DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Focused Performance Review of Select Metrics at the Ioannis A. Lougaris VA Medical Center in Reno, Nevada

HEALTHCARE INSPECTION | REPORT # 19-09486-204 | JULY 30, 2020

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Executive Summary

The VA Office of Inspector General (OIG) conducted a review at the Ioannis A. Lougaris VA Medical Center (facility) in Reno, Nevada. This review, unlike previous OIG healthcare reviews, proactively identified and evaluated declining performance metrics that could significantly affect quality of care and patient safety. The OIG selected the facility because, according to Strategic Analytics for Improvement and Learning (SAIL) data, the facility's quality performance had declined from a 4-star to a low 2-star quality rating (within one place ranking of a 1-star) over 12 months.[1] Further, OIG analysis revealed that, as of June 30, 2019, the facility's performance ranking declined more place rankings, and faster, than other Veterans Health Administration (VHA) facilities during the same period.

In exploring the reasons for the substantive decline in the quality rating over 12 months, the OIG considered those measures that had the most decline over the same period and represented the most (weighted) impact or opportunity for improvement. In addition to leaders' awareness of, and response to, negative performance trending, the review examined the facility's performance in six quality measure domains—Access, Performance Measures, Mental Health, Emergency Department Throughput, Patient Experience, and Employee Satisfaction.

The OIG did not find evidence of large-scale system or process deficits such as a dysfunctional organizational or communication structure. From a broad perspective, the OIG identified two conditions that possibly established the basis for the facility's significant performance measure decline from October 1, 2017 (quarter 1, fiscal year 2018), through September 30, 2019 (quarter 4, fiscal year 2019).[2] First, some leaders and managers acknowledged losing focus on some care processes as their attention was diverted to new or priority initiatives. The second condition—that the facility lacked consistently effective structures and processes for oversight, communication, and follow up of performance measures and related activities—meant that the loss of focus and subsequent decline in some measures was not identified timely.

In relation to the six quality domains, the OIG found staffing and pay issues, as well as inefficient processes, that may have contributed to some of the selected performance measure declines:

[1] VHA's Office of Reporting, Analytics, Performance Improvement, and Deployment (RAPID) of the Office of Organizational Excellence uses the SAIL model to understand a facility's performance in relation to nine quality domains and one efficiency and capacity domain. For most of the period covered by the OIG's review, SAIL used a star-rating system where facilities with a "5-star" rating were performing within the top 10 percent and "1-star" facilities were performing within the bottom 10 percent of VHA facilities. Facilities in the next bottom and top 20 percent of the distribution were assigned 2- and 4-star ratings, respectively. VHA SAIL metrics and methods changed as of July 1, 2019. SAIL no longer uses the star-rating system to compare facilities.

[2] In this report, the OIG uses fiscal year rather than calendar year as SAIL references performance measure data by quarter and fiscal year.

- Primary and specialty care appointments for new patients were scheduled timely; however, timeliness of mental health appointments, as well as patients' perceptions of access to primary and specialty care, needed improvement. For the period of quarter 3, fiscal year 2017 through quarter 3, fiscal year 2019, the OIG found the facility was able to schedule primary and specialty care appointments for new patients within 30 days, more often than the VHA national average. During the same time, the facility's ability to schedule mental health appointments for new patients within 30 days fell below VHA's national average.
- The facility performed well in outpatient-related measures, but performance in selected inpatient measures fell below expectations and corrective actions were slow to take shape. In fiscal year 2017, the facility outperformed the VHA average in the inpatient measures; however, facility performance dropped below the national average during quarter 1, fiscal year 2019. During the same period, national VHA performance remained the same or improved.
- The facility underperformed in the mental health domain for several years, and while modest progress had recently been made, ongoing management attention was needed to ensure continued improvements. The facility's performance on the population coverage and continuity of care composite measures had generally fallen below the national average from the end of fiscal year 2017 through fiscal year 2019.
- Several Emergency Department timeliness measures were met; however, staffing and process deficits contributed to admission delays. The facility exceeded VHA's target of less than 90 minutes but no greater than 150 minutes for admission times.
- The facility underperformed in multiple patient experience survey areas, the results of which were central to several findings in this report. Primary care provider ratings began trending downward starting in quarter 4, fiscal year 2018 as compared to the VHA national average. Specialty care provider ratings did not reflect evidence of a trend; however, variability from quarter to quarter beginning in quarter 3, fiscal year 2018 was considerable.
- Scores in the Best Places to Work measure were similar to or better than the VHA average in FYs 2018 and 2019; however, registered nurse turnover rates for the same period, coupled with nursing interviews and surveys, reflected some dissatisfaction.

Because a goal of this review was to identify lessons learned, the OIG asked facility leaders about achievements or unique programs. The OIG learned about two of the facility's initiatives focused on improving the lives of community living center patients involving virtual reality pain management and robotic pet therapy in dementia care.

This review assisted the OIG to understand underlying issues and processes that may contribute to significant performance deficits, which will, in turn, permit the OIG to further develop and

refine tools to provide a more effective and proactive approach to many of our oversight products.

The OIG made one recommendation for the Facility Director to ensure that mechanisms to report and follow up on performance deficits were well-defined and disseminated to staff, and that monitors were in place to confirm functionality.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendation and provided acceptable actions plans (see appendixes E and F). The OIG will follow up on the recently implemented and planned actions until they are completed and sustained.

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Abbreviations

AES	All Employee Survey
COS	Chief of Staff
EHR	electronic health record
EPRP	External Peer Review Program
FY	fiscal year
HEDIS	Healthcare Effectiveness Data and Information Set
OIG	Office of Inspector General
PCMH	patient-centered medical home
Q	quarter
QEC	Quality Executive Council
QSVELB	Quality, Safety, and Value Executive Leadership Board
RAPID	Reporting, Analytics, Performance Improvement, and Deployment
SAIL	Strategic Analytics for Improvement and Learning
SHEP	Survey of Healthcare Experience of Patients
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a review at the Ioannis A. Lougaris VA Medical Center (facility) in Reno, Nevada. The review, unlike previous OIG healthcare reviews, proactively identified and evaluated declining performance metrics that could significantly affect quality of care and patient safety. The goals of this review were to

- Evaluate conditions "on the ground" to better understand whether declining metrics in a particular VHA facility are an aberration, are explainable by other factors, or are indicative of larger system or process defects;
- Highlight the facility's improvement opportunities before an adverse patient outcome, an increase in the number of employees leaving, or other negative event occurs; and
- Identify common conditions, patterns, and trends such that other VHA facilities can learn from their peers' experiences and proactively address areas of concern, if any.[3]

Facility Profile

The facility is a level 1c hospital and part of Veterans Integrated Service Network (VISN) 21.[4] The facility, with 64 hospital beds and 60 community living center beds, offers a full range of inpatient and outpatient services in medicine, surgery, primary care, mental health, and geriatrics and extended care. The facility and six community-based outpatient clinics comprise the VA Sierra Nevada Health Care System, which serves veterans residing in 20 counties in northern Nevada and northeastern California. Table 1 includes budget, workload, and clinical staffing data for October 1, 2016 (quarter (Q) 1, fiscal year (FY) 2017), through September 30, 2019 (Q4 FY 2019).

[3] The OIG acknowledges that VHA facilities with dramatically improved metrics also present opportunities for lessons learned.

[4] The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and Level 3 facilities are the least complex. VHA Office of Productivity, Efficiency and Staffing. http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (The website was accessed on May 23, 2019, and is an internal VA website not publicly accessible.)

Table 1. Facility Profile, October 1, 2016, through September 30, 2019

Profile Element	FY 2017[5]	FY 2018[6]	FY 2019[7]
Total medical care budget dollars	$286,875,154	$305,976,892	$333,767,239
Number of			
• Unique patients	32,810	32,813	33,304
• Outpatient visits	421,858	457,674	460,823
• Unique employees*	1,296	1,296	1,372

Source: VHA Support Service Center, February 24, 2020
**Unique employees involved in direct medical care (cost center 8200)*

Performance Measurement

VHA's Office of Reporting, Analytics, Performance Improvement, and Deployment (RAPID) of the Office of Organizational Excellence uses the Strategic Analytics for Improvement and Learning (SAIL) model to understand a facility's performance in relation to nine quality domains and one efficiency and capacity domain.[8] Each domain is a composite of several measures and the resulting scores permit comparison of facilities within a VISN or across VHA. The model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Although SAIL has noted limitations, the data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[9]

For most of the period covered by the OIG's review, SAIL used a star-rating system where facilities with a "5-star" rating were performing within the top 10 percent and "1-star" facilities were performing within the bottom 10 percent of VHA facilities. Facilities in the next bottom and top 20 percent of the distribution were assigned 2- and 4-star ratings, respectively. The remaining 40 percent of facilities were assigned 3-star ratings. Figure 1 describes the distribution of facilities by star rating.[10] VHA discontinued the star-rating system as of July 1, 2019.[11]

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

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

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

[8] VHA program offices are responsible for the collection, validation, and modeling of data for established quality, efficiency, and access metrics that are used for SAIL model calculations.

[9] VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, and is an internal VA website not publicly accessible.)

[10] Until recently, a total of 130 facilities that provided acute care were included in the SAIL model (one has been removed for a current total of 129) as well as 16 non-acute care facilities. Ratings for the non-acute facilities are based on the distribution formed by the acute care facilities.

[11] VHA SAIL metrics and methods also changed as of July 1, 2019.

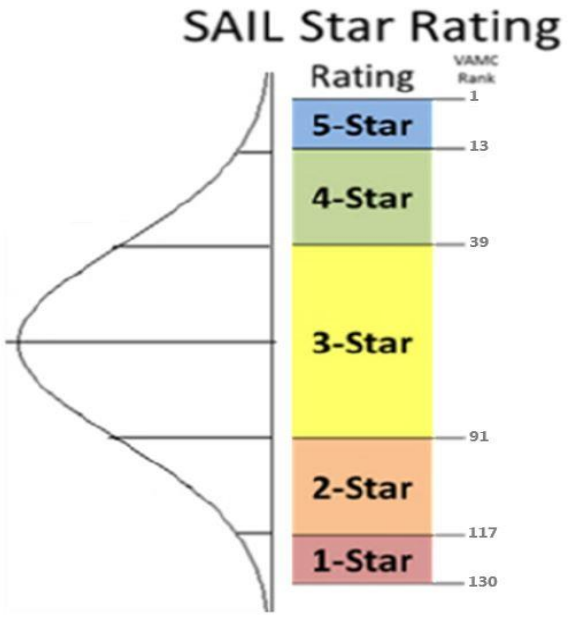

Figure 1. SAIL Star Rating distribution (Q3 FY 2019)
Source: VA Office of Reporting, Analytics, Performance Improvement, and Deployment

SAIL offers a variety of tools and reports to assist facilities in identifying lower-performing areas and opportunities for improvement. While not required, VHA facilities often employ SAIL coordinators or utilize SAIL committees to monitor performance and initiate improvement actions when needed. This facility did not have a SAIL coordinator or committee; rather, it used a combination of other committees and methods for performance improvement purposes.

