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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center in Alabama

CHIP REPORT | REPORT #20-00130-194 | SEPTEMBER 2, 2020

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Figure 1. *Tuscaloosa VA Medical Center in Alabama (Source: https://vaww.va.gov/directory/guide/, accessed on February 18, 2020)*

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Tuscaloosa VA Medical Center and one outpatient clinic in Alabama. 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 February 24, 2020, at the Tuscaloosa VA Medical Center and Selma Outpatient 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 Nursing and Patient Care Services (ADNPCS) and acting Associate Director. Organizational communications and accountability were managed through a committee reporting structure with the Executive Leadership Council having oversight for several working groups. The Director and the Associate Director were co-chairs of the Executive Leadership Council which was responsible for tracking and trending quality of care and patient outcomes.

When the OIG team conducted this inspection, the executive leaders had worked together as a group for four months. The Chief of Quality had served as the acting Associate Director since October 2019 while the permanently assigned Associate Director served as the acting Medical Center Director at another VHA facility. The Director and the ADNPCS had worked together since 2015. The Chief of Staff joined the team in August 2018 in an acting capacity prior to permanent assignment in September 2019.

The OIG reviewed employee satisfaction survey and concluded that the ADNPCS appeared to have opportunities to improve employee satisfaction. The OIG team noted that scores related to obtaining routine appointments were better than VHA averages for male and female respondents, while those related to obtaining appointments needed right away were lower than national VHA averages for female respondents. Overall, patients appeared generally satisfied with the care provided.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[1] However, the OIG identified concerns with the peer review and patient safety programs that could hinder leaders' ability to understand risk within the organization and potential for patient harm.

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk.

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

The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[2]

The executive leaders were extremely knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to specific poorly performing SAIL and Community Living Center measures.[3] In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and patient experiences.

The OIG noted opportunities for improvement in five clinical areas reviewed and issued 14 recommendations that are directed to the Director, Chief of Staff, ADNPCS, and Associate Director. These are briefly described below.

Environment of Care

The inspection team observed general compliance with requirements for the CLC, outpatient clinics, and the Selma VA Clinic. The OIG did not note any issues with the availability of medical equipment and supplies. The OIG identified vulnerabilities with the medical center's general environmental safety, cleanliness, and infection prevention efforts.

Mental Health

The medical center generally complied with requirements for assignment of a full-time suicide prevention coordinator, tracking high-risk veterans, and suicide prevention training. The OIG had concerns with completion of monthly community outreach activities and patient appointments within the required time frame.

Care Coordination

The medical center had generally complied with requirements for supervision of designees. The OIG found deficiencies with multidisciplinary committee membership and review of proposed life-sustaining treatment plans. In addition, goals of care conversations sometimes lacked documentation of required elements, warranting OIG recommendations for corrective action.

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

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

Women's Health

The medical center complied with requirements for the provision of care and performance improvement data monitoring. The OIG reviewed staffing requirements and noted that the Women Veterans Program Manager also functioned as the Maternity Care Coordinator.

High-Risk Processes

The medical center met many of the requirements for the proper operations and management of reprocessing reusable medical equipment (RME). However, the OIG identified deficiencies with the administrative processes related to maintenance of a current RME inventory file, instrument tracking, annual risk analysis report to the Veterans Integrated Service Network, cleaning schedules and temperature and humidity of reprocessing areas, and employee competency assessments.

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 Director, Chief of Staff, ADNPCS, and Associate Director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this medical center. The intent is for medical center's 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 interim Veterans Integrated Service Network Director and Medical Center Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 66–67, 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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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 Tuscaloosa VA Medical Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so that informed decisions can be made to improve care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[4] Investments in a culture of safety and continuous quality improvement, in concert with robust leadership and communication, significantly contribute to positive patient outcomes.[5] 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)[6]

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[4] 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.)

[5] 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.

[6] 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.

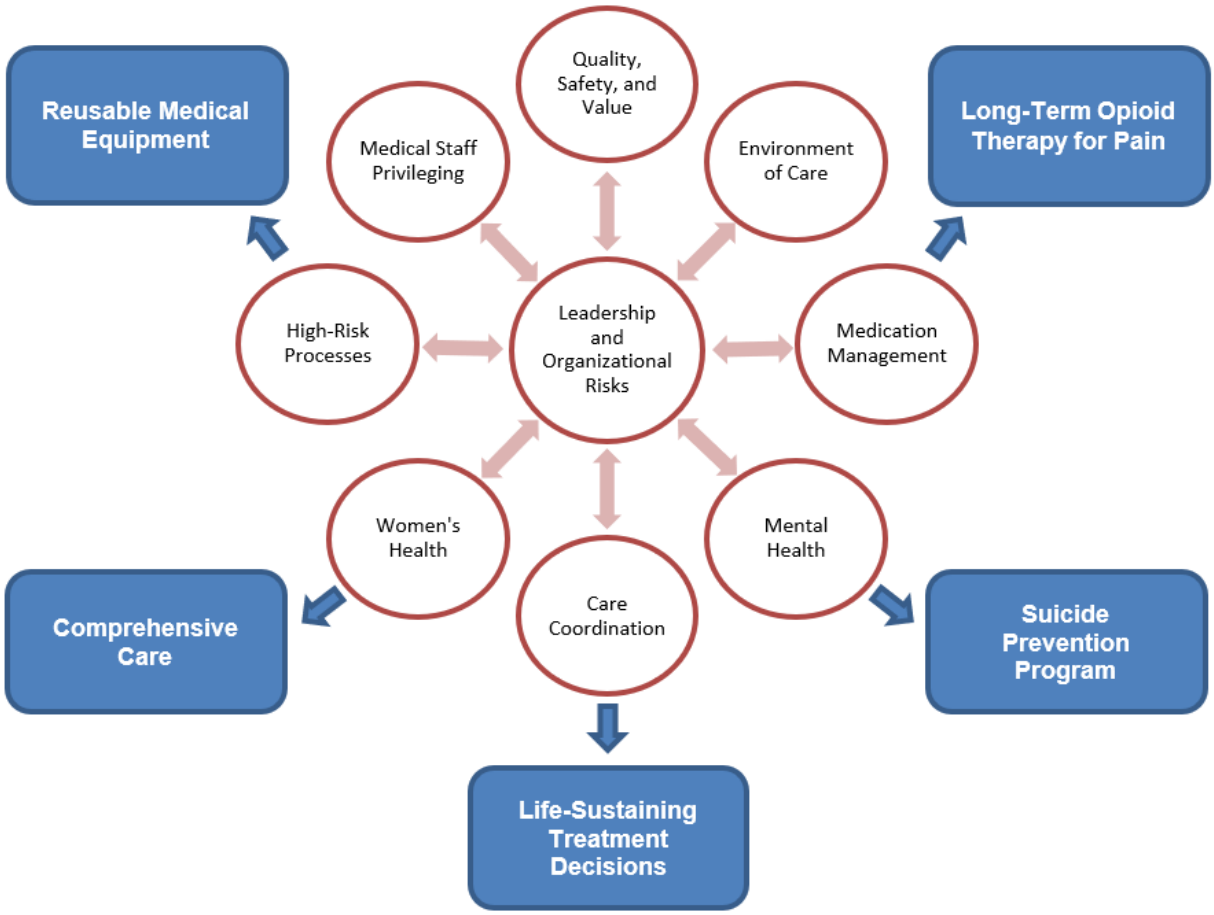

Figure 2. *Fiscal Year (FY) 2020 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

Methodology

The Tuscaloosa VA Medical Center has one outpatient clinic in Alabama. 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.[7]

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

- Acute inpatient psychiatric unit
- Community living center (CLC)[8]
- Outpatient clinics
- Sterile processing services areas

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

The inspection examined operations from April 27, 2019, through February 27, 2020, the last day of the unannounced multiday site visit.[9] While on site, the OIG referred concerns beyond the scope of the CHIP inspection to the OIG's hotline management team for further review.

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

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

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

[8] 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.

[9] The range represents the time period from the prior CHIP inspection to the completion of the unannounced, multiday CHIP site visit in February 2020.

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 healthcare system. Leadership and organizational risks can impact the healthcare system's ability to provide care in the clinical focus areas.[10] 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 Director, Chief of Staff, Associate Director for Nursing and Patient Care Services (ADNPCS), and acting Associate Director. It is important to note that at the time of OIG's inspection, the permanent Associate Director, who was assigned to the position in July 2017, was the acting Medical Center Director at another VHA facility. The Chief of Quality Management had served as the acting Associate Director since October 13, 2019. The Chief of Staff and ADNPCS oversee patient care which requires managing service directors and chiefs of programs and practices.

[10] 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.)

