DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the Roseburg VA Health Care System

Oregon

CHIP REPORT | REPORT #18-00620-277 | SEPTEMBER 17, 2018

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Figure 1. *Roseburg VA Health Care System, Oregon*
(Source: https://vaww.va.gov/directory/guide/, accessed on July 2, 2018)

Abbreviations

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CS	controlled substances
CSC	controlled substances coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
GE	geriatric evaluation
LIP	licensed independent practitioner
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	posttraumatic stress disorder
QSV	quality, safety, and value
RCA	root cause analysis
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Roseburg VA Health Care System (Facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the overall efforts of the Office of Inspector General (OIG) to ensure that our nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year.

The OIG's current areas of focus are

1. Leadership and Organizational Risks;
2. Quality, Safety, and Value;
3. Credentialing and Privileging;
4. Environment of Care;
5. Medication Management;
6. Mental Health Care;
7. Long-Term Care;
8. Women's Health; and
9. High-Risk Processes.[1]

This review was conducted during an unannounced visit made during the week of March 19, 2018. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of Facility 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 facilities identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

[1] The OIG's review of central line-associated bloodstream infections focused on those that developed during care in intensive care units. This review was not performed for the Roseburg VA Health Care System because the Facility did not have an intensive care unit.

Results and Review Impact

Leadership and Organizational Risks

At the Facility, the leadership team consists of the Interim Director, Acting Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with the Quality, Safety, and Value Leadership Board having oversight for groups such as the Executive Council of Nursing, Health & Life Safety Council, and the Executive Council of Medical Staff. The leaders are members of the Quality, Safety and Value Leadership Board through which they track, trend, and monitor quality of care and patient outcomes.

It is important to note that apart from the ADPCS, the leadership team members are new to their positions, and two of the four are in temporary assignments. The ADPCS and the Associate Director were assigned to their positions in December 2016 and January 2018, respectively. The Interim Director and Acting Chief of Staff were assigned in February and March 2018, respectively. At the time of the OIG review, the Facility was actively recruiting for a permanent Chief of Staff.

Further, some members of the prior leadership team and multiple key senior managers exited suddenly, amidst concerns related to ineffective leadership, toxic work culture, questionable personnel practices, and alleged inappropriate hospital admission practices to improve performance ratings were widely reported in the local and national press. In February 2018, the Veterans Health Administration (VHA) issued a news release that stated the previous Facility Director "…has stepped down and an interim replacement has been named. This is a step aimed at improving care for Veterans served by Roseburg, which remains one of VA's 15 lowest performing facilities."[2]

These concerns were also the subject of recent internal and external reviews, including onsite evaluations conducted from October through December 2017 by the VHA Office of the Medical Inspector[3] and an unannounced review by The Joint Commission (TJC)[4] Office of Quality and

[2] February 2, 2018 VA media release, *VA Announces Leadership Changes at Roseburg (Oregon) Medical Center*, issued by the VA Office of Public Affairs Media Relations. VA Office of Public and Intergovernmental Affairs News Releases Website. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4003, accessed on June 11, 2018.

[3] The Office of the Medical Inspector is an internal VHA department that independently evaluates health care issues to improve the quality of health care provided by the VHA.

[4] TJC is 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 VHA facilities for more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

Patient Safety (OQPS)[5] in February 2018. Furthermore, Veterans Integrated Service Network 20 deployed a consultation team to assess the Facility challenges in February 2018.

The executive leadership team members spoke frankly about the Facility's multifaceted operational, personnel, and perception challenges. The leaders were engaged in the process of developing a comprehensive gap analysis and action plan to identify and address the challenges across services, programs, and processes.

In the review of selected employee and patient satisfaction survey results regarding Facility leaders, the OIG noted that the Facility scores were similar to VHA averages in employee satisfaction while opportunities appear to exist to improve patient satisfaction.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[6] The leadership team appeared to be aware of the breadth and depth of the Facility's challenges and were actively engaged in measures to restore a culture of trust, improve employee and patient satisfaction, and improve the quality of care and efficiency metrics likely contributing to the "1-Star" rating.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[7] disclosures of adverse patient events, and Patient Safety Indicator data and did not identify any substantial organizational risk factors. However, the OIG identified concerns with hydromorphone (pain medication) shortages; gaps in provider privileging processes and evaluations; and a lack of communication between medical staff and logistics, resulting in an excessive number of On-demand (also known as "Just in Case") supplies not being properly tracked and monitored. These risk factors may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored.

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[5] TJC OQPS unannounced onsite evaluation is one of several actions that may be taken following the receipt of a patient safety allegation related to accreditation standards. TJC website. https://www.jointcommission.org/dateline_tjc/the_back_story_on_how_the_joint_commission_handles_complaints/ (Website accessed on June 11, 2018.)

[6] VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a VISN or across VHA. The SAIL model uses a "star" rating system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. (Website accessed on April 16, 2017.)

[7] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

The OIG noted findings in three of the seven areas of clinical operations reviewed and issued seven recommendations that are attributable to the Interim Director, Acting Chief of Staff, and Associate Director. These are briefly described below.

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing and privileging. However, the OIG identified deficiencies in completing required elements for the Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations.

Environment of Care

The OIG noted a generally safe environment of care. The representative community based outpatient clinic met the performance indicators evaluated. However, the OIG identified improper storage of cleaning chemicals in the Nutrition & Food Service food preparation area.

Medication Management

The OIG found general compliance with requirements for most of the performance indicators evaluated, including CSC reports, ordering procedures, and the CSC and CSIs having no conflicts of interest and completing required training. However, the OIG identified deficiencies with controlled substances (CS) monthly inspections and reconciliation of return of stock to pharmacy.

Summary

In the review of key care processes, the OIG issued seven recommendations that are attributable to the Interim Director, Acting Chief of Staff, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this Facility. The intent is for Facility 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 eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Interim Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See

Appendixes E and F, pages 54-55, and the responses within the body of the report for the full text of the Directors' comments.) The OIG considers recommendations 5 and 6 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Roseburg VA Health Care System (Facility) through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of healthcare services to veterans and to share findings with Facility leaders so that informed decisions can be made to improve care.

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.[8,9] Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.[10] Figure 2 shows the direct relationship leadership and organizational risks have with the processes used to deliver health care to veterans

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following-nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management: Controlled Substances (CS) Inspection Program; Mental Health: Posttraumatic Stress Disorder (PTSD) Care; Long-Term Care: Geriatric Evaluations; Women's Health: Mammography Results and Follow-up; and High-Risk Processes: Central Line-Associated Bloodstream Infections (CLABSI) (see Figure 2).[11] However, the CLABSI review did not apply for the Roseburg VA Health Care System because the Facility did not have an intensive care unit. Thus, the OIG focused on the remaining eight areas.

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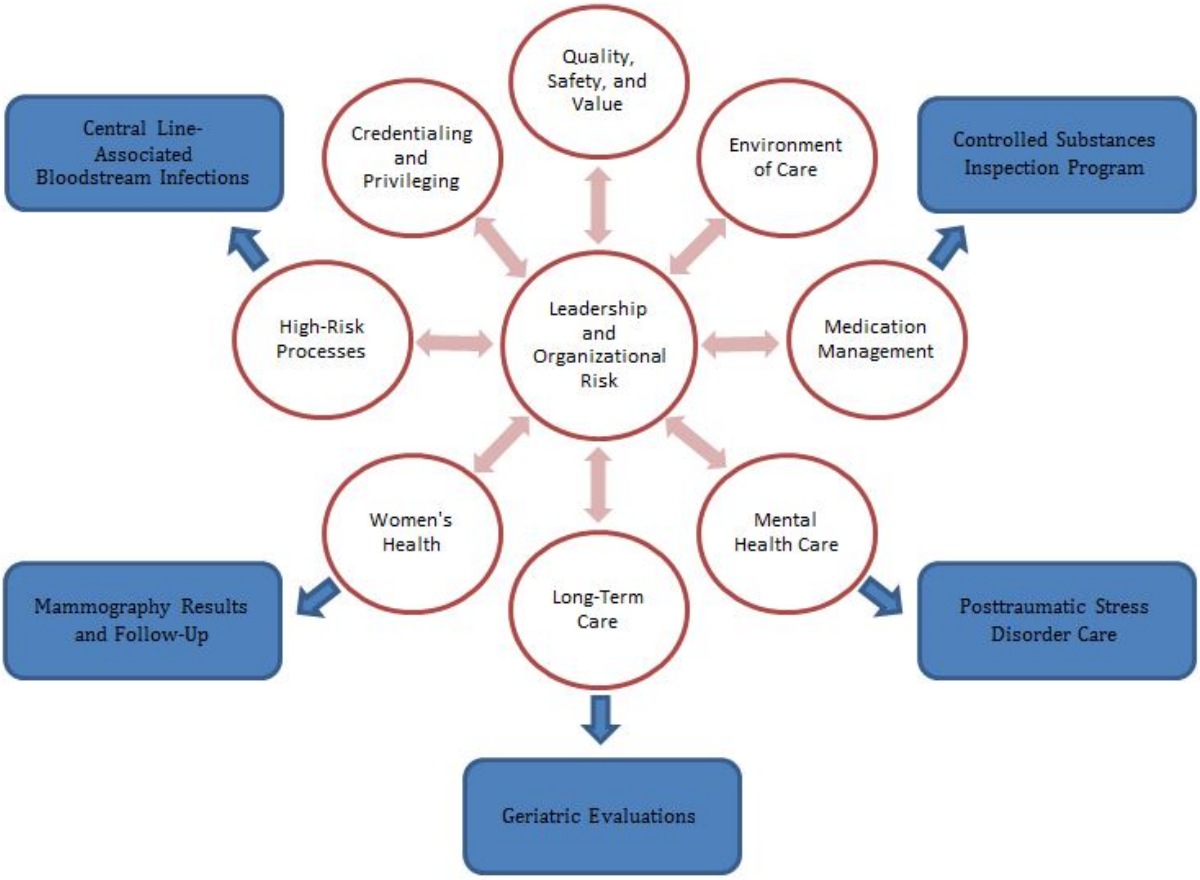
[8] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

[9] 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/. (Website accessed on March 1, 2018.)

[10] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen", March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (Website accessed March 1, 2018.)

