering their respective positions. Clinical staff must complete the Suicide Risk Management Training for Clinicians, and nonclinical staff are required to complete Operation S.A.V.E. training. VHA also mandates that all staff, clinical and nonclinical, receive annual refresher training thereafter.[99] The OIG found that 5 of 20 staff (two clinical and three nonclinical) did not complete annual refresher training as required. Lack of training could prevent clinicians from providing optimal treatment to veterans who are at risk for suicide. The Chief of Behavior Health stated that it is each service chiefs' responsibility to monitor and ensure employee compliance with annual training requirements and that service chiefs receive alerts for staff that are not compliant. However, alerts were not monitored.

Recommendation 10

10. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that staff receive annual suicide prevention refresher training.

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

[97] The OIG estimated that 95 percent of the time, the true compliance rate is between 28.6 and 56.5 percent, which is statistically significantly below the 90 percent benchmark.

[98] VHA Notice 2020-13.

[99] VHA Directive 1071.

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. Initial training is given to new employees during new employee orientation. On-going training will be ensured through the service line Talent Management System (TMS) administrator(s) generating monthly compliance reports. These will be sent to Service Chiefs to monitor and address deficiencies. The Learning Organization TMS Domain Manager will generate quarterly reports for the Executive Leadership Team to review and act on.

Learning Organization TMS domain manager will generate and submit quarterly reports to Medical Center Joint Leadership Council which the Medical Center Director chairs until 90 percent compliance is maintained for two quarters. The numerator will be the number of trainings completed and the denominator will be the total number that should have been completed.

Care Coordination: Life-Sustaining Treatment Decisions

Life-sustaining treatments (LSTs) are intended to extend the life of a patient expected to die soon without medical intervention. Life-sustaining treatments may include artificial nutrition, hydration, and mechanical ventilation. VHA issued the Life-Sustaining Treatment Decisions (LSTD) handbook to standardize practices related to discussing and documenting goals of care and LSTD. Per VHA, the goal is to encourage personalized, proactive, patient-driven treatment plans for veterans with serious illness by "…eliciting, documenting, and honoring patients' values, goals, and preferences."[100]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.[101] Implementation requirements included initiating conversations about the goals of care. A goals of care conversation is a discussion between a healthcare provider and a patient or surrogate to help define the patient's values, goals, and preferences for care and, based on the discussion, make choices about starting, limiting, or ceasing LSTs.[102] VHA requires practitioners to initiate goals of care conversations with high-risk patients—including hospice patients or their surrogates—within a time frame that meets the medical needs of the patient or at the time of a triggering event.[103]

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

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

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

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

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

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

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

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

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

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

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

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[104] Inspectors examined if the medical center established an LSTD committee that was comprised of a multidisciplinary membership, which included representation from Ethics Consultation Service, and reviewed proposed LST plans.

To determine whether the medical center complied with the OIG-selected requirements related to LSTD for hospice patients, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 45 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.[1]

Care Coordination Findings and Recommendations

The OIG found the medical center had generally complied with requirements for the care coordination elements reviewed. However, the OIG identified noncompliance with completion of

[104] VHA Handbook 1004.03(1).

LSTD progress notes and establishment of a multidisciplinary committee to review proposed LST plans when necessary, warranting OIG recommendations for corrective action.

VHA mandates that practitioners document goals of care and the resulting plans using a standardized progress note template.[105] The OIG estimated that practitioners entered life-sustaining treatment plan progress notes in 73 percent of the electronic health records reviewed.[106] Poor documentation regarding life-sustaining treatment preferences can cause "confusion among staff, miscommunication with families," and mistakes during medical emergencies.[107] The Deputy Chief of Staff and Chief of Primary Care both stated their awareness of the template and admitted a lack of provider education.

Recommendation 11

11. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that practitioners complete and document all required elements of life-sustaining treatment plan progress notes.

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. The Primary Care Service Chief targeted high volume provider trainings to disseminate information regarding Life Sustaining Treatment Decision progress notes: Safety Forum on January 16, 2020, All Team Primary Care meeting February 14, 2020, and February Resident's meeting February 4, 2020. The Primary Care Service Chief will follow-up with one-to-one education as needed based on reviews.

Life Sustaining Treatment Decision Committee will conduct reviews of ten hospice patients per month (or 100 percent if less than ten) and report quarterly to the Clinical Executive Board which the Chief of Staff chairs until 90 percent compliance is maintained for two quarters. The numerator will be the number of completed notes and the denominator will be the total number of notes that should have been completed.