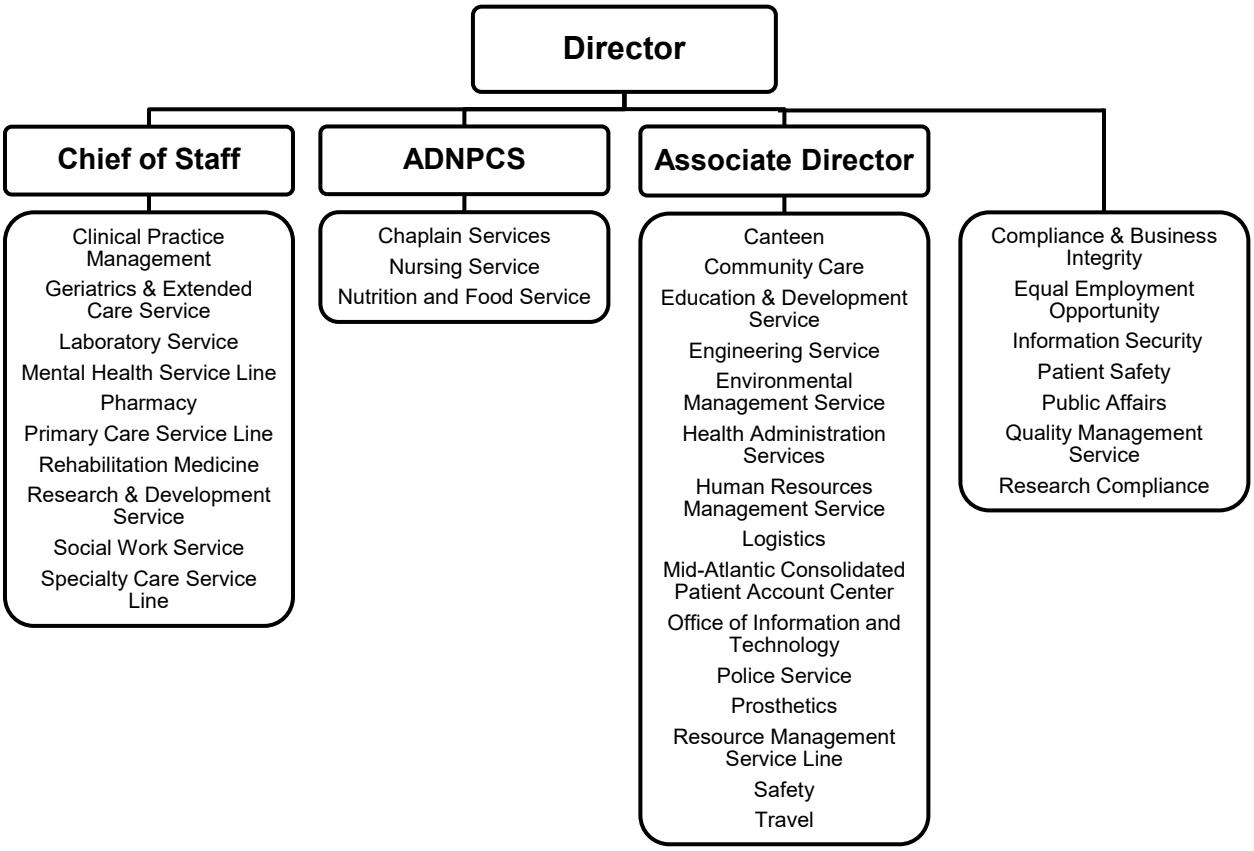

Figure 3. *Medical Center Organizational Chart*
Source: Tuscaloosa VA Medical Center (received February 24, 2020)

At the time of the OIG site visit, the executive team had been working together as a group for four months. The Director and ADNPCS had worked together since 2015 (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	September 20, 2015
Chief of Staff	August 20, 2018 (acting) September 15, 2019 (permanent)
Associate Director for Nursing and Patient Care Services	November 17, 2013
Acting Associate Director	October 13, 2019 (acting)
Associate Director	July 9, 2017 (permanent)

Source: Tuscaloosa VAMC Chief Human Resources Management Service (received February 27, 2020)

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

The executive leaders appeared to be extremely knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures and Community Living Center (CLC) SAIL measures. In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

These leaders are also engaged in monitoring patient safety and care through the Executive Leadership Council, which is chaired by the Director and co-chaired by the Associate Director. The Executive Leadership Council is responsible for tracking and trending quality of care and patient outcomes. In doing this, the Council also establishes policy, maintains quality care standards, and performs organizational management and strategic planning and oversees various working groups such as the Clinical Executive, Finance and Business, Environment of Care, and Strategic Planning Boards. See Figure 4.

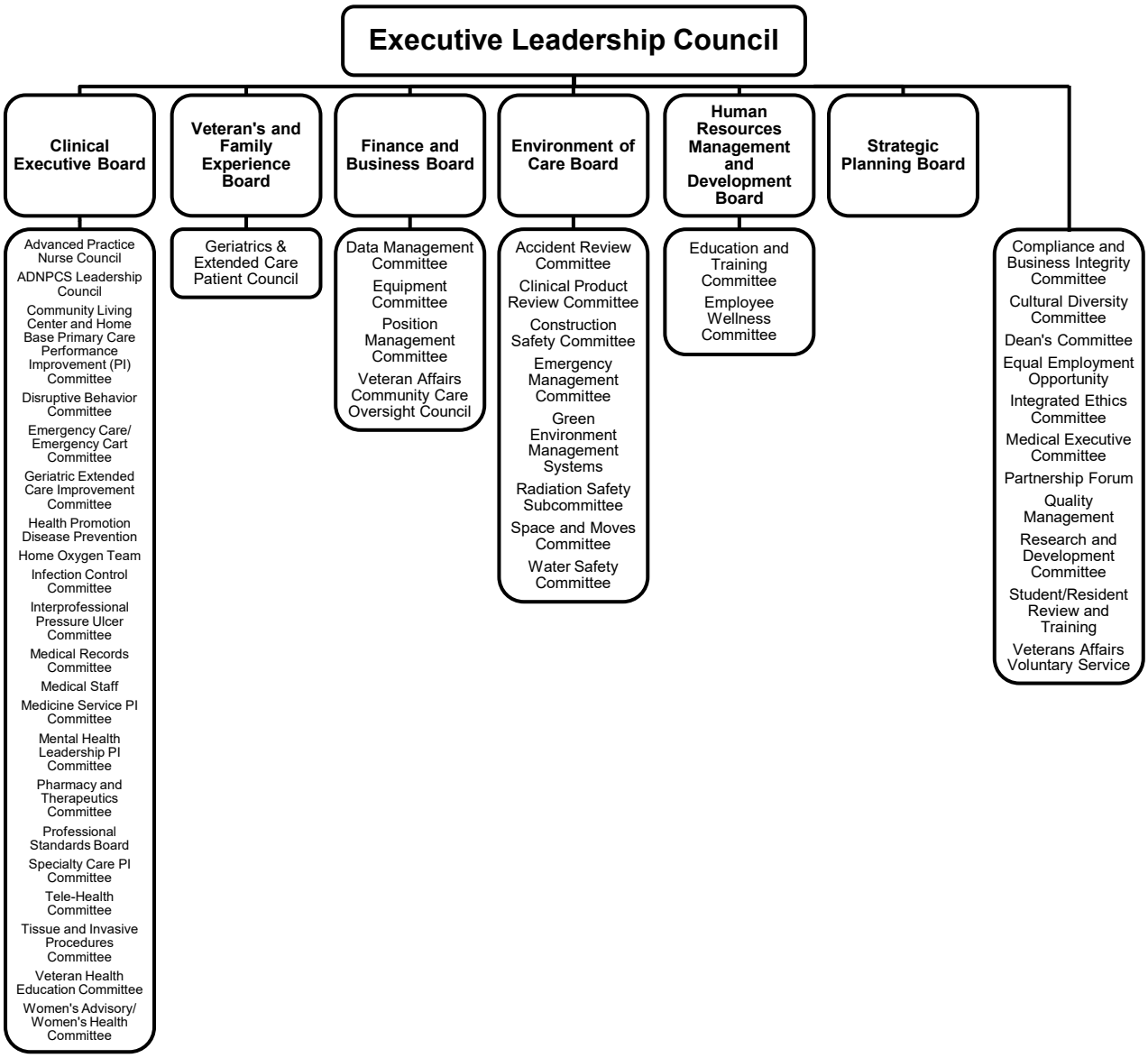

Figure 4. *Medical Center Committee Reporting Structure*
Source: Tuscaloosa VA Medical Center (received February 24, 2020)

Employee Satisfaction

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

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

October 1, 2018, through September 30, 2019.[11] 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 selected survey leadership questions was similar to the VHA average.[12] The scores related to the Director, Associate Director, and Chief of Staff were consistently higher than those for VHA and the medical center. The ADNPCS results were lower than the VHA and facility averages for three of four questions reviewed. The Director discussed initiatives to improve employee satisfaction, including I Care awards, a focus on employee strengths instead of weaknesses, an open-door policy, and enhanced communication initiatives.