[11] CHIP reviews address these processes during fiscal year (FY) 2018 (October 1, 2017, through September 30, 2018).

Figure 2. FY 2018 Comprehensive Healthcare Inspection Program Review of Healthcare Operations and Services



Source: VA OIG

Additionally, OIG staff provided crime awareness briefings to increase Facility employees' understanding of the potential for VA program fraud and the requirement to report suspected criminal activity to the OIG.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the EOC, the OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[12] and discussed processes and validated findings with managers and employees. The OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for November 17, 2014,[13] through March 19, 2018, the date when an unannounced week-long site visit commenced. On March 29, 2018, the OIG presented crime awareness briefings to 139 of the Facility's 1,217 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

This report's recommendations for improvement target problems that can impact the quality of patient care significantly enough to warrant OIG follow-up until the Facility completes corrective actions. The Interim Director's comments submitted in response to the recommendations in this report appear within each topic area.

While on site, the OIG referred issues and concerns beyond the scope of the CHIP review to our Hotline management team for further evaluation. The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and Q*uality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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

[13] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the Facility's ability to provide care in all selected clinical areas of focus.[14] To assess the Facility's risks, the OIG considered the following organizational elements:

1. Executive leadership stability and engagement,
2. Employee satisfaction and patient experience,
3. Accreditation/for-cause surveys and oversight inspections,
4. Indicators for possible lapses in care, and
5. VHA performance data.

Executive Leadership Stability and Engagement

Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ among facilities. Figure 3 illustrates the Facility's reported organizational structure. The Facility has a leadership team consisting of the Interim Director, Acting Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director.

It is important to note that apart from the ADPCS, the leadership team members are new to their positions, and two of the four are in temporary assignments. The ADPCS and the Associate Director were assigned to their positions in December 2016 and January 2018, respectively. The Interim Director and Acting Chief of Staff were assigned in February and March 2018, respectively. At the time of the OIG review, the Facility was actively recruiting for a permanent Chief of Staff.

Further, some members of the prior leadership team and multiple key senior managers exited suddenly, amidst internal and external concerns. Local and national press reported ineffective leadership, leaders and managers creating or contributing to a toxic work culture, questionable personnel practices, and alleged inappropriate hospital admission practices to improve Facility performance ratings.

[14] L. Botwinick, M. Bisognano, and C. Haraden. "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx. (Website accessed on February 2, 2017.)

In response to these concerns, VHA issued a February 2018 news release stating that the previous Facility Director "…has stepped down and an interim replacement has been named. This is a step aimed at improving care for Veterans served by Roseburg, which remains one of VA's 15 lowest performing facilities." The VHA Executive in Charge was quoted stating, "There are times that facility leadership needs to change in order to usher in a new approach that will demonstrate we are committed to delivering results for Veterans and taxpayers."[15] Additionally, the press release identified targeted areas requiring rapid improvement,[16] many of the areas are included in this review.

These concerns were also the subject of internal and external reviews, including onsite evaluations by the VHA Office of Medical Inspector[17] conducted from October through December 2017 and an unannounced review by The Joint Commission (TJC)[18] Office of Quality and Patient Safety (OQPS) in February 2018.[19] Furthermore, Veterans Integrated Service Network (VISN) 20 deployed a consultant team to assess the magnitude and depth of the Facility challenges in February 2018.

[15] February 2, 2018 VA media release, *VA Announces Leadership Changes at Roseburg (Oregon) Medical Center*, issued by the VA Office of Public Affairs Media Relations. VA Office of Public and Intergovernmental Affairs News Releases Website. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4003 (Accessed on June 11, 2018.)

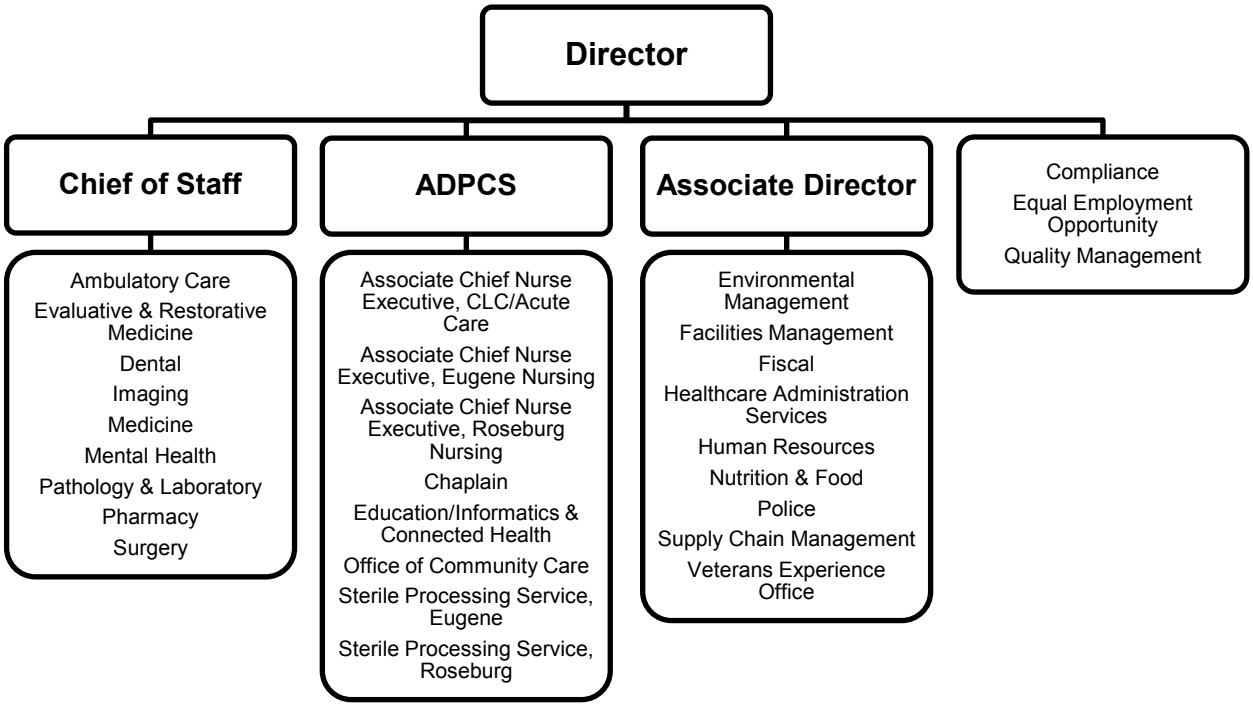
[16] Targeted areas identified for rapid improvement included access to care, performance measures, patient experience, employee satisfaction, and mortality. VA Office of Public and Intergovernmental Affairs News Releases Website. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4003 (Accessed on June 11, 2018.)

[17] The VHA Office of Medical Inspector is an internal department that independently evaluates health care issues to improve the quality of health care provided by the VHA.

[18] TJC is 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 VHA facilities for more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

[19] TJC Office of Quality and Patient Safety (OQPS) unannounced onsite evaluation is one of several actions that may be taken following the receipt of a patient safety allegation related to accreditation standards. TJC website. https://www.jointcommission.org/dateline_tjc/the_back_story_on_how_the_joint_commission_handles_complaints/ (Website accessed on June 11, 2018.)

Figure 3. Facility Organizational Chart



Source: Roseburg VA Health Care System (received March 23, 2018)

To help assess engagement of Facility executive leadership, the OIG interviewed the Interim Director, Acting Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

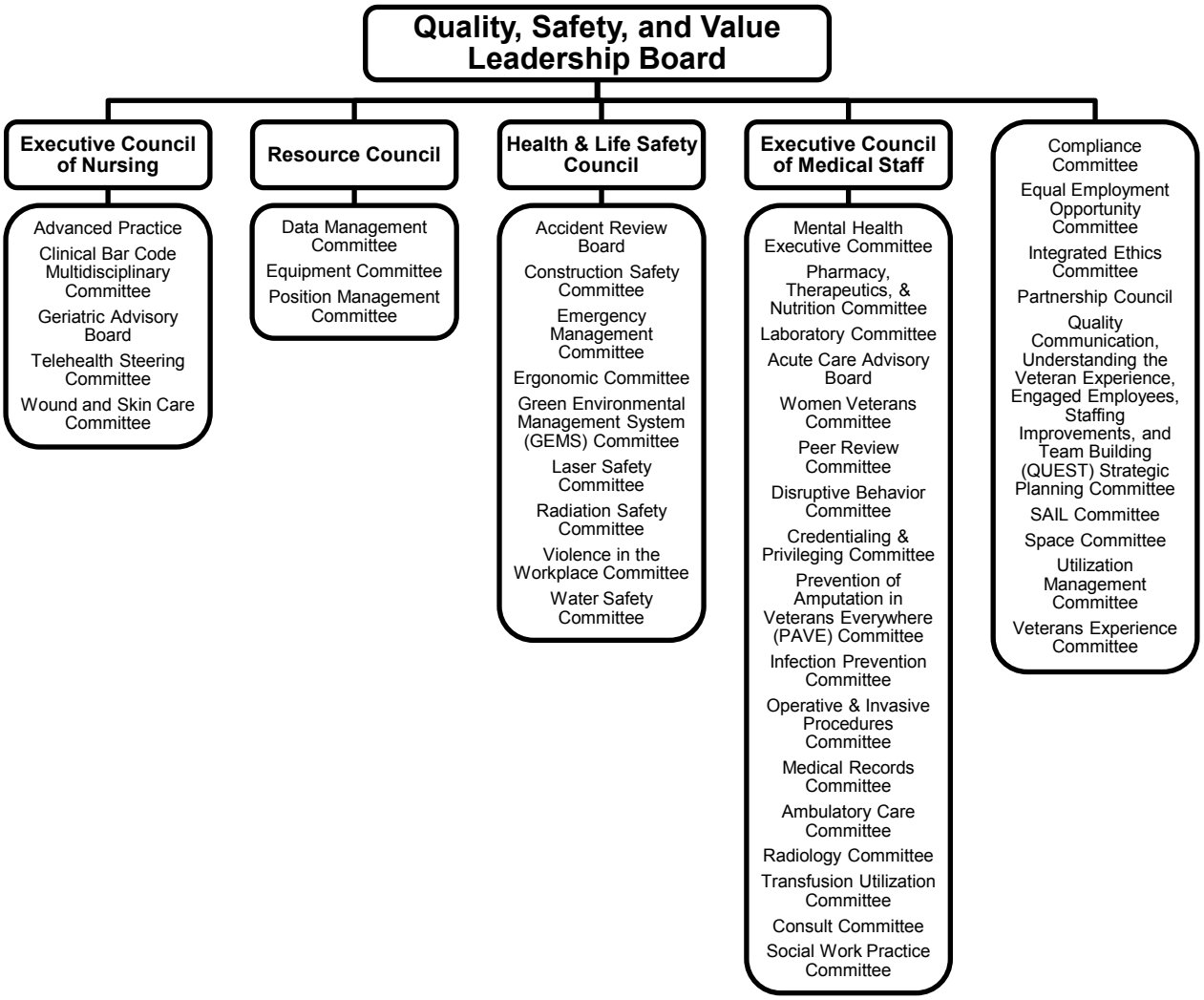
In individual interviews, these executive leadership team members spoke frankly about the Facility's multifaceted operational, personnel, and perception challenges. The Interim Director stated being specifically selected to make the difficult choices, identify problems and gaps, develop action plans, and implement meaningful change before a permanent Director is selected. The Interim Director also stated that the most critical component of developing a quality framework is to create a culture where employees are encouraged to identify and bring forward needs and challenges within their service.