Additionally, VHA requires that the LSTD multidisciplinary committee has "three or more different disciplines" and "include at least one member of the facility's Ethics Consultation Service."[108] The OIG found that the medical center did not have a multidisciplinary committee to review proposed life sustaining treatment plans. Absence of a multidisciplinary committee to

[105] VHA Handbook 1004.03(1).

[106] The OIG estimated that 95 percent of the time, the true compliance rate is between 60.0 and 86.1 percent, which is statistically significantly below the 90 percent benchmark.

[107] VHA Handbook 1004.03(1).

[108] VHA Handbook 1004.03(1).

review life sustaining treatment plans for patients who do not have decision-making capacity or a surrogate does not allow for an ethical or objective review of proposed life sustaining treatment plans. The Chief of Primary Care and the Compliance and Business Integrity Officer stated that the previous committee coordinator did not fulfill the responsibility of bringing together representatives from multiple disciplines and believed the responsibilities were too much for one person.

Recommendation 12

12. The Medical Center Director evaluates and determines any additional reasons for noncompliance and certifies that a multidisciplinary committee is established to review proposed life-sustaining treatment plans.

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. A multidisciplinary committee for review of life sustaining treatment decisions/plans will be created.

Meetings of this committee will be monitored and reported quarterly to Medical Center Joint Leadership Council which the Medical Center Director chairs until 90 percent compliance is sustained for two quarters. The numerator is the number of meetings completed and the denominator will be the number of meetings that should have occurred.

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[109] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans are anticipated to increase.[110] To help the VA better understand the needs of the growing women's veteran population, efforts have been made by VHA to identify and address the urgent needs "by examining health care use, preferences, and the barriers Women Veterans face in access to VA care."[111] Additionally, a VA report in 2016 on suicide among veterans pointed out concerning trends in suicide among women veterans and discussed "the importance of understanding suicide risk among women veterans and developing gender-tailored suicide prevention strategies."[112]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment. Facilities must, therefore, ensure availability of appropriate resources, services, and staffing ratios.[113] VHA also requires delivery of quality care to all women veterans accessing VA emergency services. In addition, VHA requires facilities to establish a multidisciplinary women veteran health committee "that develops and implements a Women's Health Program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans."[114]

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

- Provision of care requirements

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

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

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

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

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

[114] VHA Directive 1330.01(2).

  - Designated Women's Health Patient Aligned Care Team established
  - Primary Care Mental Health Integration services available
  - Gynecologic care coverage available 24/7
  - Gynecology care accessible
  - Facility women health primary care providers designated
  - CBOC women's health primary care providers designated
  - Emergency contraception accessible
- Oversight of program and monitoring of performance improvement data
  - Women Veterans Health Committee established
    - Quarterly meetings held
    - Core members attend
    - Quality assurance data collected and tracked
    - Reports made to clinical executive leaders
- Assignment of required staff
  - Women Veterans Program Manager position filled
  - Women's Health Medical Director or clinical champion on staff
  - Maternity Care Coordinator position filled
  - Women's health clinical liaison is assigned at each CBOC

Women's Health Findings and Recommendations

The medical center complied with requirements for most of the provision of care indicators and each of the selected staffing elements reviewed. However, the OIG identified weaknesses with the Designated Women Veterans Program Manager and Women Veterans Health Committee.

VHA policy states, "the WVPM [Women Veterans Program Manager] must be a health care professional such as a registered nurse (RN); social worker or psychologist; doctor of medicine (MD/DO); nurse practitioner (NP); physician assistant (PA); pharmacist; or other allied health care professional."[115] The OIG found the appointed full-time Women Veterans Program Manager was not a clinical health care professional. Failure to appoint a clinical health care professional could impact assessment of needs and implementation of services for eligible women. The Chief of Quality Management indicated that the Women Veterans Program Manager was appointed prior to the directive requirement change. The OIG noted that the

[115] VHA Directive 1330.01(2).

Women Veterans Program Manager's health care management experience and service in the capacity for nine years; therefore, the OIG made no recommendation.