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	ADNPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.*[13]	0–100 where higher scores are more favorable	72.6	74.8	91.5	84.6	82.2	88.7
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.4	3.5	4.5	4.1	3.1	4.1

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

[12] 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.

[13] 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	ADNPCS Average	Assoc. Director Average
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.6	4.6	4.2	3.0	4.3
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.7	4.8	4.3	3.2	4.6

Source: VA All Employee Survey (accessed January 21, 2020)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[14] Note that the medical center average for the survey questions reviewed were similar to VHA average. Scores related to the Medical Center Director, Chief of Staff, and Associate Director were generally better than those for VHA and the medical center. The ADNPCS scores were similar to the VHA and facility averages.

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	ADNPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.9	4.8	4.2	4.1	4.3

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADNPCS Average	Assoc. 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	3.8	4.3	4.0	3.5	4.3
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.4	1.5	1.1	1.4	1.5	0.7

Source: VA All Employee Survey (accessed January 21, 2020)

Patient Experience

To assess patient experiences with the medical center, which directly reflect on its leaders, the OIG team reviewed patient experience survey results that relate to the period of October 1, 2018, through September 30, 2019. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for VHA and the Tuscaloosa VA Medical Center.[15]

VHA also collects SHEP survey data from Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward their health care experience (see Table 4). For this medical

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

center, the patient survey results generally reflected similar ratings to the VHA average. Patients appeared satisfied with the care provided.

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.3	—[16]
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	—
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	77.3	76.8
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	78.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 23, 2019)

In 2015, women represented 9.4 percent of the total veteran population in the United States, and it is projected that women will represent 16.3 percent of living veterans by 2043. Further, from 2005 to 2015, the number of women veterans using VA health care increased by 46.4 percent, from almost 240,000 to 455,875.[17] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients' experiences by gender (see Tables 5 and 6), including those for Patient-Centered Medical Home and Specialty Care Surveys. The OIG noted that scores related to obtaining

[16] The facility does not have medical or surgical inpatient beds.

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

routine appointments were higher than VHA averages for male and female respondents, while those related to obtaining appointments needed right away were lower than national VHA averages for female respondents. However, medical center leaders appeared to be actively engaged with both male and female patients (for example, providing a spa day for women veterans, hiring a gynecologist to improve access to care, and providing drive-through flu shots).

Table 5. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2018, through September 30, 2019)

Questions	Scoring	VHA[18]		Medical Center[19]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.2	43.3	62.1	31.7
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).	59.9	49.7	67.6	57.3
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).	71.6	65.7	65.8	61.4

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed January 21, 2020)

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

[19] The medical center averages are based on 129–390 male and 10–28 female respondents, depending on the question.

Table 6. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2018, through September 30, 2019)

Questions	Scoring	VHA[20]		Medical Center[21]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.5	44.7	43.1	12.7
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	55.0	57.6	63.6
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	70.4	70.1	69.5	50.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed January 21, 2020)

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 7 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 site visit, the medical center closed 7 of 14 recommendations for improvement issued by the OIG since the previous comprehensive

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

[21] The medical center averages are based on 203–632 male and 14 or 41 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."

healthcare inspection in April 2019. The acting Chief of Quality Management reported continuing to work with medical center leaders to address the remaining seven open recommendations.

At the time of the site visit, the OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[24] Additional results included the Long-Term Care Institute's inspection of the medical center's CLCs.[25]

Table 7. 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 (*Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center Alabama*, Report No. 19-00057-238, September 27, 2019)	April 2019	14	7[26]
TJC Hospital Accreditation	February 2019	24	0
TJC Behavioral Health Care Accreditation		7	0
TJC Home Care Accreditation		14	0

Source: OIG and TJC (inspection/survey results verified with the Acting Chief of Quality Management on February 25, 2020)

[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.)

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

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

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms.

The OIG identified concerns with the peer review and patient safety programs that could hinder leaders' ability to understand risk within the organization and potential for patient harm. These concerns are discussed in greater detail below (see Quality, Safety, and Value Findings and Recommendations).

Table 8 lists the reported patient safety events from April 27, 2019 (the prior OIG comprehensive healthcare inspection), through February 24, 2020.[27]

[27] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Tuscaloosa VA Medical Center is a low complexity (3) affiliated system as described in Appendix B.)

Table 8. Summary of Selected Organizational Risk Factors (April 27, 2019, through February 24, 2020)

Factor	Number of Occurrences
Sentinel Events[28]	0
Institutional Disclosures[29]	3
Large-Scale Disclosures[30]	0

Source: Tuscaloosa VA Medical Center's Risk Manager (received February 24, 2020)

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[31]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2019. Of note, Figure 5 uses blue and green data points to indicate high performance for the Tuscaloosa VAMC (for example, in the areas of ambulatory care sensitive conditions (ACSC) hospitalization, mental health (MH) population (Popu) coverage, registered nurse (RN) turnover, and best place to work). Metrics

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

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

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

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

that need improvement are denoted in orange and red (for example, stress discussed, rating (of) primary care (PC) provider, and rating (of) specialty care (SC) provider).[32]

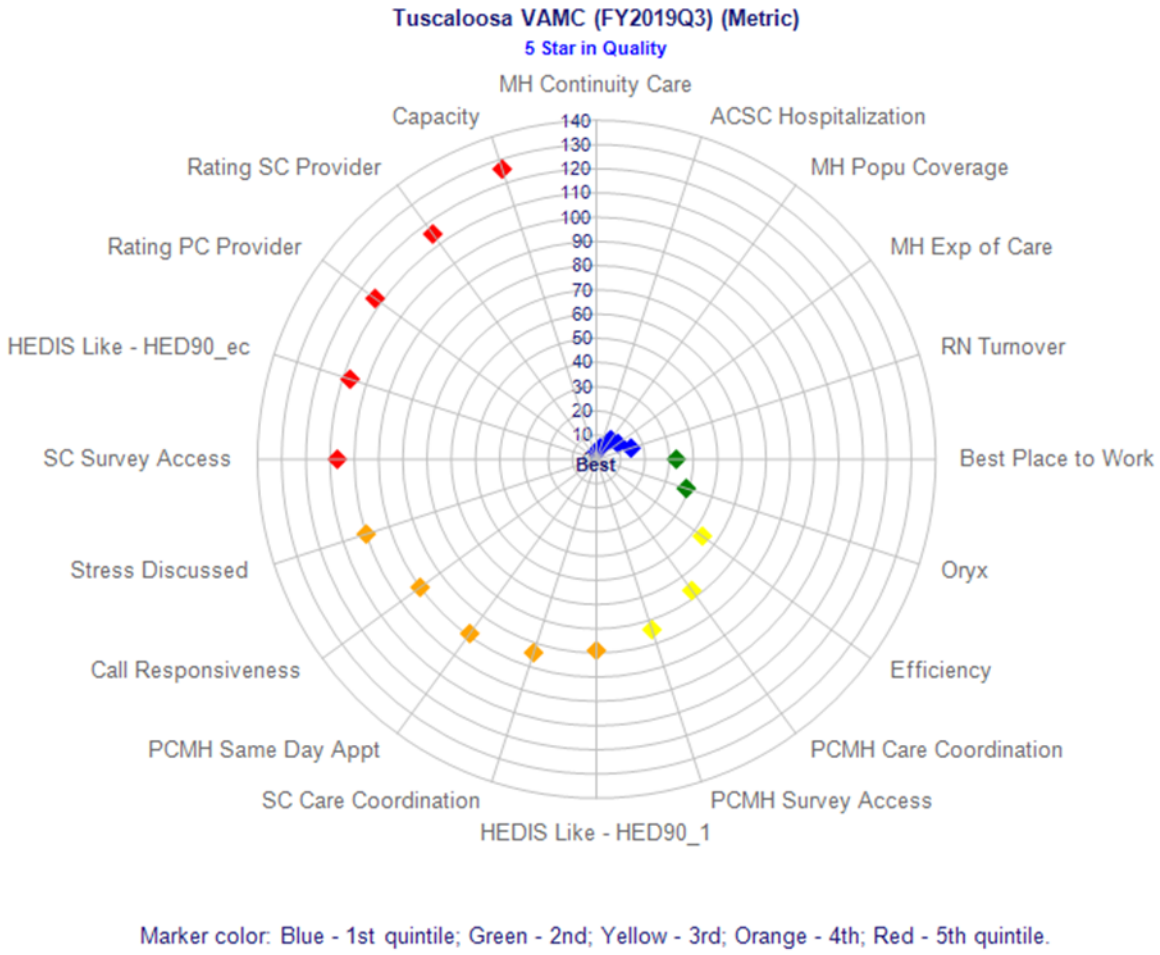

Figure 5. *System Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

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

Veterans Health Administration Performance Data for Community Living Centers

The "CLC SAIL" Value Model is a tool to summarize and compare the performance of CLCs in the VA. The model leverages much of the same data used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource to review quality measures and health inspection results.[33]