Why the OIG Performed this Review

According to SAIL data, the facility's quality performance had declined from a 4-star rating to a low 2-star rating (within one place ranking of a 1-star) over 12 months. Additional OIG analysis revealed that, as of June 30, 2019 (Q3 FY 2019), the facility's performance ranking declined more place rankings, and faster, than other VHA facilities during the same period.

Figure 2 reflects the facility's SAIL star ratings, by quarter, from October 1, 2016 (Q1 FY 2017), through June 30, 2019 (Q3 FY 2019).

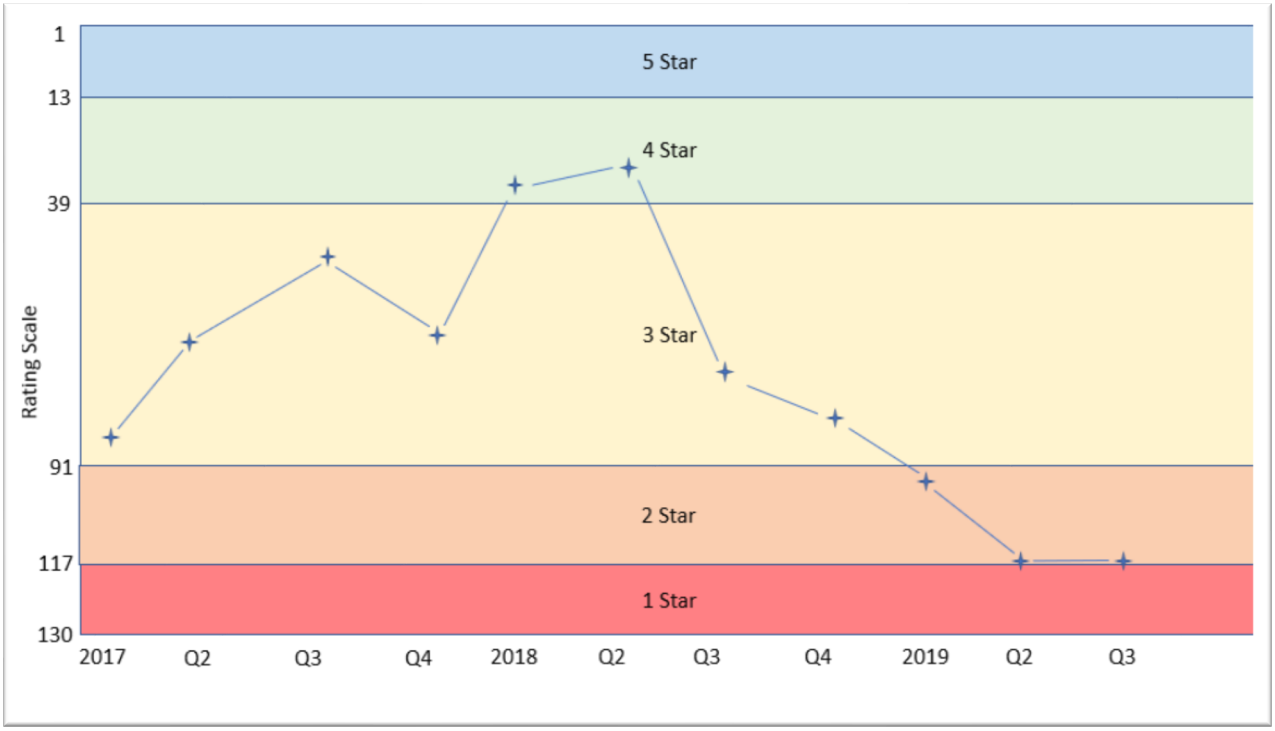

Figure 2. Facility SAIL Star Rating by quarter, Q1 FY 2017 through Q3 FY 2019
Source: OIG analysis

The purpose of the OIG's review was to identify the reasons for the facility's rapidly declining performance in select SAIL metrics so that interventions might be employed before a negative event occurred, and to document and publish those findings as a cautionary tale and lessons learned for other VHA facilities.

What the OIG Did

In exploring the reasons for the substantive decline from "4-star" rating to a low "2-star" rating over 12 months, the OIG considered those measures that had the most decline over the same period and represented the most (weighted) impact or opportunity for improvement (see appendix A). In addition to leaders' awareness of, and response to, negative performance trending, this report focuses on the facility's performance in six quality measure domains:

- Access
- Performance Measures
- Mental Health
- Emergency Department Throughput

- Patient Experience
- Employee Satisfaction

Scope and Methodology

The OIG initiated the review September 5, 2019, and conducted a site visit October 8–10, 2019.

The OIG team interviewed the Facility Director, Chief of Staff (COS), and acting Associate Director for Patient Care Services; the Chiefs of Outpatient Mental Health Service (Mental Health), Specialty Care, Medical Service, the Emergency Department, Social Work (acting), and Human Resource Management; hospitalists and nurse managers of Mental Health, Specialty Care, the Emergency Department, Community Living Center, and inpatient unit nurse managers; the Transfer and All Employee Survey (AES) coordinators; administrative officers of the relevant clinical services; patient advocates and case managers; and other staff who had knowledge related to the areas of interest.

To determine compliance with VHA requirements related to patient care, clinical functions, and the environment of care, the inspection team reviewed VHA and facility policies and guidance; OIG-selected clinical records, and administrative and performance measure data; toured the Emergency Department; and discussed processes and validated findings with managers and employees. The OIG did not assess VHA data for accuracy or completeness.

The review period covered select operations from October 1, 2016 (Q1 FY 2017), through September 30, 2019 (Q4 FY 2019). Because SAIL references performance measure data by fiscal year and quarter, appendix B provides an explanation of the time frame involved and how it is displayed in the report.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

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

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

Inspection Results

The OIG found the facility's declining performance metrics were often explainable by several factors including staffing and pay issues, and inefficient processes related to some of the selected

performance measures. The OIG did not find evidence of large-scale system or process deficits such as a dysfunctional organizational or communication structure, nor did the OIG identify or hear about adverse patient outcomes or other negative events.

The OIG identified two conditions that underpinned the findings discussed in this report. First, some leaders and managers lost focus on important care processes, possibly because of the facility's previous strong performance in most measures, coupled with attention being diverted to new or priority initiatives. This organizational drift often happens gradually, and the impact is not noticed until the deficiency is dramatic or requires substantial efforts to correct. To limit this type of drift, an effective committee oversight structure and communication processes are necessary for timely identification and early intervention to correct performance deficits in routine and non-priority areas. The second condition, which exacerbated the first condition, was that the facility lacked consistently effective structures and processes for oversight, communication, and follow-up of performance measures and related activities.

Based on OIG's experience as well as the findings in this report, it is the OIG's opinion that other VHA sites are potentially at risk for loss of focus and inadequate performance measure oversight, and leaders can learn from this facility's experience and be proactive in managing and addressing similar deficits in their own facilities.

1. Leadership and Performance Measure Oversight

The executive leadership team was knowledgeable about performance measures but acknowledged losing focus on some of the basics.

Good leadership is central to the health and success of any organization. Leaders establish the organization's culture through their words, expectations for action, and behavior.[12] The Joint Commission devotes several chapters to leadership standards, which specifically discuss the importance of the leadership team having a shared understanding of what they want to achieve and why, and how they want to achieve it. "The greater the alignment among the leadership groups with respect to the hospital's mission, vision, and goals, the more likely they can effectively function as a team to achieve those goals."[13] Leaders in VHA are responsible for ensuring veterans receive high quality health care that is safe, patient-centered, and timely. To accomplish this, leaders must be alert and responsive to early warning signs indicating potential systems breakdowns that could lead to suboptimal patient outcomes and experiences.

[12] Leadership in Healthcare Organizations, *A Guide to Joint Commission Leadership Standards*, *A Governance Institute White Paper,* Winter 2009. https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/wp_leadership_standardspdf.pdf?db=web&hash=86F0223A5C016F833DA3DDB1C62F5D20. (The website was accessed on February 18, 2020.)

[13] *A Guide to Joint Commission Leadership Standards*, Winter 2009.

At the time of the OIG visit, the executive leadership team consisted of the Facility Director,[14] COS, acting Associate Director for Patient Care Services, and Associate Director. The executive leadership team, some of whom had been working together for several years, appeared to function collaboratively and were able to articulate for the OIG team the facility's strategic priorities and goals.

The Facility Director, COS, and acting Associate Director for Patient Care Services were members of the Quality, Safety, and Value Executive Leadership Board (QSVELB), as were many clinical service chiefs. It is through this governance structure that facility leaders monitored quality of care and performance measures. The OIG reviewed monthly QSVELB meeting minutes from October 2017 through March 2019, which demonstrated consistent executive leadership team participation in QSVELB meetings and the tracking of performance improvement activities. However, performance improvement-related discussions did not consistently include action plans or progress on completing the actions.

The OIG found that facility leaders were generally knowledgeable about the declining performance metrics discussed in this report. Several leaders attributed the deterioration to taking their eye off the topic. In further discussion, some leaders expressed that the facility had historically performed well in many measures (which contributed to its previous 4-star rating) and had subsequently become complacent relative to some "bread and butter" processes as the facility focused on other performance opportunities.

Facility leaders reported taking several actions to improve and sustain performance in the selected measures to include adding performance measures as a standing agenda item to the Facility Director's morning report, enhanced recruitment and staffing, and increased attention to veteran satisfaction and engagement, among other efforts. The OIG noted that while the facility's performance in some measures was still suboptimal, overall facility performance had improved as of Q4 FY 2019.

2. Access to Care

While the facility scheduled primary and specialty care appointments for new patients timely, the timeliness of mental health appointments, as well as patients' perceptions of access to primary and specialty care, needed improvement.

The SAIL model access domain includes objective appointment wait-time data for primary, specialty, and mental health care.[15] The access domain also includes patient response data from

[14] The Facility Director was detailed to be the acting VISN Director from April 1 through October 27, 2018.

[15] Call center measures, which are also part of the SAIL access domain, include timeliness of responding to calls and abandonment rate. Call center data were excluded from this review.

seven survey questions related to the timeliness of primary and specialty care. VHA refers to primary care as Patient-Centered Medical Home (PCMH) in these surveys.

Appointment Wait Times

VHA requires that patients be able to schedule a routine (non-urgent) appointment with their primary care, specialty care, or mental health providers within 30 days of when it is clinically indicated.[16] SAIL wait-time measures reflect the percentage of new patients who were seen within 30 days of the date the appointment was made.[17] The clinically indicated appointment date may be different from the appointment made in some circumstances. Therefore, the correlation between the policy requirement and the performance measure is imperfect.

For the period of Q3 FY 2017 through Q3 FY 2019, the OIG found the facility was able to schedule primary and specialty care appointments for new patients within 30 days, more often than the VHA national average. During the same time, the facility's ability to schedule mental health appointments for new patients within 30 days fell below VHA's national average. Mental health leaders attributed performance measure deficits, including access, to previous weak mental health leadership, lack of oversight, and staffing challenges. The Chief of Mental Health told OIG about interventions to improve access, including implementation of same-day appointments, improved staffing and tele-mental health services in the community-based outpatient clinics, improved access to the Mental Health Intensive Case Management program, and increased utilization of group treatment. As of Q4 FY 2019, the Mental Health access measure was stagnant, and still fell below national averages.