The executive leaders were actively engaged in performing a comprehensive gap analysis to identify challenges across services, programs, and processes. Using this analysis, Facility leaders are developing a master action plan that incorporates recommendations from the VISN 20 consultation team, VHA Office of the Medical Inspector, and the TJC, as well as items brought forth by employees, patients, and the community.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Facility's Quality, Safety and Value Leadership Board, which tracks,

trends, and monitors quality of care and patient outcomes. The Interim Director serves as the chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Quality, Safety and Value Leadership Board also oversees various working committees such as the Executive Council of Nursing, Health & Life Safety Council, and the Executive Council of Medical Staff. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: Roseburg VA Health Care System (received March 23, 2018)

Employee Satisfaction and Patient Experience

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 at several

points in response to VA leadership 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 facility leadership.

To assess employee and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017. Tables 1 and 2 provide relevant survey results for VHA and the Facility. As Table 1 indicates, the Facility and Director's Office scores are similar to VHA averages.[20]

In executive leadership interviews, the members expressed surprise that the employee satisfaction scores were not lower. They explicitly reported there had been "intense factions" throughout the Facility that were "powerful and destructive," resulting in a toxic work culture. They identified improving the culture as a key priority. The OIG noted that the Interim Director set the vision and path for change, and the other executive leaders seemed confident in the Interim Director's decisions and direction.

Table 1. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions/Survey Items	Scoring	VHA Average	Facility Average	Director's Office Average[21]
All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?*	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	3.0	3.4
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	68.1	64.0

Source: VA All Employee Survey (accessed February 16, 2018)

VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA utilizes industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences of their health care and to support the goal of benchmarking its performance against the private sector.

[20] 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.

[21] Rating is based on responses by employees who report to or are aligned under the Director.

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes towards Facility leaders. For the Facility, three of the four patient survey results reflected lower care ratings than the VHA average. The Facility leaders acknowledged that opportunities exist and were actively taking actions to improve patient satisfaction.

Table 2. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions	Scoring	VHA Average	Facility 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.	66.7	68.8
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.	83.4	80.4
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	74.9	71.0
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.	75.2	71.4

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 22, 2017)

Accreditation/For-Cause Surveys[22] and Oversight Inspections

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 3 summarizes the relevant Facility inspections most

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

recently performed by the OIG and TJC.[23] The Facility has closed all recommendations for improvement as listed in Table 3.[24] The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[25] and College of American Pathologists,[26] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute conducted inspections of the Facility's Community Living Centers (CLC).[27]

Table 3. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the VA Roseburg Healthcare System, Roseburg, Oregon, March 4, 2015*)	November 2014	39	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Roseburg Healthcare System, Roseburg, Oregon, May 5, 2015)*	March 2015	8	0
OIG (*Healthcare Inspection – Nurse Staffing and Patient Safety Reporting Concerns, VA Roseburg Healthcare System, Roseburg, Oregon, October 12, 2016*)	November 2014 December 2014	1	0
OIG (*Healthcare Inspection – Teleradiology Concerns, VA Roseburg Healthcare System, Roseburg, Oregon, October 12, 2016*)	December 2014	1[28]	0

[23] TJC is 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 VHA facilities for more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

[24] A closed status indicates that the Facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

[25] 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 collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

[26] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

[27] Since 1999, the Long Term Care Institute has been to over 3,500 healthcare facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

[28] Recommendation 2 was directed to the Roseburg VA Health Care System.

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG (*Healthcare Inspection – Alleged Access Delays and Surgery Service Concerns, VA Roseburg Healthcare System, Roseburg, Oregon, July 11, 2017*)	December 2014 October 2015	1[29]	0
TJC			
• Regular	February 2016		
○ Hospital Accreditation		18	0
○ Nursing Care Center Accreditation		2	0
○ Behavioral Health Care Accreditation		2	0
○ Home Care Accreditation		1	0
• New Service	October 2016	0	n/a
• For Cause (OQPS)	February 2018	2	0

Sources: OIG and TJC (Inspection/survey results verified with the Interim Director on March 21, 2018)
n/a = not applicable

Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 4 summarizes key indicators of risk since the OIG's previous November 2014 Combined Assessment Program and Other Outpatient Clinics review inspections through the week of March 19, 2018.[30]

[29] Recommendation 4 was directed to the Roseburg VA Health Care System.

[30] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events 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 Roseburg VA Health Care System is a low complexity (3) affiliated Facility as described in Appendix B.)

Table 4. Summary of Selected Organizational Risk Factors (November 2014 to March 19, 2018)

Factor	Number of Occurrences
Sentinel Events[31]	0
Institutional Disclosures[32]	7
Large-Scale Disclosures[33]	0

Source: Roseburg VA Health Care System's Patient Safety Manager (received March 21, 2018)

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[34] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 5 summarizes Patient Safety Indicator data from October 1, 2015, through September 30, 2017.

Table 5. Patient Safety Indicator Data (October 1, 2015, through September 30, 2017)

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 20	Facility
Pressure ulcers	0.60	0.56	0.00
Death among surgical inpatients with serious treatable conditions	100.97	77.84	n/a
Iatrogenic pneumothorax	0.19	0.30	0.00
Central venous catheter-related bloodstream infection	0.15	0.07	0.00
In-hospital fall with hip fracture	0.08	0.09	0.00
Perioperative hemorrhage or hematoma	1.94	1.95	0.00

[31] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

[32] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which 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 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.

[33] Large-scale disclosure of adverse events (sometimes referred to as "notification") is 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.

[34] Agency for Healthcare Research and Quality website. https://www.qualityindicators.ahrq.gov/. (Website accessed on March 8, 2017.)

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 20	Facility
Postoperative acute kidney injury requiring dialysis	0.88	0.20	0.00
Postoperative respiratory failure	5.55	3.75	0.00
Perioperative pulmonary embolism or deep vein thrombosis	3.29	2.12	0.00
Postoperative sepsis	4.00	2.23	n/a
Postoperative wound dehiscence	0.52	1.97	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.59	0.00

Source: VHA Support Service Center

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

n/a = not applicable

None of the 10 applicable Patient Safety Indicator measures show an observed rate in excess of the observed rates for VISN 20 or VHA.

However, while onsite, the OIG identified three additional areas of concern and brought these to the attention of the executive leadership team who began an immediate inquiry to understand and address these areas. These concerns included: (1) a shortage of low dosage injectable hydromorphone,[35] impacting the nurses' ability to confidently administer the dose prescribed; (2) a significant gap in credentialing and privileging processes, resulting in a lack of supporting documentation of provider's practice evaluations which is used to determine initial and ongoing provider privileges (also discussed under Credentialing and Privileging on pages 20–22); and (3) a lack of communication between medical staff and logistics, resulting in inadequate tracking and monitoring of an excessive number of On-demand (also known as "Just in Case") supplies.[36]

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency but has 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.

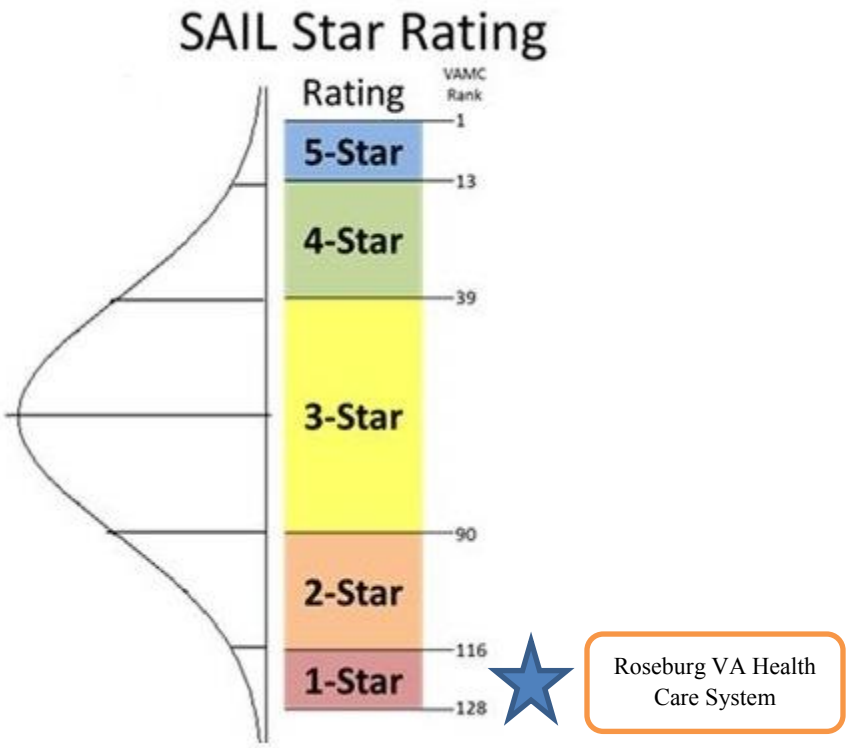
VA also uses a star-rating system where facilities with a "5-Star" rating are performing within the top 10 percent of facilities and "1-Star" facilities are performing within the bottom 10 percent

[35] Hydromorphone is a class of medication used to control pain.