Figure 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2019. Figure 6 uses blue and green data points to indicate high performance for the Medical Center CLC (for example, in the areas of new or worse pressure ulcer (PU)–short-stay (SS), help with activities of daily living (ADL)–long-stay (LS), and catheter in bladder (LS)). The metric that needs improvement is denoted in red (falls with major injury (LS)).[34]

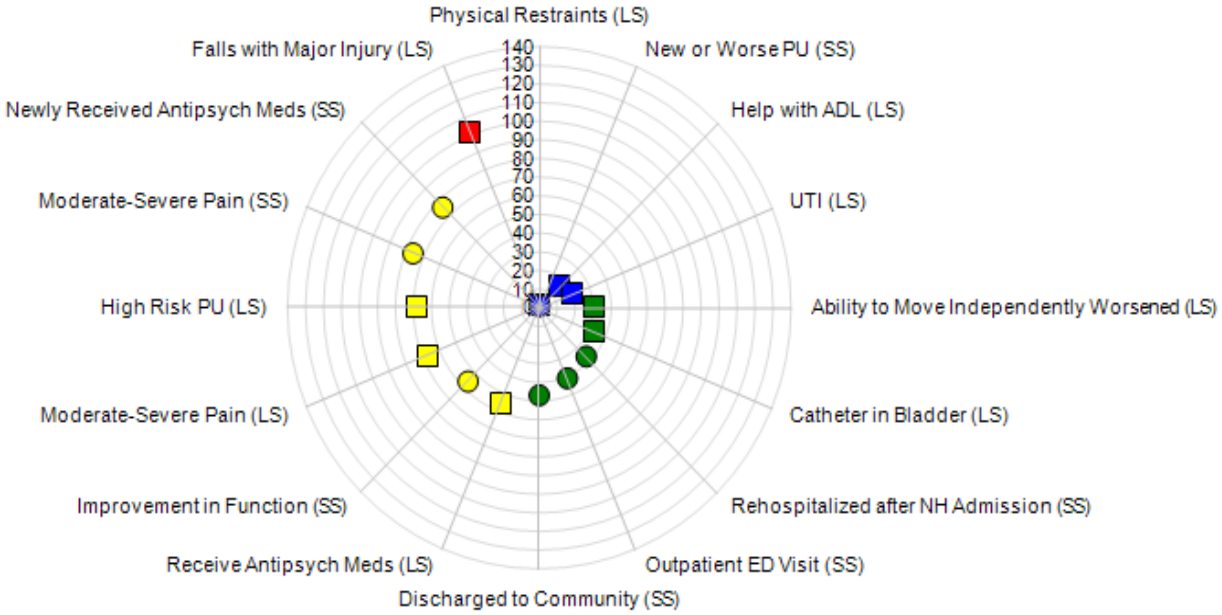

Figure 6. *Tuscaloosa CLC Quality Measure Rankings (as of September 30, 2019)*
LS = Long-Stay Measure *SS = Short-Stay Measure*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

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

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

Leadership and Organizational Risks Conclusion

At the time of the OIG site visit, the executive team had been working together as a group for four months, but the Director and the ADNPCS had worked together since 2015. Survey scores related to employees' satisfaction demonstrated similar or higher than VHA averages for the Director, Chief of Staff, and Associate Director. The ADNPCS, however, appeared to have some opportunities to improve employee satisfaction. Although, the medical center's patient experience results for obtaining routine appointments were higher than VHA averages for male and female veteran respondents, results for obtaining appointments needed right away were lower than VHA averages among female veterans. However, facility leaders seemed actively engaged with employees and patients and were working to sustain and further improve employee and patient engagement and satisfaction. The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes, such as initiating plans to maintain positive perceptions of the facility through active stakeholder engagement. The OIG's review of the facility's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors; however, the OIG continues to have concerns regarding peer review and patient safety programs. The leadership team was extremely knowledgeable about SAIL and CLC 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.[35] 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.[36] 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.[37]

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.[38] 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.[39] The OIG team examined the completion of the following elements:

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

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

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

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

[38] 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."

[39] VHA Directive 1190.

- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[40]
- 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.[41] 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.[42] 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.[43] Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the medical center.[44] The medical center was assessed for its performance on several dimensions:

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[40] VHA Directive 1190.

[41] 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."

[42] VHA Directive 1117(2).

[43] 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."

[44] VHA Handbook 1050.01.

- Annual completion of a minimum of eight root cause analyses[45]
- 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.[46]

Quality, Safety, and Value Findings and Recommendations

Generally, the OIG found medical center compliance with the establishment of the Executive Leadership Council, which is responsible for quality, safety, and value oversight functions and the utilization management program. However, concerns were identified regarding protected peer review processes and continued noncompliance with the inclusion of required content in root cause analyses.

Regarding protected peer reviews, multiple OIG inspectors encountered difficulties in locating relevant documents and identifying and tracking clinicians who were evaluated through the peer review process—documentation was often mislabeled or incomplete. However, due to the acting Chief of Quality Management's diligence in locating and providing additional and clarifying information, the OIG made no peer review recommendations.

Further, the OIG's review of root cause analyses found that none of the five root cause analyses completed since the prior OIG site visit included all of the required elements that ensure credibility, and documentation was such that it could not be determined if individuals directly involved in the adverse event triggering had been excluded in the root cause analysis process. In three root cause analyses where action plans were implemented, none had outcomes showing sustained improvement. Finally, four of the five root cause analyses lacked documentation that feedback regarding actions taken was provided to the individual or department reporting the incident. These are repeat findings from the April 2019 OIG CHIP site visit,[47] and the medical center had no evidence of improvement or movement towards resolution for the four open

[45] 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]."

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

[47] VA OIG. *Comprehensive Healthcare Inspection Program of the Tuscaloosa VA Medical Center, Alabama*, Report No. 19-00057-238, September 27, 2019.

recommendations related to RCAs from the previous inspection. The OIG made no new recommendations.

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).[48]

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.[49]

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

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[51]
  - 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 required minimum criteria for selected specialty LIPs[52]
  - Evaluation by another provider with similar training and privileges

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

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

[49] VHA Handbook 1100.19.

[50] VHA Handbook 1100.19.

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

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

Committee of the Medical Staff decided to recommend continuing privileges based on FPPE and OPPE results.

Further, VA must put processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former licensed practitioner's clinical practice, VA has an obligation to notify state licensing boards (SLBs) and to subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[53] 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."[54] The OIG reviewers assessed whether the medical center's staff

- Designated an individual and backup responsible for 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:

- Five solo/few practitioners who underwent initial or reprivileging during the previous 12 months[55]
- Three LIPs hired within 18 months before the site visit
- Seventeen LIPs privileged within 12 months before the visit
- Seven LIPs who left the medical center in 12 months before the visit

Medical Staff Privileging Findings and Recommendations

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

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

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

[55] 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 February 24, 2019, through February 24, 2020.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct Comprehensive Environment of Care Inspection Rounds and to resolve issues in a timely manner. The goal of the Comprehensive Environment of Care Program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[56]

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

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

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

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

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

- Acute inpatient psychiatric unit
- CLC
- Outpatient clinics

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

Environment of Care Findings and Recommendations

The inspection team observed general compliance with requirements for the CLC, outpatient clinics, and Selma VA Clinic. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified vulnerabilities within the medical center's environment concerning general safety and cleanliness and infection prevention.

TJC requires facilities to maintain clear means of egress.[57] The OIG found an emergency exit door in the Emergency Operations Center hallway blocked by items stored outside the door. Blocked emergency egresses and the inability to use exit doors in an emergency pose life-threatening risks for patients and employees. The Emergency Management Fire/Life Safety Specialist reported the egress in the Emergency Operations Center hallway was previously cited numerous times for being blocked. The Chief of Environmental Management Service reported checking the area the previous day and taking an inventory of what needed to be moved, but no other action was taken to clear the emergency exit at that time. However, a pathway was cleared to enable egress within two hours of the OIG identifying the issue. The Chief of Environmental Management Services could not provide a reason for the ongoing noncompliance of this area.