Patient Survey Responses

Although objective data generally showed that primary and specialty care appointments for new and established patients were completed timely, patient experience survey data were not consistent with those scores.[18] Given the incongruency, the OIG explored possible contributing factors to patients' perceptions of poor access to care through interviews with key leaders and employees (see discussion of interviews in Reported Responses section).[19]

[16] VHA Directive 1230(1), *Outpatient Scheduling Processes and Procedures,* July 15, 2016, required patient appointments be scheduled within 30 days. In June 2019, access standards changed to 20 days for primary care, mental health care, and non-institutional extended care, and 28 days for specialty care. VHA Office of Community Care, *Eligibility,* May 2019.

[17] An appointment is considered new if there were no prior appointments in the same stop code or group of stop codes in the prior 24 months.

[18] Mental health clinics are included in specialty care for these metrics.

[19] It is not a general practice for the OIG to survey patients about the quality of their healthcare experiences. The OIG team relied on facility staff members' perceptions of problem areas based on their interaction with patients.

The Survey of Healthcare Experience of Patients (SHEP) surveys benchmark VHA's performance of primary and specialty care against the private sector, identify areas that need improved access to health care, and provide insights to enhance patients' quality of care and experiences. Primary and specialty care patients are asked to rate their experience with getting timely appointments, care, and information on a scale of Never, Sometimes, Usually, and Always.[20] "A facility's item score is calculated as the percentage of responses that fall in the top category (Always)."[21] The access composite score is calculated as the average of the facility's scores on those items. A higher value is preferred. Additionally, primary care patients are asked the number of days they waited for an appointment for urgent care on a scale of same day, one day, two to three days, four to seven days, and more than seven days.[22] A facility's "item score is calculated as the percentage of responses that fall in the top two categories (same day, one day)."[23] A higher value is preferred.

From Q1 FY 2017 through Q3 FY 2019, VHA national averages for patient experience with getting timely appointments, care, and information generally fell between 49 and 52 percent for both primary and specialty care. While patient perceptions of access to primary care at the facility were periodically below the national average, perceptions of access to specialty care fell substantially below the national average for three successive quarters starting with Q3 FY 2018 (see figure 3).

[20] VSSC, *SHEP Composites and Reporting Measures Reference Guide,* http://vaww.car.rtp.med.va.gov/programs/shep/shepLearning.aspx. (The website was accessed on April 1, 2020). The relevant questions are (1) In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed? (2) In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed? and (3) In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day? Agency for Healthcare Research and Quality, *Consumer Assessment of Healthcare Providers and Systems Clinician and Group Survey*. https://www.ahrq.gov/cahps/surveys-guidance/cg/index.html. (The website was accessed on May 1, 2020.)

[21] VSSC, SAIL Value Model.

[22] VSSC, *SHEP Reference Guide*. The relevant question is "In the last 6 months, how many days did you usually have to wait for an appointment when you needed care right away?"

[23] VSSC, SAIL Value Model.

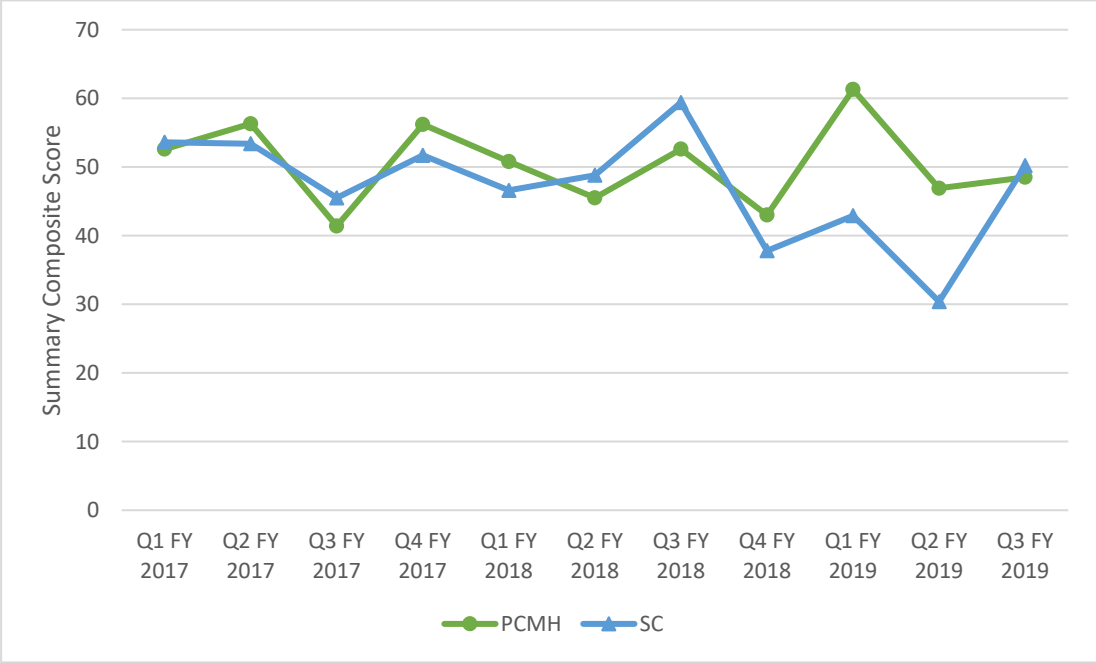

Figure 3. Timely appointments, care, and information summary composite, Q1 FY 2017 through Q3 FY 2019[24]
Source: SHEP

Reported Reasons

Based on the patient survey data, it appeared that patients were most dissatisfied when they could not get an appointment "right away" as soon as they needed the appointment. Patients were also dissatisfied when a provider's office did not answer a medical question the same day the patient called the clinic.

Key leaders and staff told the OIG they were surprised at patients' perceptions about access to care, largely because the objective data reflected good access. However, facility leaders described several factors that may have contributed to patients' perceptions about poor access:

- Due to recruitment and retention challenges of subspecialists, some patients in need of services including dermatology, cardiology, oncology, and rheumatology were referred to community care, which sometimes took longer to schedule because of limited community providers.

[24] For Q4 FY 2018 through Q2 FY 2019, the national average for patient perceptions of access to *specialty care* ranged from 49.6 to 50.7.

- Providers changed to a four-day-per-week, 10-hour-per-day work schedule, and some patients may have had to see another primary care team provider on those days when their specific provider was not readily available.
- Walk-in patients were overbooked.[25] This practice could have increased wait times in the clinic and reduced the amount of time with the provider, leading to patient frustration and the perception the provider did not have time for them.
- Patients were able to request a same-day appointment but may not have received it if a same-day appointment was not clinically indicated.[26]
- Patients could have requested an appointment outside of established clinic hours. Primary care clinic hours were Monday through Friday from 7:00 a.m. until 5:00 p.m. with the last appointment scheduled for 4:00 p.m. Specialty clinic hours were from 7:00 a.m. to 5:00 p.m. with the last appointment scheduled for 4:30 p.m. Saturday clinics were discontinued in 2017. [27]

Facility Actions

The facility's overall corrective approach focused on a "quick recovery" process in which patients were asked about their experience before they left the facility so that issues could be resolved by employees in the area where the patient voiced the concern. The COS told the OIG that in the six months prior to the OIG's visit, the facility focused on service recovery by immediately problem-solving the situation. The COS reported that medical support assistants had been provided a "script" to elicit feedback from patients after an appointment. If a patient perceived that care needs had not been met, the medical support assistant who received the complaint was to communicate with a supervisor and the nurse coordinator so that service recovery could start. The OIG was told that education and training regarding quick service recovery had been provided in medical staff meetings and to clinic staff.

Facility leaders told the OIG that they had made improvements in scheduling processes, and appointment slots were generally 30 minutes for both primary and specialty care. Further, the primary care clinic offered walk-in services with an average of about three open slots per day, and the facility was exploring the possibility of a nurse practitioner to provide Saturday primary care clinic coverage.

[25] Providers typically see overbooked patients between scheduled patients.

[26] When patients call for same-day appointments, their requests are reviewed by clinical staff such as a nurse or provider to determine if they need to be seen that day or if they can be scheduled for a different day.

[27] VHA requires outpatient clinics to extend hours of operation beyond 8:00 a.m. to 4:30 p.m., Monday through Friday. VHA facilities and community-based outpatient clinics treating 10,000 or more primary care-enrolled unique patients within a fiscal year must provide a minimum of four extended hours per week in both a primary care clinic and mental health clinic. Examples of extended hours include evenings and weekends. VHA Directive 1231, *Outpatient Clinic Practice Management*, October 18, 2019.

In relation to specialty care, the OIG was told that dermatology access had improved with the addition of a physician assistant, a full-time dermatologist, and the utilization of tele-dermatology to reduce the number of face-to-face visits. Other actions taken included the facility's enlisting the help of a national recruiter for pulmonologists, and recruiting through the University of Nevada, Reno, whose medical residents rotated to the facility. Patients who required oncology, cardiology, and rheumatology services were referred to care in the community if the patient was willing to go.

What the OIG Observed

The use of quick service recovery scripts had not consistently been communicated to relevant stakeholders or clinics. The supervisor of the specialty clinic medical support assistants told the OIG that staff in the specialty clinics had started using the script a few months prior to the OIG's visit. The nurse manager of primary care clinics told the OIG that a plan to pilot a service recovery process was being developed but had not been implemented.

The OIG noted that while patient perceptions were being reported through a committee oversight structure, actions to address subpar performance were not consistently reported or followed up. For example, the Veteran Experience team recommended that the facility develop strategies to aid staff with addressing patients' concerns. The OIG noted that, although quick service recovery to address patient concerns had been identified in 2017 as a goal of the facility, the use of a service recovery script was not implemented for nearly two years. The potential impact of the slow implementation was twofold: patients could possibly have had unresolved issues that the facility did not become aware of in order to fix root causes, and service recovery issues that were not aggregated, trended, and discussed at higher levels could not inform institutional changes, if needed.

Nevertheless, the facility's corrective actions appeared to be having the desired effect, and as of Q4 FY 2019, SAIL reflected improvement in the patient experience score related to specialty care access.

3. Performance Measures

The facility performed well in outpatient-related measures, but performance in selected inpatient measures fell below expectations and corrective actions were slow to take shape.

The SAIL model performance measure domain includes both outpatient and inpatient performance measures. The outpatient performance measures are referred to as Healthcare Effectiveness Data and Information Set (HEDIS)-like measures and include preventive care,

tobacco, behavioral health, diabetes, and ischemic heart-related measures.[28] The facility met or exceeded the VHA average for compliance with these measures and the OIG did not review them further.

Inpatient performance measures are referred to as ORYX measures and include two inpatient composite measures.[29] One composite relates to the admission screening of patients admitted for mental health services, and for the justification of more than one antipsychotic medication at discharge. The other composite measure relates to screening hospital (non-mental health) patients on admission for the use of alcohol or other substances and tobacco, as well as offering treatment to assist patients to reduce alcohol or other substances and tobacco use during the hospital stay and after discharge. This composite measure also includes whether patients received or were offered, during the hospitalization, immunization to prevent influenza.