[36] VHA Directive 1761, *Supply Chain Inventory Management*, October 24, 2016: On-demand items are supplies that are used no more than four months within a 12-month period.

of facilities. Figure 5 describes the distribution of facilities by star rating.[37] As of June 30, 2017, the Facility was rated at "1-Star" for overall quality.

Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2017)



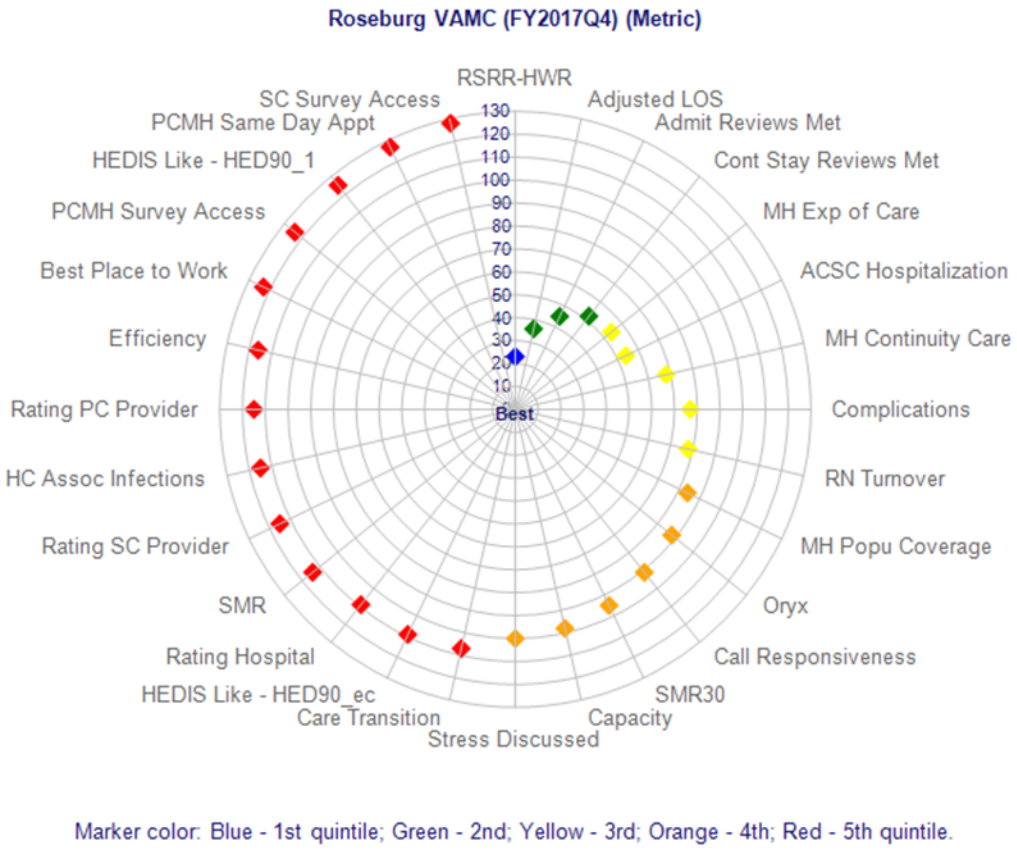
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed February 16, 2018)

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of September 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example in the areas of Risk Standardized Readmission Rate (RSRR)-Hospital Wide Readmission (HWR), Adjusted Length of Stay (LOS), and Admit Reviews Met).[38] Metrics that need improvement are denoted in orange and red (for example, Capacity, Care Transition, Best Place to Work, Patient Centered Medical Home (PCMH) Same Day Appointment (Appt), and Specialty Care (SC) Survey Access).

[37] Based on normal distribution ranking quality domain of 128 VA Medical Centers.

[38] For data definitions of acronyms in the SAIL metrics, please see Appendix D.

Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of September 30, 2017)



Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). For data definitions, see Appendix D.

Conclusion

The Facility has been and continues to be in a state of transition. Three of the four executive leaders are new to their positions, and two of the four are in interim/acting capacities. Facility challenges, including ineffective leadership, toxic work culture, questionable personnel practices, and alleged inappropriate hospital admission practices have been the focus of local, national, and VA media, as well as the subject of internal and external evaluations. The Interim Director reported readiness to make difficult decisions and take necessary action, conduct a thorough gap analysis, and implement impactful change.

The OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, and Patient Safety Indicator data and did not identify any substantial organizational risk factors. However, the OIG identified concerns with hydromorphone (pain medication) shortages;

gaps in provider privileging processes and evaluations; and inadequate tracking and monitoring of an excessive number of On-demand (also known as "Just in Case") supplies. These risk factors may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored.

The leadership team appeared to be aware of the breadth and depth of the Facility challenges and were actively engaged in measures to restore a culture of trust, improve employee and patient satisfaction, and improve the quality of care and efficiency metrics likely contributing to the "1-Star" rating.

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 using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.[39] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[40]

VHA requires that its facilities operate a Quality, Safety, and Value (QSV) program to monitor the quality of patient care and performance improvement activities. The purpose of the OIG review was to determine whether the Facility implemented and incorporated selected key functions of VHA's Enterprise Framework for QSV into local activities. To assess this area of focus, the OIG evaluated the following: protected peer reviews of clinical care,[41] utilization management (UM) reviews,[42] and patient safety incident reporting with related root cause analyses (RCAs).[43]

VHA has implemented approaches to improving patient safety, including the reporting of patient safety incidents to its National Center of Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required RCAs help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the organization.[44]

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

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

[41] According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff. (Due for recertification June 30, 2015, but has not been updated.)

[42] According to VHA Directive 1117, UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

[43] According to VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011, VHA has implemented approaches to improve patient safety, including the reporting of patient safety incidents to the VHA National Center for Patient Safety, in order for VHA to learn about system vulnerabilities and how to address them as well as the requirement to implement RCA (a widely-used methodology for dealing with safety-related issues) to allow for more accurate and rapid communication throughout an organization of potential and actual causes of harm to patients.

[44] VHA Handbook 1050.01.

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[45]

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Entry of all reported patient incidents into WebSPOT[46]
  - Annual completion of a minimum of eight RCAs[47]
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

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

[46] WebSPOT is the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database.

[47] According to VHA Handbook 1050.01, March 4, 2011, the requirement for a total of eight RCAs and aggregated reviews is a minimum number, as the total number of RCAs 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 RCAs, with the balance being aggregated reviews or additional individual RCAs.

Credentialing and Privileging

VHA has defined procedures for the credentialing and 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 (LIP).[48]

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This systematic process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.[49]

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges need to be specific, based on the individual's clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.[50]

The purpose of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of five LIPs who were hired within 18 months prior to the on-site visit,[51] and five LIPs who were re-privileged within 12 months prior to the visit.[52] The OIG evaluated the following performance indicators:

- Credentialing
  - Current licensure
  - Primary source verification
- Privileging
  - Verification of clinical privileges
  - Requested privileges

[48] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)

[49] VHA Handbook 1100.19.

[50] VHA Handbook 1100.19.

[51] The 18-month period was from September 19, 2016, through March 19, 2018.

[52] The 12-month review period was from March 19, 2017, through March 19, 2018.

    - Facility-specific
    - Service-specific
    - Provider-specific
  - Service chief recommendation of approval for requested privileges
  - Medical Staff Executive Committee decision to recommend requested privileges
  - Approval of privileges for a period of less than, or equal to, two years
- Focused Professional Practice Evaluation (FPPE)
  - Evaluation initiated
    - Timeframe clearly documented
    - Criteria developed
    - Evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee decision to recommend continuing initially granted privileges
- Ongoing Professional Practice Evaluation (OPPE)
  - Determination to continue privileges
    - Criteria specific to the service or section
    - Evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee decision to recommend continuing privileges

Conclusion

The OIG found general compliance with requirements for credentialing and privileging. However, the OIG identified deficiencies with completing required elements for FPPE and OPPEs, which warranted recommendations for improvement.

Focused Professional Practice Evaluation

VHA requires that all LIPs new to the facility have FPPEs completed and documented in the practitioner's profile and reported to an appropriate committee of the Medical Staff. The process involves the evaluation of privilege-specific competence of the practitioner who has not had previously documented evidence of competently performing the requested privileges. Results of the FPPE must be documented in the practitioner's provider profile and reported to the Executive Council of Medical Staff for consideration in making the recommendation on privileges. Evaluation methods may include chart review, direct observation, monitoring of diagnostic and

treatment techniques or discussion with other individuals involved in the care of patients. VHA also requires that FPPEs be time limited and performed by a similarly-trained and privileged provider.[53]

For two of the five completed FPPEs, supporting documentation did not include clearly defined timeframes, results, or evidence of an evaluation by a provider with similar training and privileges. Additionally, the OIG found no evidence in meeting minutes that the Executive Council of Medical Staff evaluated FPPE results in their recommendation for continuing the initially granted privileges for the five LIPs. This resulted in LIPs continuing to deliver care without a thorough evaluation of their practice. Facility managers failed to note the lack of clearly defined timeframes in the FPPE forms, and the Executive Council of Medical Staff was unaware of requirements to evaluate FPPE results and document accordingly in their decisions to recommend continuation of initially granted privileges for LIPs.

Recommendation 1

1. The Chief of Staff ensures clinical managers initiate Focused Professional Practice Evaluations that include clearly defined timeframes and monitors the clinical managers' compliance.

Facility Concurred.

Target date for completion: November 15, 2018

Facility response: The Chief of Staff (COS) is writing a Standard Operating Procedure (SOP) to define the Focused Professional Practice Evaluation (FPPE) process. The SOP will define timeframes for completion and outline criteria for completion of FPPEs. This information will be recorded in the Executive Council of Medical Staff (ECMS) Credentialing meeting minutes with standard verbiage.

Monitor: 100% of FPPEs will be audited monthly to evaluate timeliness, compliance demonstrated when 90% or greater is reached for 3 consecutive months. The results of the review will be reported to Quality, Safety, and Value Leadership Board (QSVLB).

[53] VHA Handbook 1109.19.

Recommendation 2

2. The Chief of Staff ensures Focused Professional Practice Evaluations are completed by providers with similar training and privileges and monitors compliance.