Recommendation 1

1. The Associate Director determines the reason(s) for noncompliance and ensures egresses are free of blockages.

[57] TJC. Life Safety standard LS.02.01.20 and LS.03.01.20.

Medical center concurred.

Target date for completion: September 29, 2020

Medical center response: All items blocking egress of the Emergency Operations Center hallway were removed immediately on day the surveyors cited the issue. Signage has been posted, and concrete painted to the external holding area to indicate egress routes to facilitate keeping the path clear. All Environmental Management Service staff were provided education on March 10, 2020 of the requirements to maintain a clear egress to the Emergency Operations Center hallway. Monitoring formally began in April 2020. The Associate Director will ensure the area is monitored by the Chief of Environmental Services monthly for six months to ensure sustainment of compliance of 100% or greater and report to the Environment of Care Board monthly.

TJC also requires hospitals to maintain a clean environment, continually monitor environmental conditions, and remediate conditions not meeting this requirement.[58] The OIG noted 5 of 12 observed wheelchairs had damaged wheelchair arms with exposed foam padding which prevented effective cleaning and disinfection. According to the interim Chief of Engineering, there was a policy and a process for removal or repair of damaged wheelchairs, but implementation of the process had lapsed. The Chiefs of Engineering and Environmental Management Services reported being aware that the policy and process were not being followed, but neither could provide a reason for noncompliance.

Recommendation 2

2. The Associate Director determines the reason(s) for noncompliance and ensures damaged wheelchairs are repaired or removed from service.

[58] TJC. Infection Prevention and Control standard IC.02.01.01, EP 1; and Environment of Care standard EC.02.06.01, EP 26.

Medical center concurred.

Target date for completion: February 28, 2021

Medical center response: An email message was disseminated to all supervisors on June 10, 2020 on the process for cleaning and taking wheelchairs requiring repair out of service, submitting a ticket for repair, and placing the wheelchairs in a designated location (i.e. Soiled Utility Room) for pick up by Engineering Service. Education was assigned to all medical center staff on June 12, 2020 with an expected completion date of August 31, 2020. The Associate Director will ensure compliance for non-damaged wheelchairs is monitored during the weekly Environment of Care rounds until compliance is sustained at 90% or greater for six consecutive months. Outliers will be noted monthly in the Performance Logic monitoring report and addressed as appropriate. This report will be submitted to the Environment of Care Board monthly.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[59] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[60] 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.[61] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[62]

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.[63] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[64] To achieve VHA's vision of providing patient-driven healthcare, providers are also required to obtain informed consent from patients and to provide education about the risks, benefits, and alternatives prior to initiating long-term opioid therapy.[65] 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.[66]

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

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

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[59] 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.)

[60] 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.)

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

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

[63] 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.)

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

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

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

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

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures include, but are not limited to, adherence to published clinical practice guidelines, timeliness of treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment, patient satisfaction, and quality of life.[67] 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 19 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.[68] 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 observed compliance with elements of expected performance, including clinicians conducting pain screening, documenting justification for concurrent therapy with benzodiazepines, and conducting urine drug testing when indicated. The medical center was generally compliant with the use of a multidisciplinary pain management committee to oversee and monitor required quality measures.

The VA/DoD clinical practice guidelines recommend completion of a behavior risk assessment that includes history of substance abuse, prior to initiating long-term opioid therapy.[69] The OIG found that providers assessed history of personal or family substance abuse in 84 percent of patients reviewed.[70] In the remaining 16 percent of patients reviewed, the OIG found evidence of licensed practical nurses' screening of patients for illicit drug use and/or alcohol abuse, but there was no evidence this information was reviewed, acknowledged, or used as part of the assessment conducted by the provider who is ultimately responsible when long-term opioid therapy is initiated. This could have resulted in providers prescribing opioids for patients at high risk for

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

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

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

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

misuse. The Nurse Care Manager and the Chair of the Pharmacy and Therapeutic Committee believed the requirement was met, as the guideline does not specify which provider must complete the risk screening. Upon further discussion and review with medical center leaders, the OIG will note the medical center's processes in this area. The OIG will not issue a recommendation at this time.

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.[71] 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.[72] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[73]

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.[74]

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.[75] 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 in his or her electronic health record "as soon as possible but no later than 1 business day after

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

[72] 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*.

[73] 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.*

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

[75] 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.

such determination by the SPC."[76] 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."[77] 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.[78] 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.[79]

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."[80] 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."[81] 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."[82]

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

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

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

[78] *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.

[79] 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*.

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

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

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

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."[83]

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.[84] VHA also requires that all staff receive annual refresher training.[85] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[86]

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

- Relevant documents;
- The electronic health records of 19 outpatients whose electronic health records were flagged as high risk for suicide from July 1, 2018, to June 30, 2019; and
- Staff training records.

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

[84] 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.

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

[86] 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.

Mental Health Findings and Recommendations

The medical center generally complied with requirements for assignment of a full-time SPC, tracking and following of high-risk veterans, and provision of suicide prevention training.

However, the OIG found deficiencies. With VHA's original requirement that was in place when these patients received care—that "Any patient determined to be High Risk for Suicide must have a HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"[87] —the OIG determined that 58 percent of HRS flags were placed within one business day of referral to the SPC.[88] Based on the current updated requirement that the SPC be responsible for determining placement of the HRS PRF (without a defined timeframe for doing so), the OIG further calculated that the average time from referral to HRS PRF placement for the patients reviewed was three days (observed range was 0–13 days).

Further, the OIG noted concerns with reviewing HRS flags within the required time frame. VHA required that all patients with an HRS flag be reevaluated at least every 90 days and there is documented justification for continuing or discontinuing the flag.[89] The OIG found that 68 percent of patients with an HRS PRF were reevaluated at least every 90 days.[90] 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 89 percent of patients were reviewed within the expected time frame (observed range was 66–108 days).

Additionally, the OIG noted concerns with completion of monthly outreach activities and four mental health appointments within the required time frame.

VHA facilities are required to conduct five outreach activities each month to community organizations, mental health groups, and/or other advocacy groups. Suggested outreach activities include: participating in homeless Stand Down events, attending military "welcome home" events, collaborating with state and local suicide prevention organizations, and connecting with veterans service organizations and local veteran groups.[91] The OIG found that the SPC did not complete or document the required five outreach activities for two quarters prior to the OIG visit.[92] Failure to conduct outreach could negatively impact at-risk veterans who could benefit from mental health services at VA medical centers. The SPC reported serving as the facility's Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment (REACH–VET) Coordinator and that with the addition of those collateral duties and a lack of a facility

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

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

[89] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide*; VHA Directive 2008-036.

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

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

[92] Prior two quarters were July 1, 2019, through December 31, 2019.

outreach coordinator, community outreach events were performed but not documented due to REACH–VET responsibilities and competing demands.

Recommendation 3

3. The Medical Center Director evaluates and determines any additional reason(s) for noncompliance and makes certain that the Suicide Prevention Coordinator ensures completion and documentation of at least five outreach activities each month.

Medical center concurred.

Target date for completion: November 20, 2020

Medical center response: The Suicide Prevention team discusses outreach activities during a weekly Suicide Prevention Huddle and enters all outreach activities monthly into Suicide Prevention Applications Network (SPAN) database where facility outreach activities are documented. The suicide prevention coordinator reports compliance of at least 5 outreach activities being completed and documented monthly to Mental Health Staff Performance Improvement Meeting for a 100% compliance for six consecutive months. Compliance and outliers will be documented and addressed in monthly minutes of the Mental Health Staff Performance Improvement Meeting. Performance Improvement outliers are reported to the Performance Measure Oversight Committee (reports directly to Executive Leadership Council through Quality Management). The Medical Center Director will be made aware of outliers and compliance through the monthly Performance Measure Oversight Committee minutes which the Director reviews and signs.

VHA requires a patient to have four follow-up visits with a qualified provider within 30 days of the placement of a High Risk for Suicide Patient Record Flag.[93] The follow-up assessments may occur by phone if the Veterans requests them and that request is documented. If a telephone call is requested, there must be documentation identifying the patient's preference.[94] The OIG found in the electronic health records reviewed that 42 percent of patients received the four required follow-up appointments.[95] This resulted in insufficient follow up on high-risk patients. The SPC admitted to failing to educate the Suicide Prevention Case Manager of the need to document veteran preference for telephone contacts and thought that the telephonic visits, regardless of patient preference, was acceptable.

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

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

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

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and makes certain that clinicians conduct four follow-up appointments within the required time frame.

Medical center concurred.