In FY 2017, the facility outperformed the VHA average in the ORYX measures; however, facility performance dropped below the national average during Q1 FY 2019. During the same period, national VHA performance remained the same or improved (see figure 4).

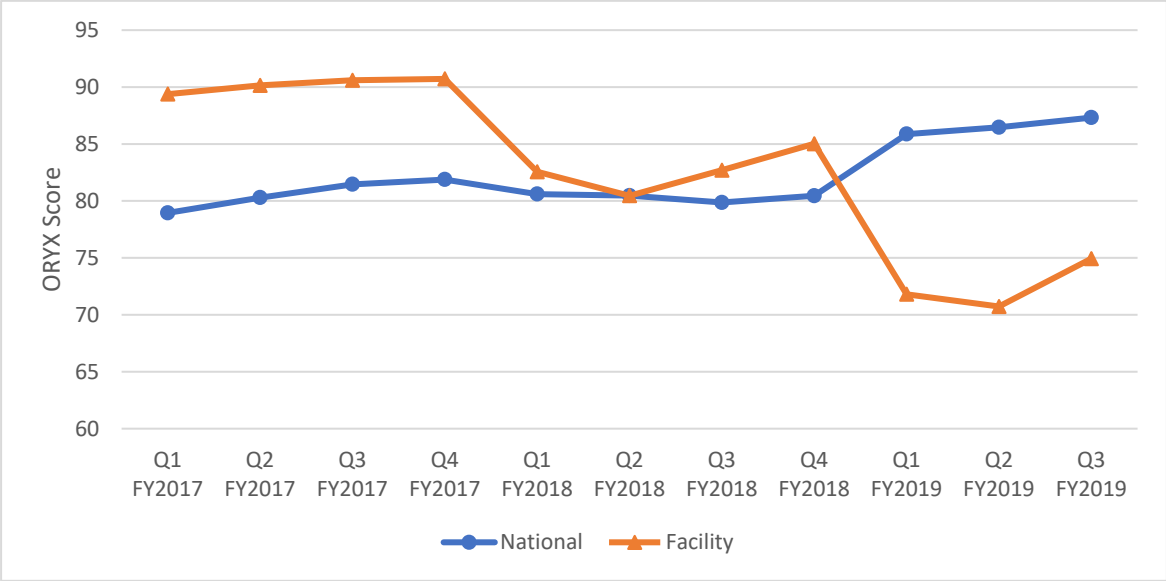

Figure 4. VHA (national) and facility ORYX measure performance Q1 FY 2017 through Q3 FY 2019
Source: External Peer Review Program (EPRP) Aggregate Report, March 12, 2020

The sub-measure with the lowest performance included offering hospitalized patients treatment for tobacco and alcohol or other substance use during their hospital stay and after discharge. Inpatient mental health measures such as screening patients on admission for the risk of violence

[28] Healthcare Effectiveness Data and Information Set. https://vaww.car.rtp.med.va.gov/programs/pm/pmEPRP.aspx. (The website was accessed on February 18, 2020, and is an internal VA website not publicly accessible.)

[29] ORYX is The Joint Commission's initiative to integrate performance measurement data into the hospital accreditation process. ORYX is a methodology that enables standardized outcomes and performance measurement across healthcare organizations.

to the patient or others, substance use disorder, trauma, patient strengths, and justification for the use of multiple antipsychotic medications also fell below national VHA performance averages.

Reported Reasons

Facility leaders and managers suggested possible explanations for the declining performance measure scores:

- *Template changes in the electronic health record (EHR).* The COS told the OIG team that facility EHR templates for admission notes were changed, inadvertently omitting the sections related to the cessation of tobacco and alcohol or other illicit substances. Facility staff were unable to say when those changes were made but told the OIG that screening requirements for tobacco and alcohol and other substances changed and they were not aware of those changes for several months.[30] The COS stated that the care was still being provided; however, it was not being documented. It then took several months to identify that the performance measure scores fell, due in part, to this template change.
- *A change in the review process.* According to staff, in addition to template changes, performance measure scores declined due to a change in the review process. Around the beginning of October 2018, the External Peer Review Program (EPRP) reviewer assigned to the facility changed and documentation that was previously accepted as meeting the performance measures was no longer adequate as it did not meet all the requirements (see appendix C for detailed information describing the External Peer Review Program).

Facility Actions

Facility staff reported to the OIG that corrections were made to the templates during Q3 FY 2019; however, those changes did not capture all the required information. The facility continued to make additional changes to the template into Q1 FY 2020. It will take several months to determine if the template changes result in improved ORYX measure performance.[31]

What the OIG Observed

The OIG was unable to find discussion of the ORYX measures in the QEC or QSVELB minutes from Q1 FY 2018 through Q3 FY 2019. According to facility staff, the measures were discussed during EPRP exit meetings; however, there were no minutes for these exit meetings and staff were not able to provide attendance sheets. Additionally, some inpatient providers were not aware of the facility's performance with the ORYX measures. While the OIG was also told that staff education was provided regarding documentation needed to meet performance measure

[30] After reviewing the ORYX measure definitions for FY 2018 and FY 2019, the OIG was unable to verify that the requirements for assessing the use of tobacco and alcohol and other substances had changed.

[31] Once the templates are changed, facility staff will need to be educated about the changes. Additionally, monthly EPRP medical record reviews include patients who were discharged the previous month.

requirements, the facility did not provide evidence of this training. The OIG concluded the facility did not have a consistent method for reporting and oversight of ORYX measures as evidenced by the lack of discussion of the measures in the QEC and QSVELB minutes. Additionally, facility staff were not consistently educated about the performance measures, how to appropriately document the care required to meet the performance measures in the EHR, or the facility's current compliance with the performance measures. Communication and training related to performance measures are important ways to engage employees and stimulate performance.

4. Mental Health Domain

The facility underperformed in the mental health domain for several years, and while modest progress had recently been made, ongoing management attention was needed to ensure continued improvements.

The SAIL mental health measures are compiled in the Office of Mental Health Operations Mental Health Management System and include three composite measures:

- The *population coverage* composite measures patients who have accessed treatment based on a specific diagnosis. The composite includes the distribution of patients accessing services by county across the catchment area and patient engagement with mental health services.[32]
- The *continuity of care* composite includes measures related to antidepressant medications, high risk for suicide patient record flags, post-discharge engagement, patients accessing care by county, evidence-based psychotherapy, and management of schizophrenia and bipolar disorder.[33]
- The *experience of care* composite measure includes results of an independent annual survey of mental health providers and quarterly survey results from a monthly random sampling of outpatients to understand the opportunities for improving mental health delivery and assess barriers to care.

The facility's performance on the population coverage and continuity of care composite measures had generally fallen below the national average from the end of FY 2017 through FY 2019. Because performance challenges in these domains were long-standing, the OIG focused instead on the experience of mental health care domain. The facility had performed

[32] Treatment programs include family and individual psychotherapy, psychosocial rehabilitation, mental health intensive case management, substance use services, and vocational programs. Diagnoses include serious mental illness, substance use disorders, depression, and post-traumatic stress disorder.

[33] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010. Patient record flags provide alerts for patients who may pose an immediate threat to other's or their own safety. The patients by county measure is included in both the population coverage composite and continuity of care composite measures.

above average for more than two years and began a precipitous decline in this domain, falling well below VHA's average, starting in Q2 FY 2018. This trend provided an opportunity to more specifically identify reasons for the decline and the associated lessons learned (see figure 5.)

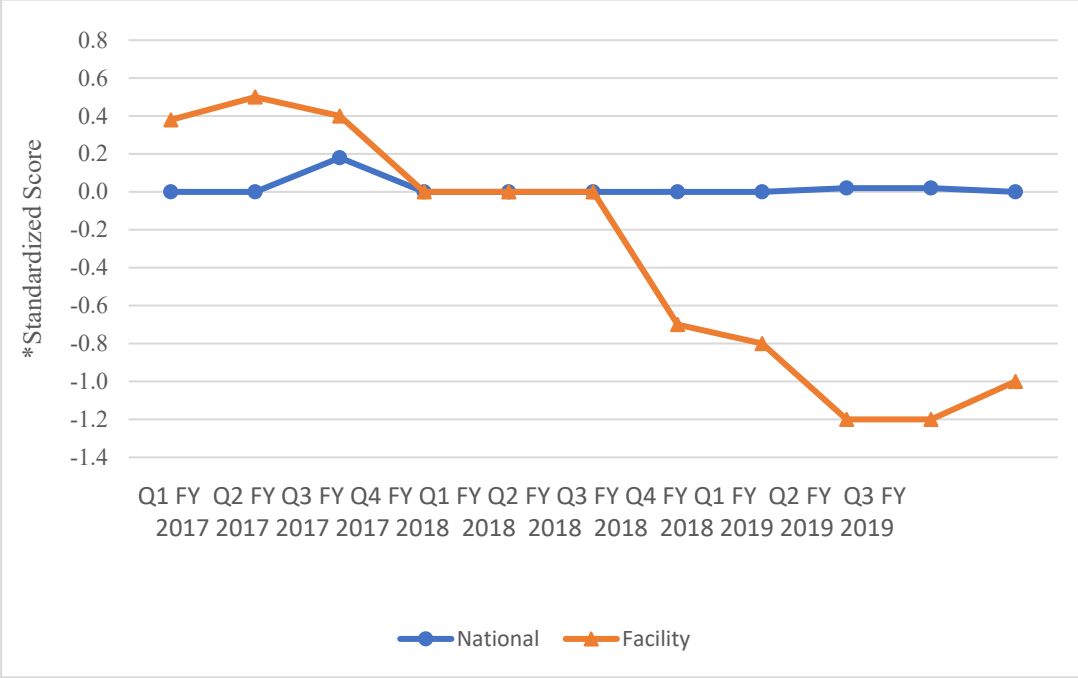

Figure 5: Experience of care domain composite, Q1 FY 2017 through Q3 FY 2019
Source: Office of Mental Health Operations Mental Health Management System, February 25, 2020
Note: It takes two steps to calculate the Mental Health Experience of Care composite score. First, at the measure level, SAIL converts raw scores to common units (termed standard scores) so they can be averaged in a meaningful way. Standardized scores are calculated as the difference from the quarterly facility mean, divided by the quarterly facility standard deviation. Next, to derive the composite score, the standard score for each constituent measure is multiplied by its weight, and these values are summed and then divided by the sum of their weights. This results in a weighted average of the standard scores for the experience of care composite.

Reported Reasons

Facility Mental Health leaders attributed performance deficits, in part, to long-standing staffing challenges. The leaders reported recruitment and hiring challenges were due to a high cost of living and comparatively low salary, as well as a change in mental health leadership, prompting separations and retirements. From Q1 FY 2018 through Q4 FY 2019, 16 employees separated due to resignations (8), terminations (6), and retirements (2).

Facility Actions

The Chief of Mental Health, who was hired in September 2017, filled two new deputy chief positions in 2019. These facility Mental Health leaders told OIG of actions to address Mental

Health staffing concerns, performance measure oversight and awareness, and resources and processes; specifically

- Prioritizing the hiring of psychiatrists, with 8 of 10 vacancies filled as of OIG's site visit in October 2019,
- Adding four nurse practitioner positions to assist with continuity of care,
- Filling several vacant administrative positions,
- Initiating weekly meetings with an assigned human resources specialist, and
- Improving recruitment incentives and strategies.