VHA requires that the Women Veterans Health Committee meets quarterly, reports to executive leadership, and has a core membership. That membership includes a Women Veterans Program Manager; a Women's Health Medical Director; "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care; and a member from executive leadership."[116]

The OIG found that the Advisory Committee For Women Veterans Charter did not designate primary care, nursing, radiology, laboratory, emergency department, or executive leadership representation. Also, the OIG reviewed committee attendance from October 2018, through September 2019, and noted inconsistent representation by a quality management representative. This resulted in a lack of expert oversight of data review and analysis as the committee planned and carried out improvements to women veterans' care. The Women Veterans Program Manager attributed noncompliance to scheduling conflicts and the organization's failure to appoint a new representative after the prior representative retired.

Recommendation 13

13. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that the Advisory Committee For Women Veterans includes required core members.

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. The committee charter, Advisory Committee for Women Veterans, was revised to reflect the required membership. A representative for Quality Management was appointed November 12, 2019. The Women Veterans Program Manager will e-mail all members along with the supervisors to ensure continued membership and attendance support by the supervisor. Going forward, attendance will be reviewed annually.

Women Veterans Program Manager will monitor attendance by all required members/alternates for 90 percent compliance until sustained for two quarters. Attendance data will be reported quarterly to the Medical Center Joint Leadership Council which the Medical Center Director chairs. The numerator will be the actual attendance of required core members and the denominator will be the number of meetings held.

[116] VHA Directive 1330.01(2).

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have a Sterile Processing Services (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment…"[117] The goal of SPS is to "...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[118] To ensure this, VHA requires facilities to conduct the following activities:

- Maintain a current inventory list of all RME
- Have standard operating procedures (SOPs) that are based on current manufacturer's guidelines and reviewed at least triennially
- Use CensiTrac® Instrument Tracking System for tracking reprocessed instruments[119]
- Perform annual risk analysis and report results to the VISN SPS Management Board
- Monitor data for reprocessing and storing RME
- Conduct annual airflow/ventilation system inspections[120]

VHA requires strict controls that closely monitor climate, storage, and sterilization parameters and additionally requires that quality assurance documentation of this monitoring be maintained for a minimum of three years.[121] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[122]

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

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

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

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

[120] VHA Directive 1116(2).

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

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

personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[123]

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued annual and essential staff competency assessments, and monthly continuing education. This ensures that staff have sufficient aptitude, knowledge, and skills to effectively and safely reprocess and sterilize RME.[124]

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

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

[123] VHA Directive 1116(2).
[124] VHA Directive 1116(2).

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

High-Risk Processes Findings and Recommendations

The medical center met many of the requirements for the proper operations. However, OIG inspectors identified deficiencies with competency assessments.

VHA requires documented competency assessments for employees who reprocess critical and semi-critical reusable medical equipment. The competency assessment must be documented with all critical action steps, two validation methods, and evaluation of proficiency. Although the medical center staff completed the required competency assessments, the OIG found that competency assessments for 10 SPS employees who reprocessed endoscopes and bronchoscopes did not include all critical action steps nor was a two-validation method used. Failure to properly assess staff competency could compromise patient safety and care. The Chief of SPS reported that competency assessments were completed and acknowledged that the competency assessment tool did not reflect all critical steps identified in the SOP, thereby rendering the competencies invalid. The Chief of SPS also reported being unaware of the correct procedure for documenting a two-verification method.

Recommendation 14

14. The Associate Director for Patient Service evaluates and determines any additional reasons for noncompliance and makes certain that Chief of Sterile Processing Services completes valid competency assessments for staff reprocessing reusable medical equipment.

Medical center concurred.

Target date for completion: December 1, 2020

Medical center response: Health Care System acknowledges non-compliance with the above recommendation. Sterile Processing Supervisors will correct all endoscope competencies to mirror the Instructions for Use and Standard Operating Procedures. All competencies will reflect the two-step verification method. A notification of change document was added to each competency folder to reflect the change thus forward. On November 22, 2019, an in-service was provided to all staff of the change in process of the two-step verification method.

Sterile Processing Service Assistant Chief will do weekly administrative reviews of all competencies to ensure the validation method is being followed prior to recording in master spreadsheet. This will be reported monthly to Nurse Executive Board which the Associate Director of Patient Services chairs until 90 percent compliance is sustained for six months. The numerator is the number of correct competencies completed and the denominator is all competencies due.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• None	• Physician UM advisors consistently document their decisions in the National Utilization Management Integration database. • All required representatives consistently participate in interdisciplinary reviews of UM data. • Root cause analyses include all required review elements.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• Providers with similar training and privileges complete OPPEs of licensed independent practitioners.	• Service chiefs complete provider exit review forms within seven calendar days of licensed health care professionals' departure from the medical center.