Target date for completion: November 20, 2020

Medical center response: The Suicide Prevention Coordinator tracks and monitors adherence with the requirement for 4 visits within the first 30 days, via monthly review of the High-Risk Flag Dashboard and monthly update of High-Risk Flag tracking spreadsheet. The Suicide Prevention Coordinator reports monthly to the Mental Health Staff PI Meeting for at least 90% compliance for six consecutive months. Compliance and outliers are documented in the monthly minutes of Mental Health Staff PI Meetings. Performance Measure outliers are reported to Performance Measure Oversight Committee (reports directly to Executive Leadership Council through Quality Management). The Medical Center Director will be made aware of outliers and compliance through the monthly Performance Measure Oversight Committee minutes which the Director reviews and signs.

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."[96]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.[97] 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.[98] 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.[99]

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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[96] 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.

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

[98] 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.

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

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

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

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

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

- Completion of LSTD notes
- Timely documentation of LSTD
- Inclusion of required elements in LSTD documentation
- Completion of LSTD note/orders by an authorized provider or delegation to a designee met 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.[100] 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 32 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

[100] VHA Handbook 1004.03(1).

Care Coordination Findings and Recommendations

The medical center had generally complied with requirements for supervision of designees. Additionally, with VHA's original requirements that were in place when these patients received care,[101] the OIG determined that

- 66 percent of patients' LST progress notes addressed identification of a surrogate if the patient loses decision-making capacity,[102]
- 31 percent of patients' LST progress notes addressed previous advance directive(s), state-authorized portable orders, and/or LST notes, and[103]
- 17 percent of patients' LST progress notes addressed the patient's or surrogate's understanding of the patient's condition.[104]

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

The OIG noted concerns with providers documenting goal(s) of care, informed consent, and a multidisciplinary committee reviewing proposed LST plans.

VHA mandates that providers document goals of care conversations that address the patient's goals and preferences and obtain consent for the LST plan.[105] The OIG determined that providers documented goal(s) of care in 76 percent and consent in 24 percent of the electronic health records reviewed.[106] Failure to discuss goals of care and obtain consent may result in ineffective processes for eliciting, documenting, and honoring patient values and preferences. Despite VHA requiring the national LST template in July 2018, a Geriatric and Extended Care provider reported that, prior to the implementation of the medical center LST policy in February 2019, providers were not using the national LST template or an alternative note that would capture and document all required elements.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures that providers document all required elements of goals of care conversations.

[101] VHA Handbook 1004.03(1).
[102] Confidence intervals are not included because the data represents every patient in the study population.
[103] Confidence intervals are not included because the data represents every patient in the study population.
[104] Confidence intervals are not included because the data represents every patient in the study population.
[105] VHA Handbook 1004.03(1).
[106] Confidence intervals are not included because the data represents every patient in the study population.

Medical center concurred.

Target date for completion: November 20, 2020

Medical center response: The Chief of Staff implemented templates in February 2020 as outlined in VHA Handbook 1004.03, which includes all the required elements of goals of care conversations and proof of Veteran/Surrogate consent of the Life Sustaining Treatment plan. The Ethics Coordinator will monitor monthly all Life Sustaining Treatment consults entered to ensure required elements of goals of care conversations are documented for at least a 90% compliance rate for six consecutive months. The Chief of Staff will be made aware of compliance and outliers as reported to Integrated Ethics Committee monthly beginning in July 2020 of which the Chief of Staff and other Quad members are a member.

Specifically, VHA requires that the LSTD multidisciplinary committee includes "three or more different disciplines" and " at least one member of the facility's Ethics Consultation Service."[107] The OIG found that the committee general membership included the required members; however, a Geriatric and Extended Care provider reported that the member representing the Ethics Consultation Service had left the medical center months prior to the site visit and had not been replaced. Lack of diverse representation within the multidisciplinary committee may impede effective decision-making for initiation, limitation, or discontinuation of life-sustaining treatments for incapacitated patients. Medical center staff were not aware of this oversight requirement until the OIG site visit.

Recommendation 6

6. The Medical Center Director evaluates and determines reason(s) for noncompliance and certifies that the multidisciplinary committee responsible for life-sustaining treatment decision reviews include three or more different disciplines and at least one member from the medical center's Ethics Consultation Service.

[107] VHA Handbook 1004.03(1).

Medical center concurred.

Target date for completion: November 20, 2020

Medical center response: Four medical providers, two Psychologist representatives and two GEC Social Worker representatives were appointed to the Ethics Subcommittee for Life Sustaining Treatment Initiative on June 10, 2020. The Ethics Coordinator monitors compliance of the subcommittee consisting of three or more disciplines for at least 90% compliance for six consecutive months and reports monthly to Integrated Ethics Committee. The Medical Center Director will be made aware of compliance and outliers as reported to Integrated Ethics Committee monthly beginning in July 2020 of which the Medical Center Director and other Quad members are a member.

For patients who lack decision-making capability and do not have a decision-making surrogate, VHA requires that a multidisciplinary committee review life-sustaining treatment plans.[108] The OIG requested a list of cases from January 2019 through December 2019 that were referred to the LSTD Committee and found that the one case referred to the LSTD Committee was not reviewed. The OIG noted that the Patient Safety Manager, who is the chair of the Ethics Committee, received an ethics consult request that this patient required a consultation and committee review, but there was no evidence of action taken or referral to the committee. Failure to ensure that life-sustaining treatment plans are reviewed by a multidisciplinary committee may impede ethical decision making for initiation, limitation, or discontinuation of life-sustaining treatments on behalf of incapacitated patients. The Patient Safety Manager was not available during the OIG site visit to discuss reasons for noncompliance.

Recommendation 7

7. The Medical Center Director determines the reason(s) for noncompliance and ensures that the multidisciplinary committee reviews life-sustaining treatment plans for patients who lack decision-making capability and do not have a surrogate.

Medical center concurred.

Target date for completion: November 20, 2020

Medical center response: The Ethics Coordinator monitors compliance of a multidisciplinary committee reviewing all life-sustaining treatment plans that are referred to the subcommittee. The Ethics Coordinator monitors monthly for at least a 90% compliance for a total of six consecutive months. The Medical Center Director will be made aware of compliance and outliers as reported to Integrated Ethics Committee monthly beginning in July 2020 of which the Medical Center Director and other Quad members are a member.

[108] VHA Handbook 1004.03(1).

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 several 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(3), *Health Care Services for Women Veterans,* February 15, 2017, amended June 29, 2020.

[114] VHA Directive 1330.01(3).

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

Women's Health Findings and Recommendations

The medical center generally complied with above requirements for the care provision indicators and performance improvement data monitoring elements reviewed. The OIG found the Women Veterans Health Committee did not have the required core members of pharmacy, social work, nursing, business office, and executive leadership attending the meetings; however, there was evidence that the medical center was actively addressing improvement actions since the previous April 2019 CHIP site visit. The OIG did not issue a recommendation. However, the OIG did note a concern with the Women Veterans Program Manager also functioning as the Maternity Care Coordinator.

VHA requires the facility to have a women veterans program manager who is full-time and free of collateral duties.[115] VHA also requires the facility to have a designated maternity care

[115] VHA Directive 1330.01(3).

coordinator.[116] The OIG found the designated Women Veterans Program Manager, who tracked mammogram scheduling and results and provided oversight of gynecological services received by VA patients through community care, was also serving as the Maternity Care Coordinator. Collateral duties could negatively impact the ability to deliver quality healthcare services to women veterans, as well as impede coordination and tracking of maternity care and outcomes. The Women Veterans Program Manager stated that the role of the Maternity Care Coordinator had always been held by the Women Veterans Program Manager because the female veteran population was small and manageable with approximately 1,700 female patients receiving care at the time of the OIG's site visit.

Recommendation 8

8. The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures the medical center's Women Veterans Program Manager is free of collateral duties.

Medical center concurred.

Target date for completion: November 20, 2020

Medical center response: The facility forwarded a letter to VISN 7 leadership for review on June 17, 2020 in preparation to request a waiver from the Deputy Under Secretary for Health for Operations and Management. The waiver includes a request for the Women Veteran Program Manager to provide collateral duties which includes tracking and monitoring mammograms, pap smears and pregnancies and serving as the Maternity Care Coordinator. The Women Veteran Program Managers continues to provide these collateral duties until a decision is made.

[116] VHA Directive 1330.01(3).

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

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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.

[123] VHA Directive 1116(2).

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued annual and essential staff competency assessments, and monthly continuing education. This ensures that staff have sufficient aptitude, knowledge, and skills to effectively and safely reprocess and sterilize RME.[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
  - Eating or drinking in the area prohibited
  - Equipment properly stored
  - Required temperature and humidity maintained

[124] VHA Directive 1116(2).