The Chief of Human Resources provided documentation to the OIG reflecting that from April 1, 2019, through September 30, 2019, 43 positions were announced and 21 selections had been made. The Chief of Mental Health reported that there were 28 vacancies as of October 2019, with "seven or eight" of those positions selected but not onboard.

To improve oversight and staff awareness, the Chief of Mental Health and/or the Deputy Chiefs reported

- Restructuring the Mental Health Executive Committee to be "metric-focused" where staff were responsible for reporting performance measures,[34]
- Structuring processes for initiating, tracking, and reporting performance metrics to address gaps, set steps for improvement, and sustain improvements,
- Reporting Mental Health performance to the QEC and the QSVELB, and
- Enhancing efforts to communicate about, and improve staff knowledge of and accountability for, performance measures.

The Chief of Mental Health and/or the Deputy Chiefs also reported the following actions to address general Mental Health-related performance deficits, including

- Improving staffing and patient outreach in certain programs,
- Restructuring reporting processes for pharmacy-related measures, and
- Addressing suicide prevention resources and barriers.

To specifically address performance in the experience of care domain, the Chief of Mental Health told OIG of actions including

[34] The Mental Health Executive Committee reviewed mental health data and included the Mental Health Service Chief, Deputy Chiefs, and supervisors.

- Revising the Mental Health intake process, which replaced multiple Mental Health program intakes, thereby decreasing patient complaints by 87 percent;
- Structuring and streamlining review of patient feedback;
- Utilizing the Veterans Mental Health Council to provide input for services;[35] and
- Creating a mobile outreach team in partnership with the Reno Police Department.

What the OIG Observed

The OIG determined that mental health service leaders provided structure and leadership, thereby creating an environment to improve performance measure scores. Mental Health employees at all levels had metric improvement added to performance plans in 2019 so they were aware of performance measures and their clinical significance, as well as staff members' roles in supporting compliance with the measures. Mental health leaders also asked employees to share their ideas for improvement. Employee involvement is the main factor in facilitating organizational change and overcoming resistance.[36]

While the interventions discussed in this section of the report had significantly improved the mental health experience of care measure through Q3 FY 2019, the other two composite measures (population coverage and continuity of care) had not materially improved. Nevertheless, the OIG found the actions to be strategic and comprehensive.

5. Emergency Department Length of Stay and Throughput

The facility met targets for several emergency department timeliness measures; however, staffing and process deficits contributed to admission delays.

The Joint Commission requires facilities to recognize that management of emergency department throughput is a hospital-wide concern, and to implement system-wide processes that support patient flow elements including admission, assessment and treatment, patient transfer, and discharge.[37] VHA requires that emergency department staff use Emergency Department Integration Software, a data collection tool used to track patient flow and other emergency

[35] In the Veterans Mental Health Council, veterans discussed with staff their experiences with mental health care and reviewed experience of care data.

[36] Syed Talib Hussain, Lei Shen, Tayyaba Akram and Muhammad Jamal Haider, "Kurt Lewin's Change Model: A Critical Review of the Role of Leadership and Employee Involvement in Organizational Change." *Journal of Innovation & Knowledge* (October 11, 2016): 123-127. https://www.researchgate.net/publication/309182963_Kurt_Lewin's_process_model_for_organizational_change_The_role_of_leadership_and_employee_involvement_A_critical_review. (The website was accessed on December 23, 2019.)

[37] The Joint Commission, *The 'Patient Flow Standard' and the 4-Hour Recommendation.* Joint Commission Perspectives 33 no. 6 (June 2013): 1-4.

department quality metrics.[38] The facility's performance in the emergency department patient flow measures for Q3 FY 2019 is described below:

- *Door to Triage*. The facility met VHA's target measure of less than or equal to 12 minutes for nursing triage timeliness. [39] The facility's average wait time in this category was 11 minutes.
- *Door to Assignment of a Provider.* The facility met VHA's target goal of less than or equal to 25 minutes. The facility's average wait time in this category was 16 minutes.
- *Door to Admit Decision*. The facility met VHA's target goal of less than or equal to 150 minutes. The facility's average wait time in this category was 126 minutes.
- *Admit Delay* (elapsed time from a provider's decision to admit to an inpatient bed in the facility and the patient's departure from the emergency department.)[40] The facility exceeded VHA's target of less than 90 minutes but no greater than 150 minutes for admission times. The facility's average time in this category was 182 minutes (see figure 6.)

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

[39] VHA Directive 1101.05 (2). Triage timeliness is measured from patient check-in until the triage nurse assesses the patient and determines the emergency severity index (ESI) score. "The ESI is a five-level emergency department triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs."

[40] Centers for Medicare Medicaid Services. The admit delay measure is based on the first documentation of the decision to admit the patient from an emergency department. Because admission processes vary at different hospitals, the first documented time can include any of the following: (1) admission order (this may be an operational order rather than the hospital admission to inpatient status order), (2) disposition order (must explicitly state to admit), (3) documented bed request, or (4) documented acceptance from admitting physician. This is not the "bed assignment time" or "report called time." https://ecqi.healthit.gov/measure-stewards/centers-medicare-medicaid-services-cms. (The website was accessed on January 20, 2020.)

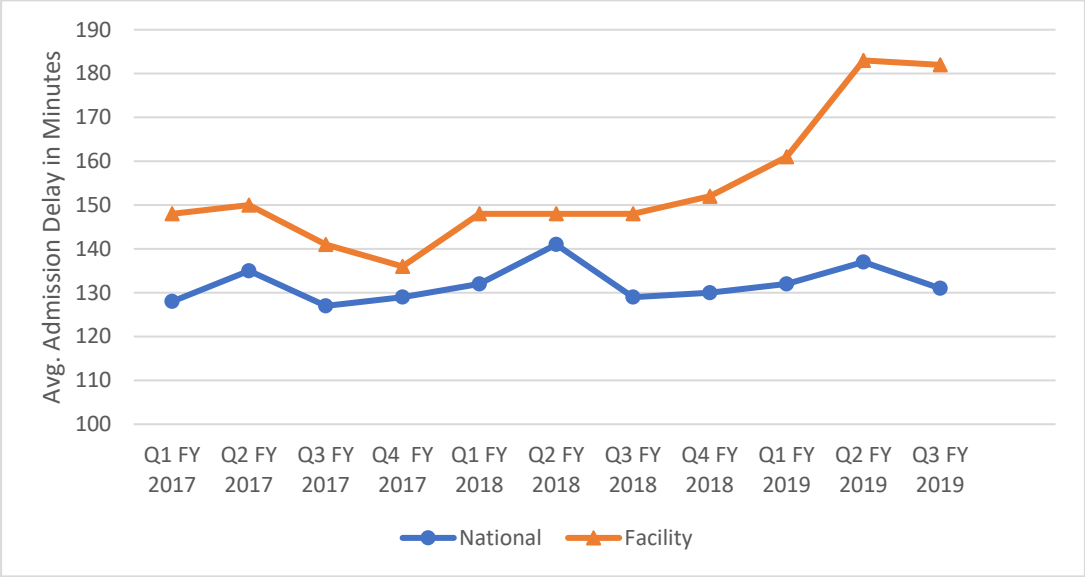

Figure 6. Comparison of VHA (national) and facility Emergency Department quarterly admit delay times in minutes, Q1 FY 2017 through Q3 FY 2019
Source: VHA Support Service Center February 20, 2020

According to facility leaders, and as reflected in some committee meeting minutes, several factors may have contributed to admission delays and are set forth below.

Provider Staffing

The Emergency Department Chief, who assumed the position in March 2018, told the OIG the department had been understaffed and that 10 full-time providers had since been hired. The Emergency Department Chief explained that it was a continuous process to maintain Emergency Department staffing levels, and that part-time and intermittent physicians and nurse practitioners supported Emergency Department operations.

Bed Control Processes

Reported Reasons

Bed control processes refer to tracking patient movement and bed availability to expedite safe patient transfers within and among healthcare facilities.[41] Several facility bed control processes were reportedly inefficient:

[41] VHA Directive 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities,* November 28, 2017.

- The facility did not have a bed control supervisor, and the coordination of admissions defaulted to the nursing supervisors. Nursing supervisors had many responsibilities during their shifts and prioritized tasks, which could have delayed admissions.
- The facility had a limited number of bed makers who were responsible for the terminal cleaning of inpatient rooms in preparation for a new admission.[42] Because of the specialized training the bed maker must possess to perform this work, another Environmental Management Service (EMS) employee without the requisite training could not perform the work. If an inpatient room was not cleaned, patients in the Emergency Department could not be transferred until the inpatient bed was available.
- EMS did not have an efficient system to report completion of terminal cleaning and room availability. Previous efforts to solve this problem, including tablet computers and wall-mounted kiosks, were not successful.

Facility Actions

Facility leaders told the OIG of instituting a provider-in-triage program to improve patient throughput, decrease length of stay in the Emergency Department, and increase efficiency in delivering care. The designated provider, based on the triage nurse's patient assessment, emergency severity index score, observation, and/or performance of a brief physical assessment, could order diagnostic testing such as laboratory and imaging studies. In addition, if no additional workup was needed, the provider may advise and discharge the patient directly from triage. The goal of the preliminary workup in triage was to determine the patient's disposition in a timelier manner. The facility also added a dedicated laboratory technician during peak Emergency Department hours.

What the OIG Observed

When the OIG team visited the Emergency Department on October 10, 2019, the provider-in-triage position could not be filled due to staffing demands. While the Emergency Department nurse manager told the OIG that the nurse triage position was staffed from about 7:30 a.m. until around 10:00 p.m., absent a provider, the provider-in-triage program would not function as intended.

The OIG reviewed Emergency Department committee meeting minutes from October 2017 through August 2019 and found evidence that Emergency Department patient flow metrics were reviewed and discussed, and Emergency Department missed opportunities and patient call back data were reported monthly to the facility's QEC. However, the same action plans were often

[42] According to the facility, a bed maker is an Environmental Management Service staff member who is specially trained to clean beds of discharged patients in preparation for new admissions. This process is referred to as terminal cleaning.

repeated from one month to the next, without evidence of implementation or monitoring for effectiveness. As of Q4 FY 2019, corrective actions, including increased staffing, had not had the desired effect, and the average time to admission was 181 minutes.

After the OIG left site, Environmental Management Service leaders added a second bed maker on weekends so that staffing consisted of three dedicated bed makers and discharge cleaners during the week and two on the weekends. Dedicated laptops were mounted on cleaning carts for use by bedmakers and discharge cleaners that tied into the Bed Management Solution program.[43] A large Bed Management Solution monitor was installed in the Environmental Management Service supervisor's office that provided real-time visibility to monitor room cleaning requests. Environmental Management Service and nursing staff could communicate electronically on the status of terminal cleaning and bed turnover.

The OIG team concluded that ongoing attention to clinical resources and dedicated admissions staffing could improve Emergency Department patient flow metrics and enhance patient experience.