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• Providers complete a behavior risk assessment on all patients prior to initiating long-term opioid therapy. • Healthcare providers consistently conduct urine drug testing as required for patients on long-term opioid therapy. • Healthcare providers consistently obtain and document informed consent for patients when initiating long-term opioid therapy. • Providers follow up with patients within the required timeframe after initiating long-term opioid therapy.	• None
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements	• None	• Staff receive annual suicide prevention refresher training.
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• Practitioners complete and document all required elements of life-sustaining treatment plan progress notes.	• A multidisciplinary committee is established to review proposed life-sustaining treatment plans.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• None	• The Advisory Committee For Women Veterans includes required core members.
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Data monitoring • Physical inspection • Staff training	• The Chief of Sterile Processing Services completes valid competency assessments for staff reprocessing reusable medical equipment.	• None

Appendix B: Medical Center Profile

The table below provides general background information for this mid-high complexity (1c) affiliated[1] medical center reporting to VISN 15.[2]

Table B.1. Profile for Harry S. Truman Memorial Veterans' Hospital (589A4) (October 1, 2016, through September 30, 2019)

Profile Element	Facility Data FY 2017[3]	Facility Data FY 2018[4]	Facility Data FY 2019[5]
Total medical care budget in dollars	$306,952,270	$351,742,477	$348,987,898
Number of:			
• Unique patients	38,999	38,673	38,818
• Outpatient visits	418,994	446,241	449,017
• Unique employees[6]	1,026	1,202	1,414
Type and number of operating beds:			
• Community living center	41	41	41
• Domiciliary	14	14	14
• Medicine	34	34	34
• Mental Health	11	11	11
• Residential rehabilitation	8	8	8
• Surgery	16	18	26
Average daily census:			
• Community living center	31	32	31
• Domiciliary	10	13	14
• Medicine	34	35	39
• Mental health	6	8	6
• Neurology	1	1	1
• Residential rehabilitation	7	7	6

[1] Associated with a medical residency program.

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

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

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

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

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

Profile Element	Facility Data FY 2017[3]	Facility Data FY 2018[4]	Facility Data FY 2019[5]
• Surgery	11	11	12

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

Appendix C: VA Outpatient Clinic Profiles[1]

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Jefferson City, MO	589G8	8,009	1,770	Anesthesia Dermatology Eye Orthopedics Podiatry	n/a	Weight management
Kirksville, MO	589GE	4,806	601	Dermatology Orthopedics	n/a	Weight management
Waynesville, MO	589GF	8,064	3,034	Anesthesia Dermatology Orthopedics	n/a	Weight management

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

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

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

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

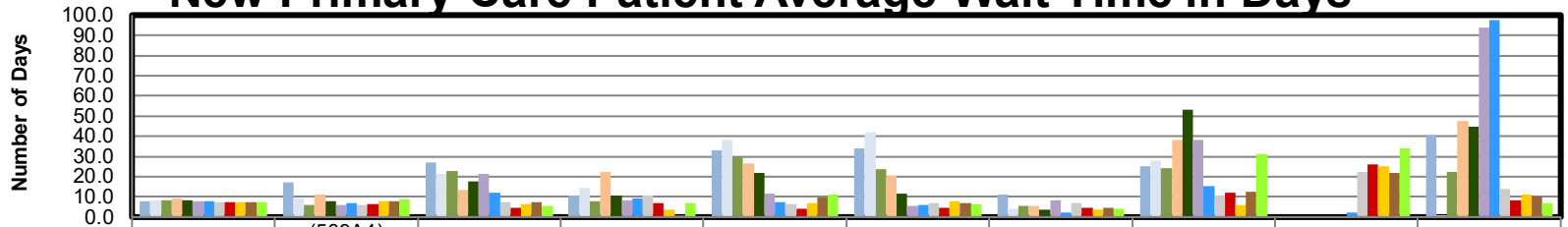
[5] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Osage Beach, MO	589GH	6,574	2,590	Dermatology Orthopedics Urology	n/a	Weight management
Mexico, MO	589GX	4,835	880	Dermatology Orthopedics	n/a	Weight management
St. James, MO	589GY	4,968	2,137	Dermatology Orthopedics	n/a	Weight management Nutrition
Sedalia, MO	589JA	5,312	1,435	Dermatology Orthopedics	n/a	Weight management
Marshfield, MO	589JD	4,590	1,827	Dermatology Eye Orthopedics	n/a	Weight management