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

High-Risk Processes Findings and Recommendations

The medical center met many of the requirements for the proper operations and management of reprocessing RME. The airflow between the decontamination room and hallway was appropriate; however, a greater than one-inch gap in the door leading to SPS decontamination was reported to medical center leaders. Subsequently during the site visit, the Interim Chief of Engineering stated that measures would be taken to reduce the gap and validate airflow. Additionally, the OIG identified deficiencies with some administrative processes and staff competencies.

VHA requires that "The Chief, SPS, must maintain a file (electronic or paper copy) for all reusable devices. This file must contain the manufacturer's IFU [instructions for use] for the proper method of sterilization for each item."[125] The OIG found that the medical center had an inventory list for reusable medical devices; however, the list did not accurately reflect the current inventory and lacked the current manufacturers' instructions for use among equipment that inspectors sampled for review. This resulted in the potential for equipment loss or inadequate processing of reusable devices. The Associate Chief Nurse of Operations had responsibility for SPS since December 2019 and was unaware of this requirement. The SPS Tech was also unaware that the instructions for use needed to be retained in SPS once SOPs are in place.

Recommendation 9

9. The Associate Director for Nursing and Patient Care Services evaluates and determines any additional reason(s) for noncompliance and makes certain that the Associate Chief Nurse of Operations maintains an accurate file of all reusable devices that includes current manufacturers' instructions for use.

[125] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: November 20, 2020

Medical center response: A one-time audit was initiated in May 2020 of all current Reusable Medical Equipment used at the Medical Center to ensure items are reflected in the facility's Reusable Medical Equipment index. The audit is scheduled to be completed by June 2020. The Associate Chief Nurse of Operations ensures each reusable medical device has current manufacturers' instructions for use (IFU) that includes the proper method of sterilization for each item. An up to date RME index and current manufacturers' IFU will be reported monthly to the Associate Director for Nursing and Patient Care Services through the Infection Control Committee starting in June 2020 to ensure compliance. Will monitor for compliance for six consecutive months.

VHA requires that facilities deploy CensiTrac®, a system for instrument-level tracking.[126] The OIG did not find evidence that CensiTrac® was installed and operational. This resulted in a potential for inefficient and unsustainable procedures and lack of document and record control processes. The Associate Chief Nurse of Operations stated the medical center was allocated funding and in the process of purchasing the system at the time of the visit.

Recommendation 10

10. The Associate Director for Nursing and Patient Care Services determines the reason(s) for noncompliance and makes certain that the CensiTrac® instrument tracking system is installed and operational.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Associate Chief Nurse of Operations will ensure the system is purchased and installed onsite with applicable training for staff. The Associate Director of Nursing and Patient Care Services will monitor the status of installation and operation of CensiTrac® through the monthly Infection Control Committee minutes.

VHA requires that the SPS Chief perform an annual risk analysis and report the results to the VISN SPS Management Board.[127] The OIG did not find evidence that the FY 2019 risk analysis results were reported to the VISN SPS Management Board. Failure to report risk analyses results can delay or prevent the identification of problems, process failures, and missed opportunities for mitigation. The Associate Chief Nurse of Operations who is responsible for SPS was unaware of the requirement to send the results to the VISN.

[126] VHA DUSHOM Memorandum, *Instrument Tracking Systems for Sterile Processing Services*, January 1, 2019.
[127] VHA Directive 1116(2).

Recommendation 11

11. The Associate Director for Nursing and Patient Care Services evaluates and determines any additional reason(s) for noncompliance and makes certain that the Associate Chief Nurse of Operations reports the annual risk analysis to the Veterans Integrated Service Network Sterile Processing Services Management Board.

Medical center concurred.

Target date for completion: November 20, 2020

Medical center response: The risk assessment for 2020 is scheduled to be completed in July and reported to the VISN 7 SPS Board Meeting with confirmation to be included in the monthly Infection Control Committee minutes. The Associate Director for Nursing and Patient Care Services will ensure compliance and documentation through the monthly Infection Control Committee minutes as he is a member of the infection control Committee.

According to VHA, Sterile Processing Services in cooperation with Environmental Management Service or an equivalent service must "develop, implement and enforce a written daily cleaning schedule…Other surfaces such as walls, and air intake and return ducts, should be cleaned monthly or more often if needed."[128] The OIG observed that the posted cleaning schedule included documentation of daily cleaning; however, the items listed for weekly and monthly cleaning lacked signatures verifying completion. The missing signatures to certify that cleaning was performed as identified on the schedule resulted in a lack of assurance of a clean and safe patient care environment. The SPS Tech stated the cleaning schedule completion with inaccurate or missing information stemmed from a lack of attention to detail.

Recommendation 12

12. The Associate Director evaluates and determines any additional reason(s) for noncompliance and ensures that Sterile Processing Services areas are cleaned as scheduled.

[128] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: August 31, 2020

Medical center response: Training was held for Environmental Management Staff (EMS) staff assigned to this area in March 2020. After three full months of monitoring the posted cleaning schedule, the process is successful as evidenced by 100% compliance for March, April and May. The Chief of Environmental Service continues monitoring monthly for three more months, for a total of six consecutive months of at least 90% compliance and report to Environment of Care Board (EOCB). The Associate Director will be aware of compliance and outliers through Environment of Care Board minutes and serving as the chair.

VHA requires that temperature and humidity be maintained within 66 to 75 degrees Fahrenheit for clean or sterile storage areas.[129] The OIG found that monitoring was occurring in the sterile storage areas; however, the reference ranges on the monitoring forms specified 64–75 or 72–78 degrees. As a result, on days where the temperature exceeded the maximum of 75 degrees, no action was taken. Failure to achieve air quality standards can lead to the growth of fungi and bacteria in the environment, potentially leading to the spread of healthcare-associated infections. The Associate Chief Nurse of Operations was not able to provide a reason for the monitoring of incorrect temperature and humidity reference ranges.

Recommendation 13

13. The Associate Director for Nursing and Patient Care Services determines the reason(s) for noncompliance and ensures that Sterile Processing Services maintains required climate control parameters for areas where reusable medical equipment is reprocessed and stored.

Medical center concurred.

Target date for completion: November 20, 2020

Medical center response: The Associate Chief Nurse of Operations developed a new template that is being used in areas where Reusable Medical Equipment is stored that validates compliance of temperature and humidity monitoring. This template reflects the need to maintain a temperature within 66 to 75 degrees Fahrenheit for clean or sterile storage areas and to ensure corrective actions are taken when deficits are found. The Associate Director of Nursing and Patient Care Services will ensure compliance of the use of the form in all areas to include corrective actions if applicable through the monthly Infection Control Committee minutes. Will monitor for at least 90% compliance for six consecutive months.

[129] 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.

VHA requires that SPS staff complete competency assessments for the reprocessing of RME.[130] The OIG found that all three SPS staff did not have competency assessments specific to the two pieces of equipment evaluated by the OIG. This could result in improper cleaning of the RME and compromise patient safety. The Associate Chief Nurse of Operations was unable to provide a reason for past competencies not being completed and stated that one SPS staff member, who had been hired approximately eight months prior to the OIG site visit, was still in orientation, resulting in incomplete competencies.

Recommendation 14

14. The Associate Director for Nursing and Patient Care Services determines the reason(s) for noncompliance and ensures that Sterile Processing Services staff receive competency assessments for reprocessing reusable medical equipment.

Medical center concurred.

Target date for completion: November 20, 2020

Medical center response: The Associate Chief Nurse of Operations facilitated corrective actions to ensure proper Sterile Processing Staff training. The Associate Director of Nursing and Patient Care Services will ensure the documentation of new competencies have been completed and staff complete all applicable competency assessments on a quarterly basis through the Infection Control Committee minutes. Will monitor for at least 90% compliance for six consecutive months.

[130] VHA Directive 1116(2).

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• None	• None
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• None	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Medical center
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Accommodation and privacy for women veterans
	  ○ Logistics
	• Inpatient mental health unit
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Accommodation for women veterans
	  ○ Logistics
	• Community-based outpatient clinic
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Privacy for women veterans
	  ○ Logistics
		• Egresses are free of blockages.
		• Damaged wheelchairs are repaired or removed from service.
			• None

Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• None	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements	• Clinicians conduct four follow-up appointments within the required time frame.	• The SPC ensures completion and documentation of at least five outreach activities each month.
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• Providers document all required elements of goals of care conversations. • The multidisciplinary committee reviews LST plans for patients who lack decision-making capability and do not have a surrogate.	• The multidisciplinary committee responsible for LSTD reviews include three or more different disciplines and at least one member from the medical center's Ethics Consultation Service.
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• None	• The Women Veterans Program Manager is free of collateral duties.
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Data monitoring • Physical inspection • Staff training	• The CensiTrac® instrument tracking system is installed and operational. • SPS areas are cleaned as scheduled. • SPS maintains required climate control parameters for areas where RME is reprocessed and stored.	• The Associate Chief Nurse of Operations maintains an accurate file of all reusable devices that includes current manufacturers' Instructions for Use. • The Associate Chief Nurse of Operations reports the annual risk analysis to the VISN SPS Management Board. • SPS staff receive competency assessments for reprocessing RME.