6. Patient Experience

Declining patient scores across multiple domains were central to several findings in this report.

VHA uses SHEP surveys to measure patient experiences.[44] The surveys give patients the opportunity to rate

- Performance of primary and specialty care providers (provider rating—outpatient measure),
- Whether providers know the patient's important medical history and provide feedback from test results (care coordination—outpatient measure),
- Whether patients understand instructions for their healthcare after they are discharged from the hospital (care transition—inpatient measure), and

[43] VHA Directive 1002. Bed Management Solution is a web-based VistA interface for tracking patient movement and bed availability. Nursing Service was responsible for this program.

[44] Aaron Legler et al. "*Effect on VA Patient Satisfaction of Provider's Use of an Integrated Viewer of Multiple Electronic Health Records*" Journal of General Internal Medicine 34, no. 1 (October 18, 2018): 132-6. SHEP derives its outpatient surveys from the Consumer Assessment of Healthcare Providers and Systems family of surveys; Agency for Healthcare Research and Quality, *What is Patient Experience?* Rockville, MD, March 2017. Patient experience describes the interactions patients have with the healthcare system, including care from doctors, nurses, and staff in hospitals. Patient experience and patient satisfaction, while often used interchangeably, are not the same thing. Patient experience is whether something that should happen in a health care setting, like clear communication with a provider, actually happened. Patient satisfaction is about whether a patient's expectations about a healthcare encounter, like receiving a prescription for medication, were met. https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html. (The website was accessed on February 9, 2020.)

- Whether providers pay attention to mental and emotional health (stress discussed—outpatient measure for primary care only).

See appendix D for details of the survey questions, reporting measures, and scoring methods.

The OIG reviewed national and facility patient survey data for Q1 FY 2017 through Q3 FY 2019 and found primary care provider ratings began trending downward starting in Q4 FY 2018 as compared to the VHA national average (see figure 7.)[45] While specialty care provider ratings did not reflect evidence of a trend, variability from quarter to quarter beginning in Q3 FY 2018 was considerable (see figure 8.)

The facility's performance in the care coordination, care transition, and stress discussed measures often fell a few percentage points below the VHA national average, but the underperformance was mostly consistent, without evidence of a downward trend.

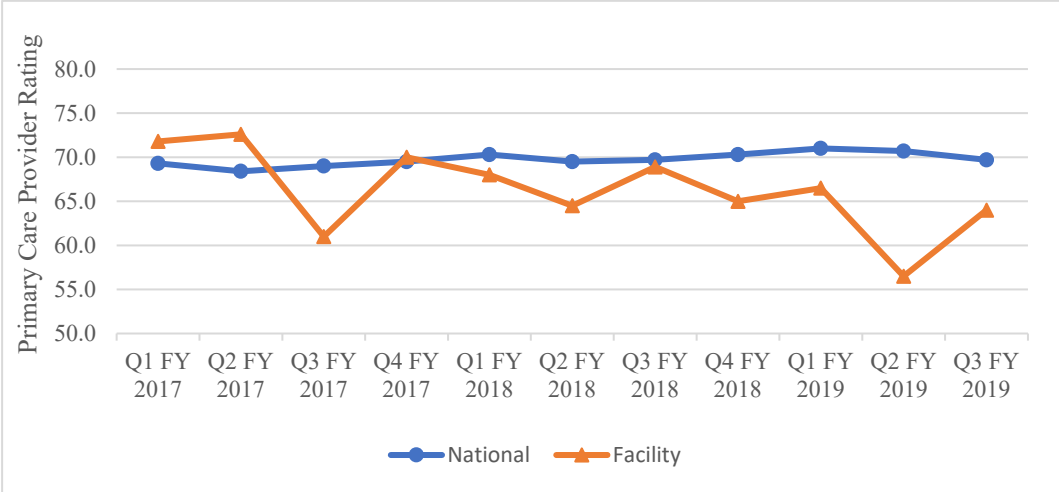

Figure 7. Primary care provider rating national average vs. facility, Q1 FY 2017 through Q3 FY 2019
Source: OIG analysis of VHA Support Service Center data

[45] In 2018, the facility sent out 8,972 surveys and had a 41.1 percent response rate; the VHA-wide response rate was 36.1 percent. In 2019, the facility sent out 9,245 surveys and had a 39.3 percent response rate; the VHA-wide response rate was 35.0 percent. The SHEP and PCMH surveys adjust for factors such as the characteristics of patients and differences between participating and non-participating patients. These adjustments allow for the results to be comparable between both VA and non-VA facilities. Rebecca Anhang Price, et al., *Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings*. Journal of Geriatric Internal Medicine 33, no. 10 (April 25, 2018): 1631-8.

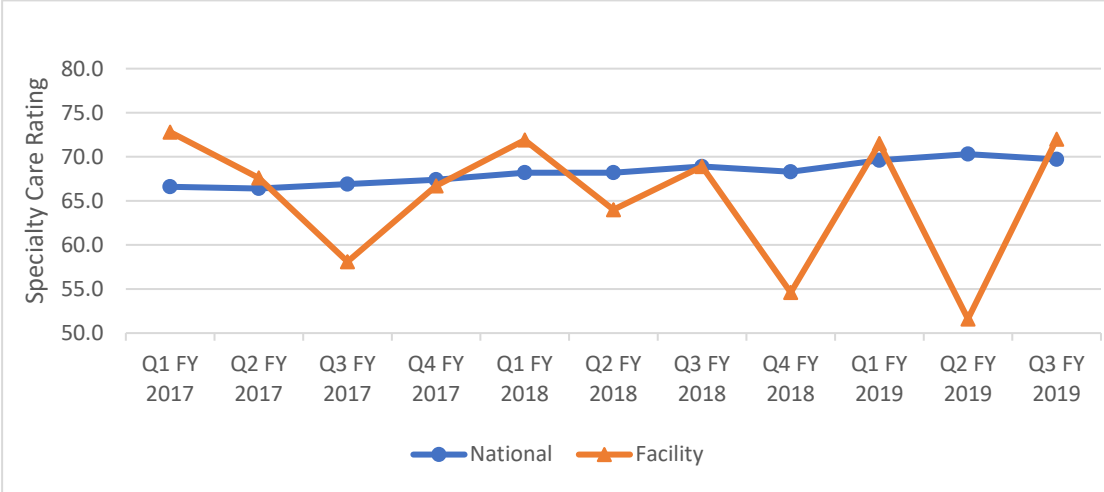

Figure 8. Specialty care provider rating national average vs. facility, Q1 FY 2017 through Q3 FY 2019
Source: OIG analysis of VHA Support Service Center data

Reported Reasons

Several presumed reasons for suboptimal patient experience scores are outlined in other sections of this report. The Veteran Engagement Council (VEC) meeting minutes for Q1 FY 2018 through Q2 FY 2019 documented that patient experience was the facility's lowest performing domain in SAIL.

Facility Actions

As noted previously, the facility reported implementation of quick service recovery so that patient concerns could be resolved by employees at the point of care. The COS told the OIG that the process had been in place for about a year, with added emphasis over the last six months. As reflected in an August 2019 Medicine Service PowerPoint presentation to the SAIL RAPID team, quick recovery was formally implemented on August 1, 2019.

Additional actions to improve patient experience included managers monitoring Veterans Signals (VSignals) for early service recovery and sharing the complaints and concerns with providers to increase their awareness and give them a chance at service recovery.[46] For example, after dermatology service received a few "back-to-back" complaints, feedback (about the complaints) was provided to the dermatologist and the outpatient survey scores began to improve. Further, the OIG was told that inpatient attending physicians started meeting weekly with resident

[46] Since June 2017, VA began digitally collecting customer feedback from veterans receiving VA services and VA digital properties in the Veterans Signals (VSignals) program. Since then, veterans have responded with more than 4 million surveys, including more than 1.9 million comments. This feedback is accessible to VA employees across the country for action.

physicians to review care transitions and improvement opportunities.[47] The residents were instructed, after providing a patient with discharge instructions, to confirm understanding of the discharge instructions. Also, inpatient nurse managers were to ask patients whether they (the patients) understood their discharge instructions.

VEC meeting minutes in August 2018 documented, "Our lowest performing metric is the Stress Discussed item," with subsequent minutes reflecting a plan to develop "Stress cards for Primary Care" and "Examine if cards can be better worded to specifically ask about stress question." January and February 2019 VEC minutes documented that changes to the stress cards had been completed. After the OIG's site visit, facility leaders told the OIG that the stress cards had not been implemented.[48]

What the OIG Observed

The facility's efforts to enhance patient experience appeared to be having the desired effect in most of the measures. As of Q4 FY 2019, the OIG noted improvement in the primary and specialty care provider ratings, as well as the care transition area. Two other measures—care coordination and stress discussed—had not changed significantly from previous quarters.

While VEC meeting minutes for the period Q1 FY 2018 through Q4 reflected discussion of deficient patient experience scores and the need for improvement, the OIG found examples of slow or marginally effective implementation. In addition to the stress cards noted above, another example is from the May 2018 VEC minutes, which reflected "Staff are broadly not aware of performance metrics for the hospital" and included a suggestion to improve awareness through trainings and Daily Management System boards.[49] At the time of the OIG's visit in October 2019, multiple staff members told OIG interviewers that they were not aware of the facility's performance metrics and data.

Additionally, the OIG determined there was insufficient documentation from the QSVELB meeting minutes for the OIG to determine if the progress of initiatives or improvement actions were being monitored through this oversight structure.

[47] "The attending physician is a doctor who has completed medical school, residency training and is board certified or eligible in a particular specialty." The attending physician supervises all the care delivered to a patient. "A resident is a physician who has completed medical school and is receiving further training in a chosen specialized medical field. Residents practice medicine under the supervision of a fully credentialed attending physician." https://www.amc.edu/PhysicianDirectory/pages/medical_staff_terminology.cfm. (The website was accessed on March 11, 2020.)

[48] Instead of stress cards, facility leaders reported that, as of March 2020, a clinical reminder was being developed including referral resources for patients with concerns.

[49] The Daily Management System is a communication system that ensures a stable and safe work environment, reinforces standard work, discusses difficulties in meeting standard work, and tracks issues to resolution.

7. Employee Satisfaction

The facility's Best Places to Work scores were similar to or better than the VHA average in 2018 and 2019; however, registered nurse turnover rates for the same period, coupled with nursing interviews and surveys, reflected dissatisfaction.

The SAIL employee satisfaction domain includes the All Employee Survey (AES) Best Places to Work data and registered nurse turnover data. The AES is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[50] Although the OIG recognizes that employee satisfaction survey data can be subjective, the data are a starting point for discussions and indicate areas for further inquiry.

Best Places to Work

Employee feedback gained through the AES results are used to calculate a Best Places to Work composite score ranging from 0–100 points based on survey items related to overall satisfaction, organizational satisfaction, and organizational commitment. In FYs 2018 and 2019, data reflected that the facility performed well in the Best Places to Work measure, with scores ranging from 64.95 percent to 69.88 percent respectively. These scores were similar to or better than the VHA averages. No further OIG review in this area was indicated.