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

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

New Primary Care Patient Average Wait Time in Days



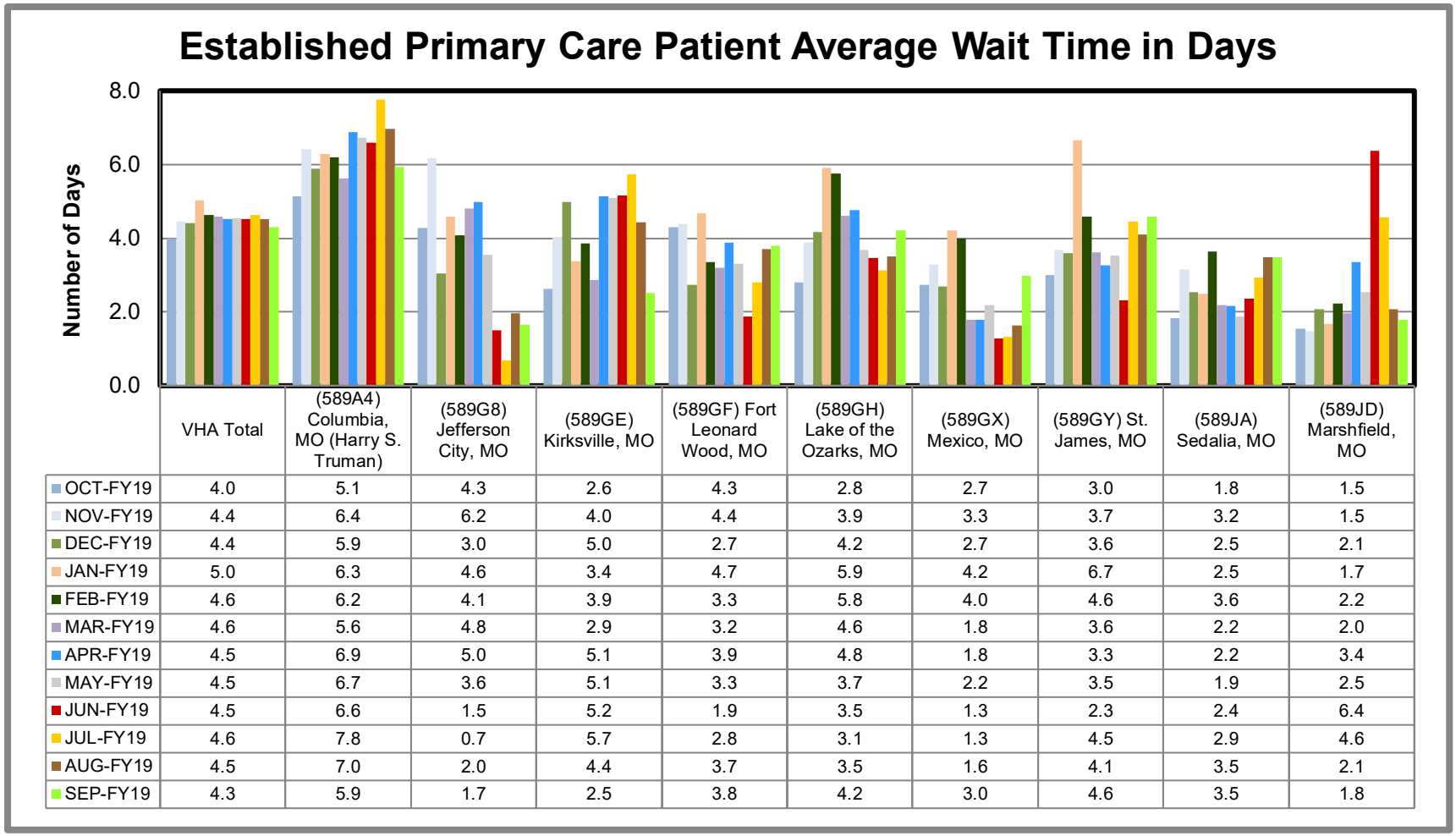
	VHA Total	(589A4) Columbia, MO (Harry S. Truman)	(589G8) Jefferson City, MO	(589GE) Kirksville, MO	(589GF) Fort Leonard Wood, MO	(589GH) Lake of the Ozarks, MO	(589GX) Mexico, MO	(589GY) St. James, MO	(589JA) Sedalia, MO	(589JD) Marshfield, MO
OCT-FY19	8.0	17.2	26.8	10.7	33.2	34.0	11.2	25.0	0.0	40.5
NOV-FY19	8.5	9.3	21.3	14.5	38.4	42.1	4.2	28.0	0.0	1.0
DEC-FY19	8.6	6.0	22.7	7.9	29.6	23.8	5.5	24.3	0.0	22.3
JAN-FY19	9.0	11.0	13.4	22.6	26.4	20.4	5.4	38.2	0.0	47.5
FEB-FY19	8.5	7.8	17.8	10.5	22.0	11.6	3.9	53.2	0.0	44.7
MAR-FY19	8.1	5.9	21.4	8.5	11.8	5.3	8.1	38.0	0.0	94.0
APR-FY19	7.8	6.8	12.0	9.2	7.2	6.2	2.1	15.3	2.4	97.8
MAY-FY19	7.6	6.0	7.2	10.4	6.4	6.7	7.0	10.8	22.3	14.0
JUN-FY19	7.6	6.5	4.7	6.8	4.0	4.6	4.5	12.2	26.2	8.2
JUL-FY19	7.3	7.7	6.4	3.6	6.9	7.9	3.5	6.2	25.2	11.2
AUG-FY19	7.4	7.9	7.2	0.9	9.5	6.8	4.5	12.7	21.9	10.0
SEP-FY19	7.3	8.8	5.5	6.9	11.2	6.6	4.2	31.3	33.8	7.1