Facility Concurred.

Target date for completion: November 15, 2018

Facility response: The COS is writing an SOP to define the FPPE process. The SOP will define the criteria for selecting providers with similar training and privileges for FPPE completion. The FPPE provider will be recorded in the ECMS Credentialing meeting minutes.

Monitor: 100% of FPPEs will be audited monthly to evaluate appropriate peer selection, compliance demonstrated when 100% is reached for 3 consecutive months. The results of the review will be reported to Quality, Safety, and Value Leadership Board (QSVLB).

Recommendation 3

3. The Chief of Staff ensures that the Executive Council of Medical Staff uses the results of Focused Professional Practice Evaluations in the decision to recommend continuation of initially granted privileges and monitors compliance.

Facility Concurred.

Target date for completion: November 15, 2018

Facility response: The Chief of Staff (COS) is writing a Standard Operating Procedure (SOP) to define the Focused Professional Practice Evaluation (FPPE) process. The SOP will define criteria for continuation of initially granted privileges. If for any reason, the criteria have not been met, the continuation of initial privileges will be declined or modified accordingly. This information will be recorded in the Executive Council of Medical Staff (ECMS) Credentialing meeting minutes with standard verbiage.

Monitor: Facility will provide approved SOP with required elements. Compliance will be recorded in the Executive Council of Medical Staff (ECMS) Credentialing meeting minutes with standard verbiage. Facility will provide ECMS minutes for 3 consecutive months at 100% compliance.

Ongoing Performance Practice Evaluation

VHA requires that at the time of reprivileging, service chiefs consider relevant, service- and practitioner-specific data utilizing defined criteria when recommending the renewal of LIPs' privileges to the Executive Council of Medical Staff. Such data is maintained as part of the practitioner's provider profile and may include direct observation, clinical discussions, and clinical reviews.[54] The OPPE process is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact the quality of care and patient safety.

For three of five provider profiles reviewed, the OIG found no evidence that the determination to continue current privileges was based on the results of OPPE data. As a result, LIPs continued to deliver care without a thorough evaluation of their practice. The Medical Staff Coordinator and service line managers cited staffing changes and inaccurate OPPE guidance from previous senior leaders as the reasons the service chiefs had inconsistent, and often insufficient, methods of maintaining LIPs' profiles.

Recommendation 4

4. The Chief of Staff ensures that clinical managers consistently collect and maintain Ongoing Professional Practice Evaluation data and monitors compliance.

Facility Concurred.

Target date for completion: November 15, 2018

Facility response: The COS is developing an Ongoing Professional Practice Evaluation (OPPE) SOP. The SOP will include criteria for the Associate Chief of Staff or Service Chief to collect and maintain OPPE data or supporting documentation in the provider folders. COS will ensure compliance is met through monthly audits completed by the Medical Staff Office and findings will be reported to ECMS Credentialing Staff.

Monitor: Facility will audit 30 randomized provider folders to assess OPPE's to ensure appropriate data and monitors are collected and documented. Compliance will be demonstrated when a rate of 90% or greater is achieved for 3 consecutive months. The results of the audits will be reported to ECMS Credentialing Staff.

[54] VHA Handbook 1100.19.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC 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.[55]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements.[56] The OIG also determined whether the Facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case with a special emphasis on construction safety[57] and Nutrition and Food Services processes.[58]

VHA requires a safe and healthy worksite for staff, patients, and the general public during construction and renovation-related activities. The implementation of a proactive and comprehensive construction safety program reduces the potential for injury, illness, accidents, or exposures.[59]

The Nutrition and Food Services Program must provide quality meals that meet the regulatory requirements for food safety in accordance with the U.S. Food and Drug Administration's Food Code and VHA's food safety program. Facilities must have a hazard analysis critical control point food safety plan, food services inspections, a food service emergency operations plan, and safe food transportation and storage practices.[60]

In all, the OIG team inspected five inpatient units (medical telemetry, inpatient MH, post-anesthesia care, and The Lodge and River House CLCs.), the Emergency Department, the primary care clinic, the specialty care clinic (shared clinic space for audiology, infectious disease, renal, and wound care), and Nutrition & Food Service. The team also inspected the Eugene CBOC.[61] The OIG reviewed the most recent Infection Prevention Risk Assessment,

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[55] VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

[56] Applicable requirements include various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

[57] VHA Directive 7715, *Safety and Health during Construction*, April 6, 2017.

[58] VHA Handbook 1109.04, *Food Service Management Program*, October 11, 2013.

[59] VHA Directive 7715.

[60] VHA Handbook 1109.04.

[61] Each outpatient site selected for physical inspection was randomized from all primary care CBOCs, multi-specialty CBOCs, and healthcare centers reporting to the parent Facility and was operational and classified as such in VA's Site Tracking Database by August 15, 2017.

Infection Prevention Committee minutes for the past six months, and other relevant documents, and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent Facility
  - EOC rounds
  - EOC deficiency tracking
  - Infection prevention
  - General safety
  - Environmental cleanliness
  - General privacy
  - Women veterans' exam room privacy
  - Availability of medical equipment and supplies
- Community Based Outpatient Clinic
  - General safety
  - Medication safety and security
  - Infection prevention
  - Environmental cleanliness
  - General privacy
  - Exam room privacy
  - Availability of medical equipment and supplies
- Construction Safety[62]
  - Completion of infection control risk assessment for all sites
  - Infection Prevention/Infection Control Committee discussions on construction activities
  - Dust control
  - Safety and security
  - Selected requirements based on project type and class[63]

[62] Construction Safety performance indicators did not apply since the Facility had no applicable construction projects.

- Nutrition and Food Services
  - Hazard Analysis Critical Control Point Food Safety System plan
  - Food Services inspections
  - Emergency operations plan for food service
  - Safe transportation of prepared food
  - Environmental safety
  - Infection prevention
  - Storage areas

Conclusion

General safety, infection prevention, and privacy measures were in place at the Facility. The representative CBOC met the performance indicators evaluated. However, the OIG noted concerns with the availability of supplies, as described under Leadership and Organizational Risks on page 13 of this report. The OIG also identified deficiencies in Food and Nutrition Services with the storage of cleaning supplies in the food preparation area which warranted a recommendation for improvement.

Nutrition & Food Service: Environmental Safety

VHA requires that chemicals must be stored separately from food items. Poisonous and toxic materials such as cleaning solutions must be stored in secured locked areas and/or cabinets.[64] Failure to properly store toxic materials increases the threat of accidental exposure to chemicals and places patients, visitors, and staff at risk. The OIG noted that cleaning chemicals were stored in an open food preparation area of Nutrition & Food Service. Facility staff believed that cleaning solutions used daily were exempt from this requirement.

Recommendation 5

5. The Associate Director ensures Nutrition & Food Service staff store cleaning solutions separately from food items and monitors compliance.

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[63] VA Master Construction Specifications, Section 01-35-26, Sub-Section 1.12. The Type assigned to construction work ranges from Type A (non-invasive activities) to Type D (major demolition and construction). Type C construction involves work that generates a moderate to high level of dust or requires demolition or removal of any fixed building components or assemblies. The Class assigned to construction work ranges from Class I (low-risk groups affected) to Class IV (highest risk groups affected). Class III construction projects affect patients in high-risk areas such as the Emergency Department, inpatient medical and surgical units, and the pharmacy.

[64] VHA Handbook 1109.04.

Facility concurred.

Target date for completion: Completed

Facility response: At the time of the OIG Review, the cleaning solutions were immediately removed from the area containing food items. Following the OIG exit, the Chief of Nutrition and Food Service educated staff on the importance of cleaning solutions being stored away from areas with food items. A new process was developed and put into place as of April 1, 2018. The cleaning solutions are now stored in a closet separate from the food items. The staff has conducted monthly sanitation inspections using the National NFS Standardized Inspection Forms and there have been no further instances of cleaning solutions being stored in the food preparation area. Please see attached redacted inspection forms for April, May, and June 2018.

Monitor: Monitored results of National NFS Standardized Inspections, conducted by different inspectors, for evidence of cleaning solution storage in food areas.

Audits completed:

04/17/2018

No chemical sprays used around food, Chemicals are separate from foods during delivery and storage

05/21/2018

No chemical sprays used around food, Chemicals are separate from foods during delivery and storage

06/11/2018

No chemical sprays used around food, Chemicals are separate from foods during delivery and storage

The facility requests closure of this recommendation. The OIG considers this recommendation closed based on information and reports provided.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.[65] Diversion by healthcare workers—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—remains a serious problem that can increase serious patient safety issues, causes harm to the diverter, and elevates the liability risk to healthcare organizations.[66]

VHA requires that facility managers implement and maintain a CS inspection program to minimize the risk for loss and diversion and to enhance patient safety.[67] Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSI), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.

The OIG review of these issues was conducted to determine whether the Facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.[68] The OIG interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[69] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[70] CS inspection quarterly trend reports for the prior four quarters;[71] and other relevant documents. The OIG evaluated the following performance indicators:

- CSC reports
  - Monthly summary of findings to the Director
  - Quarterly trend report to the Director
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Annual physical security survey of the pharmacy/pharmacies by VA Police

[65] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (Website accessed on August 21, 2017.)

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

[67] VHA Directive 1108.02(01), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

[68] VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

[69] The review period was July 1, 2017, through December 31, 2017.

[70] The review period was January 1, 2017, through December 31, 2017.

[71] The four quarters were from January 1, 2017, through December 31, 2017.

  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transition
  - Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from conflicts of interest
  - Appointed in writing by the Director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSIs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated
  - Security and documentation of drugs held for destruction[72]

[72] The "Destructions File Holding Report" lists all drugs awaiting local destruction or turn-over to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

- Accountability for all prescription pads in pharmacy
- Verification of hard copy outpatient pharmacy CS prescriptions
- Verification of 72-hour inventories of the main vault
- Quarterly inspections of emergency drugs
- Monthly CSI checks of locks and verification of lock numbers

Conclusion

The OIG found general compliance with requirements for most of the performance indicators evaluated, including CSC reports, ordering procedures, and the CSC and CSIs having no conflicts of interest and completing required training. However, the OIG identified deficiencies in CS area inspections that warranted recommendations for improvement.