Registered Nurse Turnover Rate

The registered nurse turnover rate measures losses of registered nurses, a key indicator in health organizations recognized for quality patient care, nursing excellence, and innovations in professional nursing practice. Registered nurse turnover rates are calculated based on permanent employees who quit or were terminated.[51]

SAIL data reflected that the registered nurse turnover rate increased from 3.6 percent in Q2 FY 2018 to 11 percent in Q2 FY 2019, with some improvement to 8.4 percent in Q3 FY 2019. VHA's average registered nurse turnover rate in Q3 FY 2019 was 6.2 percent. Several conditions appeared to contribute to the increase in registered nurse turnover, including low and inconsistent nurse salaries, poor communication, and other conditions.

[50] VHA National Center for Organization Development, *AES Survey History Understanding Workplace Experiences in VA,* http://aes.vssc.med.va.gov/research/Pages/default.aspx. (This website was accessed on December 16, 2017).

[51] VSSC, SAIL Value Model. Facility quit rate, also called "regrettable losses," is defined as "voluntary resignations and transfers out of the facility. This turnover rate is important to analyze since these losses are voluntary and potentially preventable." Termination rate is defined as "terminations including resignations and retirements in lieu of termination, but excluding losses to military, transfers, and expired appointments." The registered nurse turnover data exclude advanced practice nurses, certified nurse specialists, students, trainees, intermittent staff, fellows, and registered nurses who retire.

Reported Reasons

A. Nurse Salaries

The OIG confirmed that, in general, private-sector nurses in the Reno community earned about $15,000 per year more than facility nurses. Excerpts from two AES responses illustrate frustrations with low nursing pay:

> *Cost of living in the area has increased over 30 percent in the last 2 years with only a 1.4 percent raise in pay for inpatient care nurses for the same period, causing many nurses to leave for higher paying jobs in areas with a lower cost of living.*

> *Our salary is drastically lower compared to the surround[ing] area for our job type, so applicants don't apply and several quality employees have left because other agencies pay significantly more and the cost of living in this area is high*.

In addition, facility leaders and direct care nurses told the OIG about a nurse salary survey conducted in late 2017 in order to evaluate whether facility salaries were competitive with the community. As a result of the survey, salaries were increased for nurses in some services while remaining stagnant in other areas. Therefore, some registered nurses chose to retire, move, or transfer from inpatient and specialty care to primary care for higher salaries. One nurse noted in the AES that nurses with inpatient-related experience and skills, such as critical care experience, were leaving to go to outpatient areas and were being replaced by inexperienced nurses. The nurse noted that salaries should be equitable to retain skilled nurses in their area of expertise.

B. Communication

Some nursing staff and other stakeholders told the OIG that staff felt information was not adequately communicated and disseminated from facility and service line leaders. Some staff reported that SHEP and AES data results were not communicated to direct patient care staff even though staff were being held accountable to improve metrics, and that staff were being given new duties without being told the rationale for how these actions would improve service to patients. Several AES responses attributed nursing dissatisfaction to lack of communication:[52]

> *My suggestion for improving relates to accountability and communication. Accountability in terms of executive leadership providing direct support to myself and others in similar positions with regard to mandates we have to uphold from local and national offices. And communication from top to bottom throughout.*

[52] 2019 All Employee Survey free text comments of personal opinions are designed to aid an organization to understand the survey scores' overarching themes.

Communication is very poor. It would be great if we could have a program implemented and be educated on our part of what to do.

C. Other Explanations

Facility leaders provided several other explanations for nursing losses such as the leadership style of the former chief of inpatient nursing and new efforts to address long-standing staff performance concerns that resulted in non-regrettable nursing losses. One leader attributed the turnover to registered nurses returning to school in pursuit of higher education, the facility's low intensive care unit complexity, and additional career growth opportunities.[53]

Facility Actions

Facility leaders cited several actions to improve nurse satisfaction and reduce turnover. The Facility Director told the OIG that, to improve staff relations, the chief of inpatient nursing was moved to a different position and the chief of geriatric nursing was moved to an office in the community living center. The acting Associate Director for Patient Care Services told the OIG that Nursing Service had implemented "stay interviews" to understand the reasons a nurse stays with the facility. This information allowed leaders to capitalize on those reasons to retain nurses, and to proactively address nurse dissatisfiers before a nurse left facility employment.

What the OIG Observed

Although leaders and managers suggested several reasons for the increasing registered nurse turnover, the facility did not consistently document exit interviews with outgoing staff to determine the reasons for departure. While exit interviews are not a VHA requirement, the OIG concluded the facility was missing an opportunity to monitor, track, and trend the reasons for the departures and put systems in place to retain skilled and experienced registered nurses.

The OIG was told that one of the facility's community-based outpatient clinics was realigned with another VISN 21's healthcare facility. The reassignment of the clinic's registered nurses counted as a loss to the facility, increasing the turnover rate to 10.1 percent in Q4 FY 2019.[54]

[53] VHA. *Data Definitions for Facility Complexity Models*. The ICU complexity is important because some graduate nursing programs such as adult-gerontology acute care nurse practitioner and certified registered nurse anesthetist require experience in critical care for admission. Higher level ICUs provide more complex patient care experiences in which to build a nursing body of knowledge. "The ICU level indicates the complexity of the ICU cases that can be handled by the hospital with ICU level 1 being the most complex and ICU level 4 being the least complex." http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (This website was accessed on January 6, 2020.) VA Sierra Nevada Health Care System has an ICU Level 3 complexity.

[54] Registered nurse turnover was removed from the SAIL metrics during Q4 FY 2019. The OIG analyzed available data and determined the Q4 FY 2019 registered nurse turnover rate to be 10.1 percent.

Organizational Accomplishments

Because a goal of this review was to identify lessons learned, the OIG asked facility leaders about achievements or unique programs. Leaders told the OIG about several initiatives that were focused on improving the lives of community living center patients. Two initiatives are described below.

Virtual Reality in Pain Management

"At least 100 million Americans suffer from some form of chronic pain."[55] Despite limited research showing its effectiveness, opioid medication is frequently prescribed to treat that pain. The long-term use of opioid medication can result in multiple harmful side effects, including increased mortality, overdose, myocardial infarction, and sleep-disordered breathing.

Because of increased risks associated with opioid medications to treat pain, providers are incorporating other options into their practices. Virtual reality is an immersive technology that can help distract the patient from feeling pain. By engaging a patient's visual and auditory processing capabilities, along with some physical activity, virtual reality reduces the brain's ability to process pain.

The facility piloted the use of virtual reality as an intervention for pain management in the community living center in June 2019. By the end of July 2019, ten patients were identified for inclusion in the pilot, three of whom completed virtual reality sessions. After the sessions, one patient reported no pain during the session; one patient reported no change in the level of pain but did report relief in the stress level; and one patient reported no change in the level of pain but declined opioid medication.

Because of the small number of patients included in the facility's pilot, the OIG was provided with additional VHA data regarding the effectiveness of this pain management modality. The Charles George VA Medical Center in Asheville, North Carolina, implemented the use of virtual reality for pain management. Between July 18, 2018, and October 10, 2019, 76 participants completed a voluntary survey. Eighty-nine percent of responding participants reported that the virtual reality session helped distract them from their discomfort. Seventy-five percent of the responding participants reported the virtual reality session reduced their discomfort.

Moving forward, the facility identified the need to resolve internet connectivity issues, develop a process for scheduling patients, complete infection control standard operating procedures, and develop a community living center pain protocol.

[55] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*, February 2017. https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPG022717.pdf. (The website was accessed on March 9, 2020.)

Robotic Pet Therapy in Dementia Care

Anxiety and behavioral problems are common in patients with dementia, which can lead to those patients being prescribed psychotropic medications.[56] The emotional benefits of pet therapy are well-documented, and pet therapy has been a mainstay in hospitals and long-term care settings for many years. Robotic pets have been shown to have similar positive effects without the negative aspects of traditional pets. One study of 61 participants showed the robotic pet decreased stress and anxiety in the treatment group (versus the control group) and resulted in reductions in the use of psychoactive medications and pain medications in elderly clients with dementia. [57]

The facility implemented the use of robotic pets in the community living center, using the Cohen-Mansfield Agitation Inventory scale to determine if the use of the robotic pet had a positive impact on resident behaviors.[58] Of the eight patients the facility reported, six scored lower on the Cohen-Mansfield Agitation Inventory three months after adopting the robotic pet.[59] The facility also reported that four patients who experienced falls three months prior to adopting the robotic pet showed a reduction in the number of falls three months after adopting the pet.

Conclusion

This review assisted the OIG to understand underlying issues and processes that may contribute to significant performance deficits, which will, in turn, permit the OIG to further develop and refine tools to provide a more effective and proactive approach to other OIG oversight products.

The OIG did not find evidence of large-scale system or process deficits. Rather, the OIG found staffing and pay issues, as well as inefficient processes, that may have contributed to some of the selected performance measure declines. In the OIG's experience, these conditions were not unique to the facility. Nevertheless, they represented opportunities for improvement.

From a broader perspective, the OIG identified two conditions that possibly established the basis for the facility's significant performance measure decline in FYs 2018–2019. First, some leaders

[56] Psychotropic medications are commonly administered to elderly patients to manage behavior and psychiatric symptoms. Pamela L. Lindsey, *Psychotropic Medication Use among Older Adults: What All Nurses Need to Know*. Journal of Gerontological Nursing (September 2009): 28-38. https://www.healio.com/nursing/journals/jgn/2009-9-35-9. (The website was accessed on March 12, 2020.)

[57] Petersen, Sandra, Susan Houston, Huanying Qin, Corey Tague, and Jill Studley. *The Utilization of Robotic Pets in Dementia Care.* Journal of Alzheimer's Disease 55 (2017): 569-574. https://www.ncbi.nlm.nih.gov/pubmed/27716673. (The website was accessed on October 14, 2019.)

[58] American Psychological Association, The Cohen-Mansfield Agitation Inventory is a 29-item scale to assess agitation. Elderly people are evaluated by a primary caregiver regarding how frequently they display verbally agitated and physically aggressive and non-aggressive behaviors. https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/cohen-mansfield. (The website was accessed on March 11, 2020.)

[59] One patient's score stayed the same and one patient did not complete the final inventory.

and managers acknowledged losing focus on some care processes as their attention was diverted to new or priority initiatives. The second condition—that the facility lacked consistently effective structures and processes for oversight, communication, and follow-up of performance measures and related activities—meant that the loss of focus and subsequent decline in some measures was not identified timely.

Recommendation

The Ioannis A. Lougaris VA Medical Center Director ensures mechanisms to report and follow up on performance deficits are well-defined and disseminated to staff and monitors to confirm functionality.