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the medical center's explanation for the increased wait times for the CBOC name.

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

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



	VHA Total	(589A4) Columbia, MO (Harry S. Truman)	(589G8) Jefferson City, MO	(589GE) Kirksville, MO	(589GF) Fort Leonard Wood, MO	(589GH) Lake of the Ozarks, MO	(589GX) Mexico, MO	(589GY) St. James, MO	(589JA) Sedalia, MO	(589JD) Marshfield, MO
OCT-FY19	4.0	5.1	4.3	2.6	4.3	2.8	2.7	3.0	1.8	1.5
NOV-FY19	4.4	6.4	6.2	4.0	4.4	3.9	3.3	3.7	3.2	1.5
DEC-FY19	4.4	5.9	3.0	5.0	2.7	4.2	2.7	3.6	2.5	2.1
JAN-FY19	5.0	6.3	4.6	3.4	4.7	5.9	4.2	6.7	2.5	1.7
FEB-FY19	4.6	6.2	4.1	3.9	3.3	5.8	4.0	4.6	3.6	2.2
MAR-FY19	4.6	5.6	4.8	2.9	3.2	4.6	1.8	3.6	2.2	2.0
APR-FY19	4.5	6.9	5.0	5.1	3.9	4.8	1.8	3.3	2.2	3.4
MAY-FY19	4.5	6.7	3.6	5.1	3.3	3.7	2.2	3.5	1.9	2.5
JUN-FY19	4.5	6.6	1.5	5.2	1.9	3.5	1.3	2.3	2.4	6.4
JUL-FY19	4.6	7.8	0.7	5.7	2.8	3.1	1.3	4.5	2.9	4.6
AUG-FY19	4.5	7.0	2.0	4.4	3.7	3.5	1.6	4.1	3.5	2.1
SEP-FY19	4.3	5.9	1.7	2.5	3.8	4.2	3.0	4.6	3.5	1.8

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness
Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL)), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

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

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

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

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

Source: VHA Support Service Center

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

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

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

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 9, 2020

From: Director, VA Heartland Network (10N15)

Subj: Comprehensive Healthcare Inspection of the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri

To: Director, Office of Healthcare Inspections (54CH03)

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

Attached is the facilities response to the Comprehensive Healthcare Inspection of the Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri draft report.

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

(Original signed by:)

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

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: June 4, 2020

From: Director, Harry S. Truman Memorial Veterans' Hospital (589/A4)

Subj: Comprehensive Healthcare Inspection of the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri

To: Director, VA Heartland Network (10N15)

1. Thank you for the opportunity to review and respond to the Comprehensive Healthcare Inspection of the Harry S Truman Memorial Veterans' Hospital.
2. I have reviewed and concur with the recommendations in the draft report. Corrective action plans have been developed and implemented and are outlined in the attached report.

(Original signed by:)

Patricia L. Hall, FACHE

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