Controlled Substances Area Inspections: Monthly Inspections

VHA requires CSIs to conduct monthly inspections of CS storage areas and for CSCs to refrain from conducting these routine inspections.[73] This allows the CSCs to focus on program oversight responsibilities. The OIG noted that in four of the six months of CS inspections reviewed, an alternate CSC conducted monthly inspections in six of the 10 CS areas selected for review.[74] When CSCs conduct frequent monthly inspections, program oversight may be compromised. The CSCs were unaware that the alternate CSC was also required to refrain from conducting routine inspections. Facility managers stated that the alternate CSC routinely conducted monthly inspections due to an insufficient number of CSIs.

Recommendation 6

6. The Interim Director ensures that controlled substances inspectors complete routine monthly controlled substance inspections and that controlled substances coordinators refrain from conducting routine inspections and monitors compliance.

[73] VHA Directive 1108.02(01).

[74] Pain clinic, emergency department, radiology, progressive care unit, short stay, and gastroenterology.

Facility concurred.

Target date for completion: Completed.

Facility response: The Controlled Substance Coordinator (CSC), including alternates were removed from the monthly rotation of inspections as of April 1, 2018 and will not be added back into the rotation.

The CSC will only perform a Controlled Substance Inspection if the circumstances fall within the approved circumstances noted in VHA Directive 1108.02(1) Inspection of Controlled Substances, November 28, 2016. Since the OIG visit in March 2018, the CSC (or alternate CSC) has participated in 2 area CS Inspections. As per VHA Directive 1108.02(1), page 8, this has only occurred within the approved parameters of: training new inspectors, validating competency… or in cases of unplanned leave, illness or other emergency to ensure the completion of all monthly inspections. The CSC may also complete an inspection when there is a trend with findings in an area.

All required monthly Controlled Substance Inspection (CSI) reports will include the approved reason for any CSC completions.

Monitor: Facility will submit CSI inspection log for the months of April, May, June, and July demonstrating evidence that the CSC did not participate in inspections 95% of the time for 3 consecutive months. For circumstances approved by VHA Directive 1108.02, facility's CSC will document in the monthly CSI report as to why she conducted the inspection.

April Log 2018:

25/25=100% with no CSC conducting inspections

May Log 2018:

24/25 = 96% with no CSC conducting inspections. Please see May CSI report for reason.

June Log 2018:

25/25 = 100% with no CSC conducting inspections

The facility requests closure of this recommendation. The OIG considers this recommendation closed based on information and reports provided.

Controlled Substances Area Inspections: Reconciliation of Return of Stock for One Random Day

VHA requires CS program staff to reconcile the distribution (restocking/refilling) of CS to every automated dispensing cabinet and one random day's return of expired or overstock of CS to

pharmacy.[75] The reconciliation provides the opportunity to identify potential drug diversion activities and any discrepancies with refilling or returning CS.

The OIG noted that CS program staff did not conduct reconciliations of the returns to pharmacy stock in any of the 10 CS areas for the six months of inspection reports reviewed. Failure to complete required inspections of CS areas may cause delays in identifying any potential drug diversion activities. The CSCs were aware of the requirement but did not have access to the pharmacy reports required for reconciliation. Approximately five months prior to the OIG onsite review, the previous CSC identified and discussed the requirement with pharmacy managers. The Chief of Pharmacy acknowledged the alert but failed to follow up on the identified noncompliance.

Recommendation 7

7. The Interim Director ensures that reconciliation of controlled substance returns to pharmacy stock is performed during controlled substance inspections and monitors compliance.

Facility concurred.

Target date for completion: November 15, 2018

Facility Response: CSC ensures the reconciliation of controlled substances returns to pharmacy stock is performed during controlled substance inspection. The results of the pharmacy stock reconciliation will be included in the Controlled Substance report provided to Quality, Safety, and Value Leadership Board.

Monitor: Facility will submit the CSI monthly reports to the OIG for 3 consecutive months (July, August and September) report at 100% for 3 consecutive months with reconciliation of controlled substance return to pharmacy stock results.

[75] VHA Directive 1108.02(01).

Mental Health Care: Posttraumatic Stress Disorder Care

Posttraumatic Stress Disorder (PTSD) may occur "following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury, or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."[76] For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. Non-war zone military experiences, such as the crash of a military aircraft, may also contribute to the development of PTSD.[77]

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed.[78] VHA requires that

1. PTSD screening is performed for every new patient and then is repeated every year for the first five years post-separation and every five years thereafter, unless there is a clinical need to re-screen earlier;
2. If the patient's PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.[79]

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 49 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Completion of suicide risk assessment by acceptable provider within required timeframe
- Offer to patient of further diagnostic evaluation

[76] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (rescinded November 16, 2017).

[77] VHA Handbook 1160.03.

[78] A PTSD screen is not required if the patient received a PTSD diagnosis in outpatient setting in the past year; has a life expectancy of 6 months or less; has severe cognitive impairment, including dementia; is enrolled in a VHA or community-based hospice program; or has a diagnosis of cancer of the liver, pancreas, or esophagus.

[79] Department of Veterans Affairs, Information Bulletin, *Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 6, 2015.

- Referral for diagnostic evaluation
- Completion of diagnostic evaluation within required timeframe

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.[80] As a group, veterans experience more chronic disease and disability than their non-veteran peers. VA must plan for the growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.[81] Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.[82]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[83] This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. The healthcare team would then manage the patient with treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.[84] Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.[85]

In determining whether the Facility provided an effective geriatric evaluation, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the EHRs of 42 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Provision of or access to GE
- Program oversight and evaluation
  - Evidence of GE program evaluation
  - Evidence of performance improvement activities through leadership board
- Provision of clinical care
  - Medical evaluation by GE provider

[80] VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

[81] VHA Directive 1140.04.

[82] Chad Boult, Lisa B. Boult, Lynne Morishita, Bryan Dowd, Robert L. Kane, and Cristina F. Urdangarin, "A randomized clinical trial of outpatient geriatric evaluation and management," *Journal of the American Geriatrics Society* 49, no. 4 (April 2001): 351–359.

[83] Public Law 106-117.

[84] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

[85] VHA Directive 1140.04.

  - Assessment by GE nurse
  - Comprehensive psychosocial assessment by GE social worker
  - Patient or family education
  - Plan of care based on GE
- Geriatric management
  - Implementation of interventions noted in plan of care

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.[86] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veterans Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.[87] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services, including mammography services to eligible women veterans.[88]

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Communication with patients must be documented.[89]

The OIG examined whether the Facility complied with selected VHA requirements for the reporting of mammography results by reviewing relevant documents and interviewing selected employees and managers. The OIG also reviewed the EHRs of 45 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Electronic linking of mammogram results to radiology order
- Scanning of hard copy mammography reports, if outsourced
- Inclusion of required components in mammography reports
- Communication of results and any recommended course of action to ordering provider
- Communication of results and any recommended course of action to patient

[86] U.S. Breast Cancer Statistics. http://www.BreastCancer.org. (Website accessed on May 18, 2017.)

[87] Veterans Health Care Amendments of 1983, Pub. L. 98-160 (1983).

[88] Veterans Health Care Act of 1992, Title I, Pub. L. 102-585 (1992).

[89] VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017, and further amended July 24, 2018); VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011, which was rescinded and replaced by VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018.

- Performance of follow-up mammogram if indicated
- Performance of follow-up study[90]

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

[90] This performance indicator did not apply to this Facility.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Seven OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Interim Director, Chief of Staff, and Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• Clinical Managers initiate FPPEs that include clearly defined timeframes. • FPPEs are completed by providers with similar training and privileges. • The Executive Council of Medical Staff uses the results of Focused Professional Practice Evaluations in the decision to recommend continuation of initially granted privileges. • Clinical managers consistently collect and maintain OPPE data.	• None

Environment of Care	• Parent Facility
	  ○ EOC rounds and deficiency tracking
	  ○ Infection prevention
	  ○ General safety
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• CBOC
	  ○ General safety
	  ○ Medication safety and security
	  ○ Infection prevention
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
		• None	• Nutrition & Food Service staff store cleaning solutions separately from food items.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

	• Nutrition and Food Services
	  ○ Hazard Analysis Critical Control Point Food Safety System plan
	  ○ Food Services inspections
	  ○ Safe transportation of prepared food
	  ○ Environmental safety
	  ○ Infection prevention
	  ○ Storage areas		

Medication Management	• CSC reports • Pharmacy operations • Annual physical security survey • CS ordering processes • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections	• None	• CSIs complete routine monthly CS inspections and CSCs refrain from conducting routine inspections. • Reconciliation of CS returns to pharmacy stock is performed during CS inspections.
Mental Health Care: Posttraumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• None	• None
Long-Term Care: Geriatric Evaluations	• Provision of or access to GE • Program oversight and evaluation • Provision of clinical care • Geriatric management	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Mammography Results and Follow-Up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• None	• None

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low-complexity (3)[91] affiliated[92] Facility reporting to VISN 20.

Table 6. Facility Profile for Roseburg VA Health Care System, Roseburg (653) (October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[93]	Facility Data FY 2016[94]	Facility Data FY 2017[95]
Total Medical Care Budget in Millions	$201.6	$212.2	$224.7
Number of:			
• Unique Patients	28,009	29,619	28,950
• Outpatient Visits	300,424	338,539	344,212
• Unique Employees[96]	830	943	935
Type and Number of Operating Beds:			
• Community Living Center	50	50	50
• Domiciliary	30	30	22
• Medicine	12	12	12
• Mental Health	22	14	10
Average Daily Census:			
• Community Living Center	39	44	45
• Domiciliary	10	13	12
• Medicine	8	6	5
• Mental Health	8	8	7

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.

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

[92] Associated with a medical residency program.

[93] October 1, 2014, through September 30, 2015.

[94] October 1, 2015, through September 30, 2016.

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

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

VA Outpatient Clinic Profiles[97]

The VA outpatient clinics in communities within the catchment area of the Facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 7 provides information relative to each of the clinics.

Table 7. VA Outpatient Clinic Workload/Encounters[98] and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[99] Provided	Diagnostic Services[100] Provided	Ancillary Services[101] Provided
Eugene, OR	653BY	30,514	14,051	Cardiology Dermatology Endocrinology Gastroenterology Neurology Pulmonary/ Respiratory Disease Poly-Trauma Anesthesia Eye Orthopedics Podiatry Urology	Laboratory & Pathology Radiology	Nutrition Pharmacy Prosthetics Social Work Weight Management Dental

[97] Includes all outpatient clinics in the community that were in operation as of August 15, 2017.