Appendix A: Strategic Analytics for Improvement and Learning (SAIL) Value Model[60]

Table A.1. Measures and Weights in the SAIL Value Model prior to Q4 FY 2019

Composite	Domain (Weight)*	Measure	Weight (percent)*
Quality	Acute Care Mortality (12 percent)	In-hospital Standardized Mortality Ratio (SMR)*	6.0
		30-Day SMR	6.0
	Avoidable Adverse Events (12 percent)	In-Hospital Complications*	6.0
		Healthcare Associated Infections	6.0
		Inpatient-Post Acute Care Events*	0.0
		Patient Safety Indicators	0.0
	Length of Stay and Throughput (12 percent)	Adjusted Length of Stay	7.2
		% Admit and Continued Stay Reviews Met	4.8
		Emergency Department Throughput	0.0
	Mental Health (12 percent)	Population Coverage	4.0
		Continuity of Care	4.0
		Experience of Care	4.0
	Performance Measures (8 percent)	ORYX	4.0
		HEDIS EPRP Based	2.4
		HEDIS eQM Based	1.6
	Employee Satisfaction (8 percent)	AES Best Places to Work	4.0
		Registered Nurse Turnover*	4.0
	Patient Experience (12 percent)	Overall Rating of Hospital (Inpatient)	3.0

[60] VSSC, SAIL Value Model.

		Care Transition (Inpatient)	2.0
		Rating of PC and SC Providers	4.0
		PCMH and SC Care Coordination	2.0
		Stress Discussed (PCMH)	1.0
	Care Transition (12 percent)	Ambulatory Care Sensitive Conditions Hospitalizations	7.2
		All Cause 30-Day Readmissions	4.8
		Excess Days in Acute Care*	0.0
	Access to Care (12 percent)	Timely Appointment, Care, and Information (PCMH and SC)	6.7
		Days Waited for Urgent Care (PCMH)	1.7
		Call Pick Up Speed and Abandonment	3.6
		PC, SC, and MH Wait Times	0.0
Efficiency/ Capacity	Clinical and Administrative Efficiency		
	Physician Capacity		
	Advanced Practice Provider Capacity*		

Source: VHA SAIL data metrics

**Beginning with Q4 FY 2019, these domains and measures no longer apply. Additionally, the domains are no longer weighted.*

Appendix B: Fiscal Year and Quarter Abbreviations

Because SAIL references performance measure data by fiscal year and quarter, the following table explains the time frame involved and how it is displayed in this report.

Table B.1. Explanation of Abbreviations

Time Frame	Explanation	Display
October 1 through December 31, 2016	1st quarter fiscal year 2017	Q1 FY 2017
January 1 through March 31, 2017	2nd quarter fiscal year 2017	Q2 FY 2017
April 1 through June 30, 2017	3rd quarter fiscal year 2017	Q3 FY 2017
July 1 through September 30, 2017	4th quarter fiscal year 2017	Q4 FY 2017
October 1 through December 31, 2017	1st quarter fiscal year 2018	Q1 FY 2018
January 1 through March 31, 2018	2nd quarter fiscal year 2018	Q2 FY 2018
April 1 through June 30, 2018	3rd quarter fiscal year 2018	Q3 FY 2018
July 1 through September 30, 2018	4th quarter fiscal year 2018	Q4 FY 2018
October 1 through December 31, 2018	1st quarter fiscal year 2019	Q1 FY 2019
January 1 through March 31, 2019	2nd quarter fiscal year 2019	Q2 FY 2019
April 1 through June 30, 2019	3rd quarter fiscal year 2019	Q3 FY 2019
July 1 through September 30, 2019	4th quarter fiscal year 2019	Q4 FY 2019

Source: OIG

Appendix C: External Peer Review Program

For over 25 years, VHA has used EPRP for quality performance data management, research, and public reporting. The program serves to monitor care provided to veterans. EPRP contracts with Quality Insights, Inc. to ensure accurate data reporting. VHA data are collected from medical record abstraction and electronic databases; the data inform the HEDIS and ORYX performance measures.[61] Each VHA facility designates an EPRP liaison to coordinate data abstraction processes and functions.

Quality Insights provides data collection, analysis, and reports to VHA. Performance Measurement administers the EPRP VHA-wide contract with Quality Insight. According to VHA, "Performance Measurement is within the Office of Reporting, Analytics, Performance Improvement, and Deployment and reports to the Offices of the Under Secretary and Principal Deputy Under Secretary for Health."[62] Measures are reported as part of the SAIL report, The Joint Commission accountability measures, and Centers for Medicare and Medicaid Services for external reporting.

Table C.1. ORYX90_1 Performance Measures

Composite Name	Quality Measure	Measure Description
HBIPS90	Ipsa1a	Hospital Based Inpatient Services: Admission screening-completed overall rate
HBIPS90	Ipsa6a	Hospital Based Inpatient Services: Justification for multiple antipsychotic discharge medications overall rate
GM90	Sub10	Alcohol Use Screening
GM90	Sub20	Alcohol Use Brief Intervention Offered or Provided
GM90	Sub40	Alcohol/Other Drug Use Disorder Treatment Provided or Offered at Discharge
GM90	imm4	Influenza Immunization
GM90	tob10	Inpatient Tobacco Use Screening
GM90	tob20	Tobacco Use Treatment Provided or Offered
GM90	tob40	Tobacco Use Treatment Provided or Offered at Discharge

Source: SAIL data definitions

[61] EPRP abstractors are registered nurses, registered health information administrators, or registered health information technicians.

[62] VHA Guide, *External Peer Review Program Guide,* September 1, 2018.

Appendix D: Survey Questions and Reporting Measures

Rating of Primary Care and Specialty Care Providers[63]

The survey uses the following question "Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?"

The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).

Stress Discussed[64]

The survey uses the following question "In the last 6 months, did you and anyone in this provider's office talk about things in your life that worry you or cause you stress?" Responses are Yes or No.

The reporting measure is calculated as the percentage of responses that fall in the top category (Yes).

Care Coordination[65]

The survey uses the following questions:

- "In the last 6 months, how often did this provider seem to know the important information about your medical history?"
- "In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?"
- "In the last 6 months, how often did you and someone from this provider's office talk about all the prescription medicines you were taking?"

Responses for each question are: Never, Sometimes, Usually, or Always. The score on each item is calculated as the percentage of responses that fall in the top category (Always).

[63] Agency for Healthcare Research and Quality, *Consumer Assessment of Healthcare Providers and Systems Clinician and Group Survey.* https://www.ahrq.gov/cahps/surveys-guidance/cg/index.html. (This website was accessed on May 1, 2020)

[64] Agency for Healthcare Research and Quality, *Supplemental Patient-Centered Medical Home Items for the CAHPS® Clinical and Group Survey 3.0*. https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/item-sets/PCMH/about_pcmh-item-set-cg30-2314.pdf. (This website was accessed on May 1, 2020)

[65] Agency for Healthcare Research and Quality, *Consumer Assessment of Healthcare Providers and Systems Clinician and Group Survey*.

The reporting measure is calculated as the average of the scores on the three items.

Care Transition (Inpatient)[66]

The survey uses the following questions:

- "During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left."
- "When I left the hospital, I had a good understanding of the things I was responsible for in managing my health."
- "When I left the hospital, I clearly understood the purpose for taking each of my medications."

Responses for each question are: Strongly disagree, Disagree, Agree, or Strongly agree. The score on each item is calculated as the percentage of responses that fall in the top category (Strongly Agree). The reporting measure is calculated as the average of the scores on the three items.

[66] Hospital Consumer Assessment of Healthcare Providers and Systems, *HCAHPS Survey,* pp. 3-4. https://hcahpsonline.org/en/survey-instruments/. (This website accessed on May 1, 2020.)

Appendix E: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 17, 2020

From: Director, VISN 21 Sierra Pacific Network (10N21)

Subj: Healthcare Inspection—Focused Performance Review of Select Metrics at the Ioannis A. Lougaris VA Medical Center in Reno, Nevada

To: Director, Rapid Response, Office of Healthcare Inspections (54RR00)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review the draft report. Leadership at the Reno facility has developed a very robust process to ensure ongoing monitoring of metrics and will ensure when opportunities for improvement are identified, that action is taken.

2. Should you have any questions please contact the VISN 21 office.

(*Original signed by*:)

John A. Brandecker
Network Director

Appendix F: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 17, 2020

From: Director, Ioannis A. Lougaris VA Medical Center Reno, NV (654)

Subj: Healthcare Inspection—Focused Performance Review of Select Metrics at the Ioannis A. Lougaris VA Medical Center in Reno, Nevada

To: Director, VISN 21 Sierra Pacific Network (10N21)

1. Thank you for the opportunity to review the draft report. I concur with the recommendation to ensure mechanisms to report and follow up on performance deficits are well-defined and disseminated to staff and monitor to confirm functionality.
2. An associated action plan has been developed with a target date for completion of September 30, 2020

(*Original signed by*:)

Lisa Howard
Director, VA Sierra Nevada Health Care System

Facility Director Response

Recommendation

The Ioannis A. Lougaris VA Medical Center Director ensures mechanisms to report and follow up on performance deficits are well-defined and disseminated to staff and monitors to confirm functionality.

Concur.

Target date for completion: September 30, 2020

Director Comments

Oversight of performance metrics is a priority for VA Sierra Nevada Health Care System (VASNHCS) as metrics are indicators of evidence-based, quality patient care. In 2019, the VASNHCS began our journey to becoming a High Reliable Organization. Through leadership engagement and continuous process improvement, we have become more focused on sensitivity to operations, being preoccupied with failure, and ensuring a just and safe culture for our veterans and staff. This journey has also led us to embrace a culture of speaking up, stopping the line, and committing to zero harm. Through this journey and our commitment to zero harm, we have renewed our focus on oversight and communication of metrics throughout the health care system.

As part of improved communication, transparency and accountability, Next Level Huddles were created by Leadership in the fall of 2019 where each service shares a quick overview of metrics, their action plans to address fall outs, and needs for assistance if necessary. These huddles occur on a rotating weekly basis. Great success, networking, and partnering has come from these huddles. Although temporarily suspended during COVID [coronavirus disease] operations, Next Level Huddles are being reinstituted, effective June 2020. The huddles were initially hosted in the Executive Leadership suite and will now be hosted virtually to support physical distancing. Attendance will be documented by Quality Management or Executive Leadership Health Systems Specialists; however, minutes are not taken given the informal nature of the discussions.

An additional change focused on improving metric oversight and communication came in the form of changes to Quality Executive Council. The Council format and focus was restructured in November 2019. Reporting of metrics and associated action plans is more robust. Reports are now submitted with metric trending over time. When opportunities for improvement are noted by the Council, discussions occur with the appropriate staff, and actions are monitored for improvement and brought back to the Council for follow-up. A calendar is regularly published listing which performance metrics and reports are due for presentation, some monthly, others quarterly, etc. Quality Executive Council is regularly attended by Executive Leadership, and

minutes from this Council are then presented quarterly at the Quality Safety Value – Executive Leadership Board (QSV-ELB). Although temporarily suspended during COVID operations, Quality Executive Council is resuming regular meetings virtually in June 2020.

A third initiative we have undertaken to improve dissemination of metrics throughout the facility is an update to service-level huddle boards. Following a similar format, all huddle boards are in the process being revamped to incorporate more service-specific performance metrics, to include adapting to an electronic format to support virtual huddles. This permits front line staff to have knowledge and oversight of the metrics they can influence while giving them ownership and pride in their daily work. Quality Management staff will help guide and facilitate the process to include performing random monthly audits (i.e., spot checks) of service-level huddle boards to ensure compliance with metric status and dissemination. Results of audits will be reported to QSV-ELB quarterly.

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