Appendix B: Medical Center's Profile

The table below provides general background information for this low complexity (3) affiliated[1] medical center reporting to VISN 7.[2]

Table B.1. Profile for Tuscaloosa VA Health Care System (679) (October 1, 2016, through September 30, 2019)

Profile Element	Medical Center Data FY 2017[3]	Medical Center Data FY 2018[4]	Medical Center Data FY 2019[5]
Total medical care budget	$157,800,275	$152,427,351	$170,057,475
Number of:			
• Unique patients	16,416	16,472	16,372
• Outpatient visits	197,994	203,835	206,198
• Unique employees[6]	826	898	921
Type and number of operating beds:			
• Community living center	114	134	134
• Domiciliary	136	128	128
• Mental health	43	43	43
• Residential rehabilitation	12	12	12
Average daily census:			
• Community living center	104	118	131
• Domiciliary	101	110	105
• Mental health	34	41	37
• Residential rehabilitation	10	11	10

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

[1] Associated with a medical residency program.

[2] The VHA medical centers are classified according to a facility complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs."

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

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

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

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

Appendix C: VA Outpatient Clinic Profiles[1]

The VA outpatient clinics in communities within the catchment area of the healthcare system 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
Selma, AL	679GA	1,897	120	n/a	n/a	Pharmacy Social work Nutrition

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

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

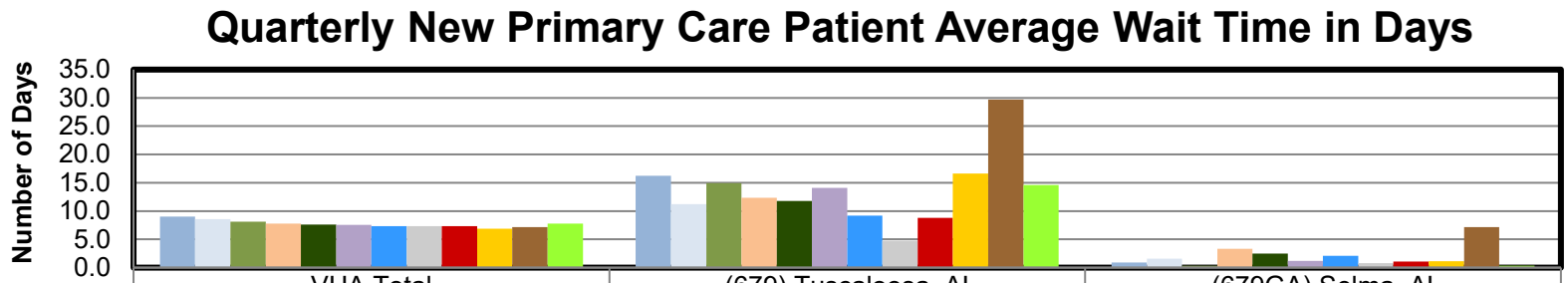
[2] The definition of an "encounter" can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. An encounter is a "professional contact between a patient and a practitioner vested with responsibility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

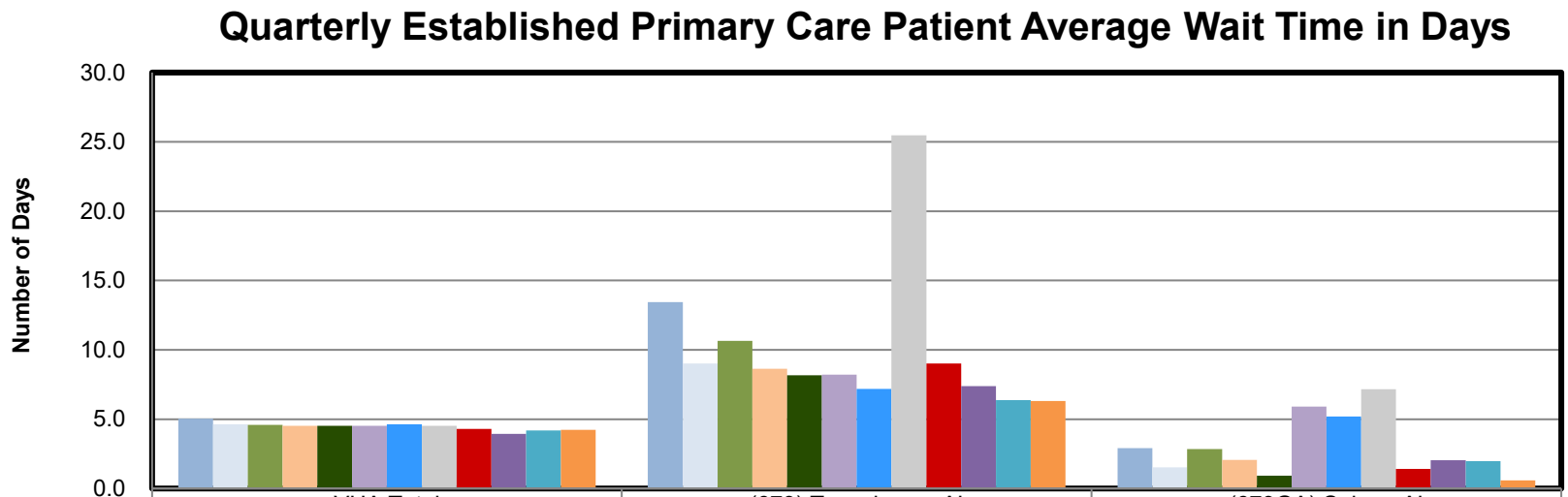
Appendix D: Patient Aligned Care Team Compass Metrics[1]



	VHA Total	(679) Tuscaloosa, AL	(679GA) Selma, AL
JAN-FY19	9.0	16.3	0.9
FEB-FY19	8.5	11.2	1.6
MAR-FY19	8.1	14.9	0.3
APR-FY19	7.8	12.4	3.3
MAY-FY19	7.6	11.8	2.5
JUN-FY19	7.6	14.1	1.2
JUL-FY19	7.3	9.2	2.1
AUG-FY19	7.4	4.8	0.8
SEP-FY19	7.3	8.8	1.1
OCT-FY20	6.9	16.6	1.2
NOV-FY20	7.1	29.7	7.1
DEC-FY20	7.8	14.6	0.3

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
Data Definition: "The average number of calendar days between 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	(679) Tuscaloosa, AL	(679GA) Selma, AL
JAN-FY19	5.0	13.4	2.9
FEB-FY19	4.6	9.0	1.5
MAR-FY19	4.6	10.6	2.9
APR-FY19	4.5	8.6	2.1
MAY-FY19	4.5	8.2	0.9
JUN-FY19	4.5	8.2	5.9
JUL-FY19	4.6	7.2	5.2
AUG-FY19	4.5	25.5	7.2
SEP-FY19	4.3	9.0	1.4
OCT-FY20	3.9	7.4	2.0
NOV-FY20	4.2	6.4	2.0
DEC-FY20	4.2	6.3	0.6

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

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

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

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

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

Source: VHA Support Service Center

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

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

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

Measure	Definition
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
Rehospitalized after NH Admission (SS)	Short-stay measure: percent of residents who were re-hospitalized after a nursing home admission.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 19, 2020

From: Interim Director, VA Southeast Network VISN 7 (10N7)

Subj: Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center in Alabama

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

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

1. I have had the opportunity to review the Draft Report: Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center, Tuscaloosa, AL.
2. VISN 7 submits concurrence to the findings, recommendations 1-2 and 6-17 and non-concurrence to recommendations 3-5. VISN 7 concurs with the attached Tuscaloosa VA Medical Center action plan.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(Original signed by:)

Joe D. Battle

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: June 11, 2020

From: Director, Tuscaloosa VA Medical Center (679/00)

Subj: Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center in Alabama

To: Interim Director, VA Southeast Network (10N7)

Tuscaloosa VA Medical Center has reviewed all 17 recommendations brought forth as a result of the Office of Inspector General site visit that occurred February 24-28, 2020. I attest reasons for noncompliance were considered when developing action plans.

(Original signed by:)

John F. Merkle, FACHE, VHA-CM

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