[98] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

[99] Specialty care services refer to non-PC and non-MH services provided by a physician.

[100] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

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

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[99] Provided	Diagnostic Services[100] Provided	Ancillary Services[101] Provided
North Bend, OR	653GA	7,449	2,905	Cardiology Dermatology Endocrinology	EKG	Pharmacy Weight Management
Brookings, OR	653GB	3,916	1,236	Cardiology Dermatology Endocrinology	n/a	Pharmacy Weight Management

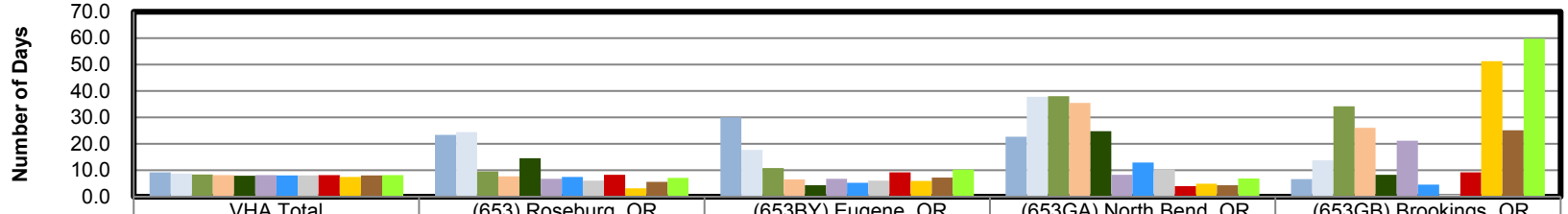
Source: VHA Support Service Center and VA Corporate Data Warehouse

Note: The OIG did not assess Eugene, OR VA Clinic (653QA) data for accuracy or completeness.

n/a – not applicable

Appendix C: Patient Aligned Care Team Compass Metrics[102]

Quarterly New PC Patient Average Wait Time in Days



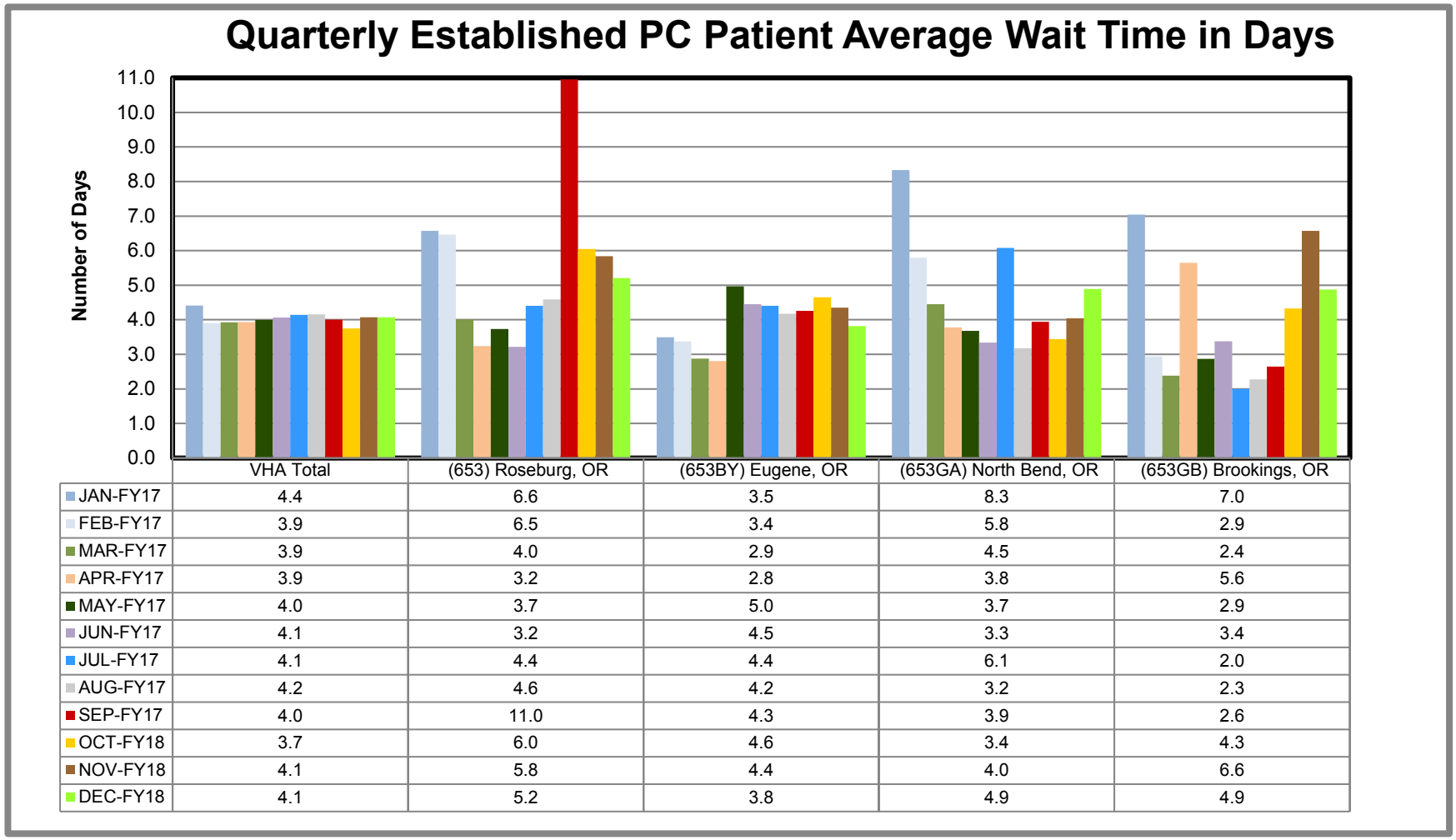
	VHA Total	(653) Roseburg, OR	(653BY) Eugene, OR	(653GA) North Bend, OR	(653GB) Brookings, OR
JAN-FY17	9.2	23.4	30.0	22.7	6.7
FEB-FY17	8.7	24.4	17.7	37.8	13.8
MAR-FY17	8.4	9.5	10.9	38.1	34.2
APR-FY17	8.2	7.7	6.6	35.5	26.1
MAY-FY17	7.9	14.6	4.4	24.9	8.3
JUN-FY17	8.2	6.8	6.8	8.3	21.2
JUL-FY17	8.0	7.5	5.3	13.0	4.6
AUG-FY17	8.1	6.0	6.1	10.4	1.0
SEP-FY17	8.2	8.3	9.2	4.0	9.3
OCT-FY18	7.5	3.2	6.0	5.0	51.3
NOV-FY18	8.0	5.6	7.2	4.3	25.2
DEC-FY18	8.1	7.1	10.3	6.9	59.7

Source: VHA Support Service Center

Note: The OIG did not assess Eugene, OR, CBOC (653QA) data for accuracy or completeness. The OIG has on file the Facility's explanation for the increased wait times for the Brookings, OR, CBOC.

Data Definition: The average number of calendar days between a new patient's PC 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 FY 2015, this metric was calculated using the earliest possible create date.

[102] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.

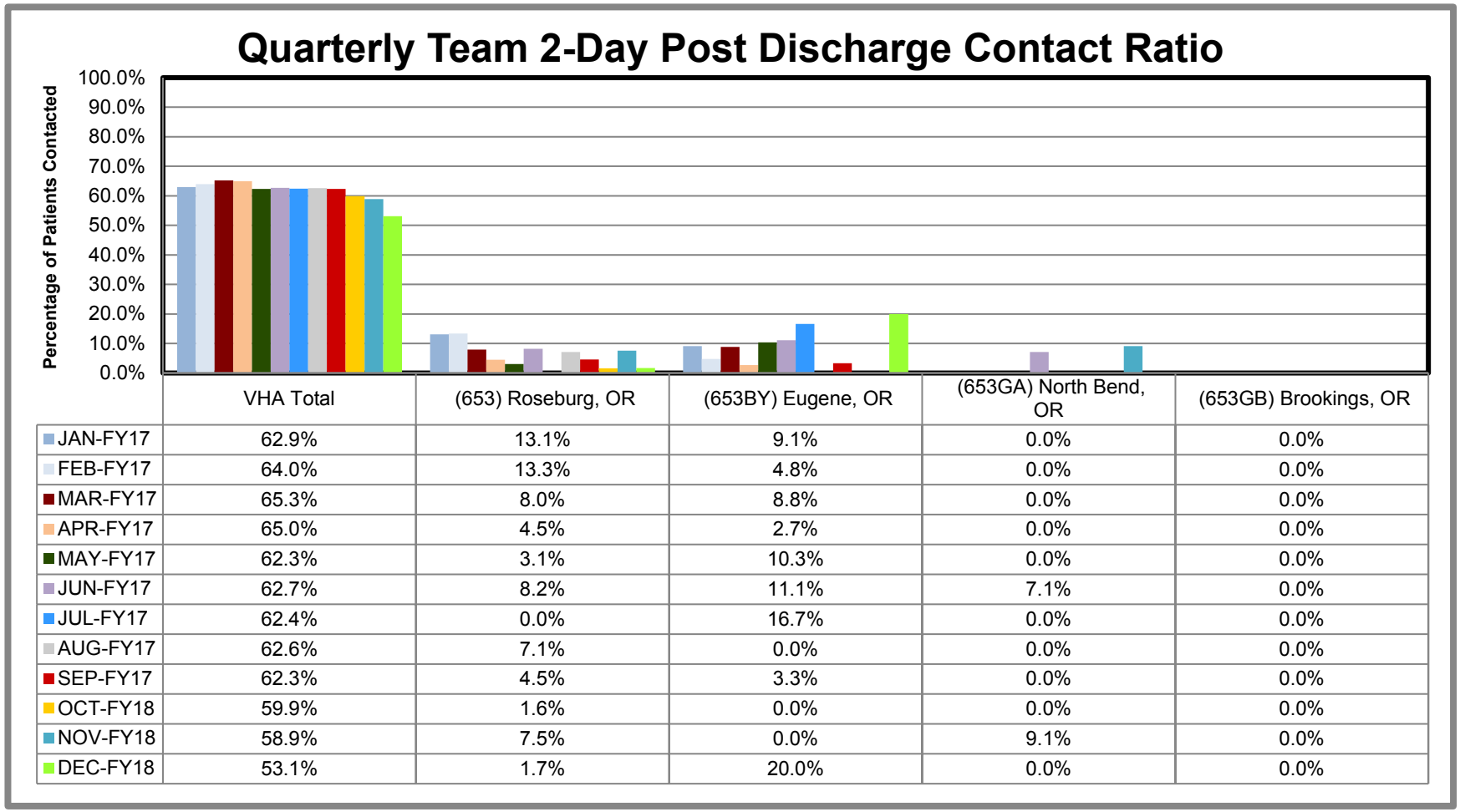


	VHA Total	(653) Roseburg, OR	(653BY) Eugene, OR	(653GA) North Bend, OR	(653GB) Brookings, OR
JAN-FY17	4.4	6.6	3.5	8.3	7.0
FEB-FY17	3.9	6.5	3.4	5.8	2.9
MAR-FY17	3.9	4.0	2.9	4.5	2.4
APR-FY17	3.9	3.2	2.8	3.8	5.6
MAY-FY17	4.0	3.7	5.0	3.7	2.9
JUN-FY17	4.1	3.2	4.5	3.3	3.4
JUL-FY17	4.1	4.4	4.4	6.1	2.0
AUG-FY17	4.2	4.6	4.2	3.2	2.3
SEP-FY17	4.0	11.0	4.3	3.9	2.6
OCT-FY18	3.7	6.0	4.6	3.4	4.3
NOV-FY18	4.1	5.8	4.4	4.0	6.6
DEC-FY18	4.1	5.2	3.8	4.9	4.9

Source: VHA Support Service Center

Note: The OIG did not assess Eugene, OR VA Clinic (653QA) data for accuracy or completeness.

Data Definition: *The average number of calendar days between an established patient's PC 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.*

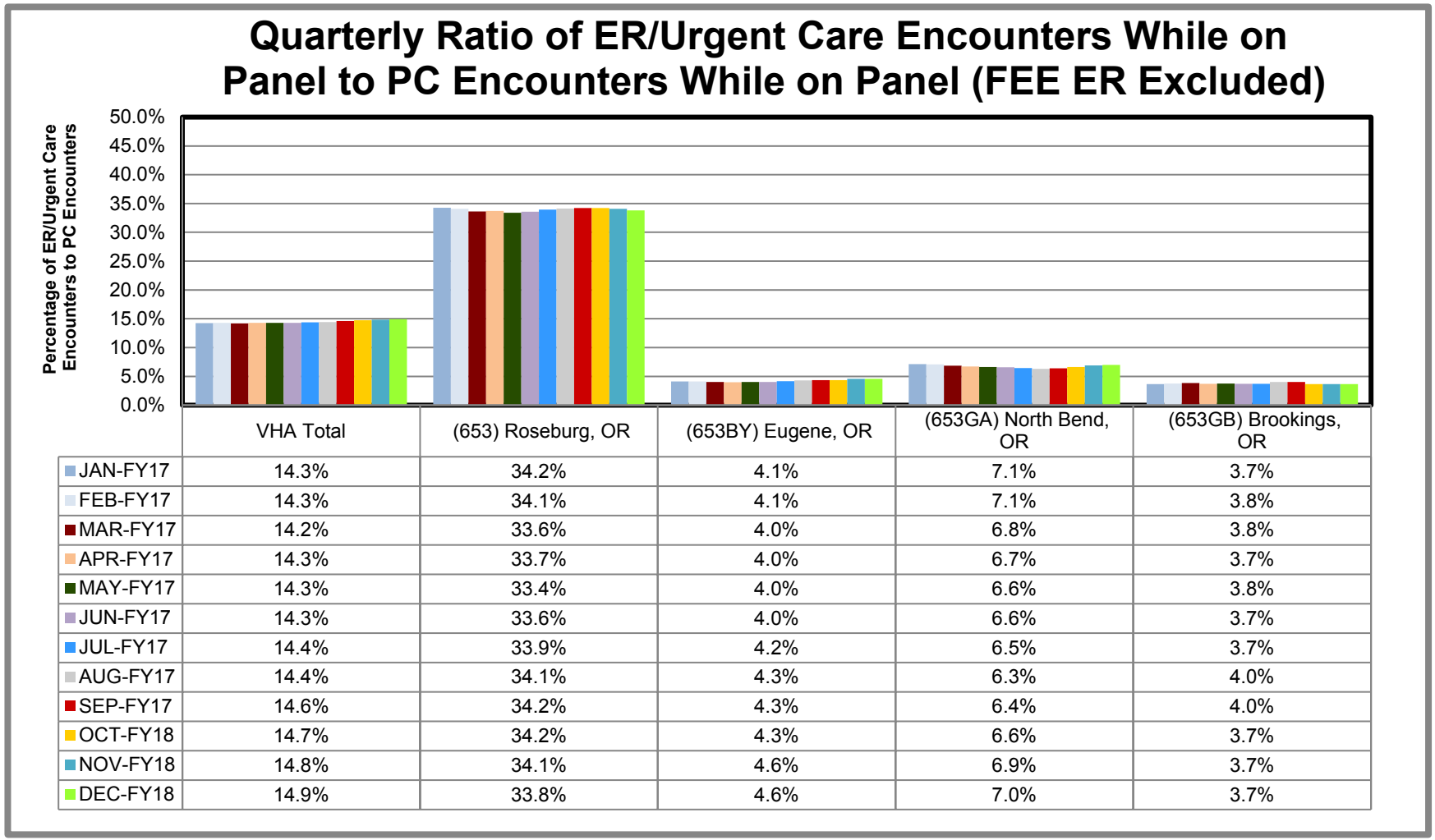


	VHA Total	(653) Roseburg, OR	(653BY) Eugene, OR	(653GA) North Bend, OR	(653GB) Brookings, OR
JAN-FY17	62.9%	13.1%	9.1%	0.0%	0.0%
FEB-FY17	64.0%	13.3%	4.8%	0.0%	0.0%
MAR-FY17	65.3%	8.0%	8.8%	0.0%	0.0%
APR-FY17	65.0%	4.5%	2.7%	0.0%	0.0%
MAY-FY17	62.3%	3.1%	10.3%	0.0%	0.0%
JUN-FY17	62.7%	8.2%	11.1%	7.1%	0.0%
JUL-FY17	62.4%	0.0%	16.7%	0.0%	0.0%
AUG-FY17	62.6%	7.1%	0.0%	0.0%	0.0%
SEP-FY17	62.3%	4.5%	3.3%	0.0%	0.0%
OCT-FY18	59.9%	1.6%	0.0%	0.0%	0.0%
NOV-FY18	58.9%	7.5%	0.0%	9.1%	0.0%
DEC-FY18	53.1%	1.7%	20.0%	0.0%	0.0%

Source: VHA Support Service Center

Note: The OIG did not assess Eugene, OR VA Clinic (653QA) data for accuracy or completeness.

Data Definition: *The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17."*



	VHA Total	(653) Roseburg, OR	(653BY) Eugene, OR	(653GA) North Bend, OR	(653GB) Brookings, OR
JAN-FY17	14.3%	34.2%	4.1%	7.1%	3.7%
FEB-FY17	14.3%	34.1%	4.1%	7.1%	3.8%
MAR-FY17	14.2%	33.6%	4.0%	6.8%	3.8%
APR-FY17	14.3%	33.7%	4.0%	6.7%	3.7%
MAY-FY17	14.3%	33.4%	4.0%	6.6%	3.8%
JUN-FY17	14.3%	33.6%	4.0%	6.6%	3.7%
JUL-FY17	14.4%	33.9%	4.2%	6.5%	3.7%
AUG-FY17	14.4%	34.1%	4.3%	6.3%	4.0%
SEP-FY17	14.6%	34.2%	4.3%	6.4%	4.0%
OCT-FY18	14.7%	34.2%	4.3%	6.6%	3.7%
NOV-FY18	14.8%	34.1%	4.6%	6.9%	3.7%
DEC-FY18	14.9%	33.8%	4.6%	7.0%	3.7%

Source: VHA Support Service Center

Note: The OIG did not assess Eugene, OR VA Clinic (653QA) data for accuracy or completeness.

Data Definition: *This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a LIP divided by the number of PC Team Encounters WOT with an LIP* ***plus*** *the total number of VHA ER/Urgent Care Encounters WOT with an LIP.*

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[103]

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	% 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 Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Capacity	Physician Capacity	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
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont Stay Reviews Met	% 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
Efficiency/Capacity	Efficiency and Physician Capacity	A higher value is better than a lower value

[103] VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: February 14, 2018.

Measure	Definition	Desired Direction
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Healthcare associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower 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 Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	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
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Rating Hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value

Measure	Definition	Desired Direction
SC Survey Access	Timely Appointment, care and information (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (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
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress Discussed	Stress Discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 31, 2018

From: Director, Northwest Network (10N20)

Subj: CHIP Review of the Roseburg VA Health Care System, OR

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to provide a status report on follow-up to the findings from the Comprehensive Healthcare Inspection Program (CHIP) Review of the Roseburg VA Health Care System, Roseburg, OR.

2. Attached please find the facility concurrence and response to the findings from the review.

3. I concur with the findings, recommendations, and submitted action plans.

(Original signed by:)

John A. Mendoza, Deputy Network Director
For
Michael J. Murphy

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix F: Interim Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 23, 2018

From: Interim Director, Roseburg VA Health Care System (653/00)

Subj: CHIP Review of the Roseburg VA Health Care System, OR

To: Director, Northwest Network (10N20)

1. On behalf of the VA Roseburg Healthcare System, Roseburg, Oregon, I would like to provide our response from the finding of the: Comprehensive Healthcare Inspection Program (CHIP) Review of the Roseburg VA Healthcare System, Roseburg, OR.
2. Attached is our response. I concur with the findings, recommendations, and action plans being submitted.
3. Please feel free to contact us if you have any concerns or questions regarding the information included in our responses.

(Original signed by:)

David L. Whitmer, FACHE
Interim Director

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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