DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Portland Health Care System in Oregon

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Figure 1. *VA Portland Health Care System in Oregon.*

Source: <https://vaww.va.gov/directory/guide/> (accessed September 9, 2020).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
DDPCS	Deputy Director for Patient Care Services
FPPE	focused professional practice evaluation
FY	fiscal year
HRS	high risk for suicide
LIP	licensed independent practitioner
LST	life-sustaining treatment
LSTD	life-sustaining treatment decision
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
RME	reusable medical equipment
SAIL	Strategic Analytics for Improvement and Learning
SLB	state licensing board
SOP	standard operating procedure
SPC	suicide prevention coordinator
SPS	Sterile Processing Services
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Portland Health Care System and multiple outpatient clinics in Oregon. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

1. COVID-19 pandemic readiness and response[1]

2. Quality, safety, and value

3. Medical staff privileging

4. Medication management (targeting long-term opioid therapy for pain)

5. Mental health (focusing on the suicide prevention program)

6. Care coordination (spotlighting life-sustaining treatment decisions)

7. Women's health (examining comprehensive care)

8. High-risk processes (emphasizing reusable medical equipment)

The OIG conducted an unannounced virtual review of the VA Portland Health Care System during the week of September 14, 2020. However, due to active wildfires and ongoing evacuations within close proximity of the healthcare system, the OIG suspended the virtual review and rescheduled it for the following week. The OIG held interviews during the week of September 21, 2020, and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes.

Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this healthcare system's performance within the identified focus

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[1] "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It." World Health Organization, accessed August 25, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 (coronavirus disease) is an infectious disease caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)."

areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this healthcare system and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued 17 recommendations directed to the Director, Chief of Staff, and Deputy Director for Patient Care Services. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual review, the healthcare system's leadership team consisted of the Director, Chief of Staff, Deputy Director for Patient Care Services, Deputy Director, and Associate Director. Organizational communications and accountability were managed through a committee reporting structure, with the Executive Leadership Board overseeing several working groups. The leaders monitor patient safety and care through the Quality, Safety and Value Council, which is responsible for tracking and trending quality of care and patient outcomes.

When the OIG conducted this inspection, the healthcare system's leaders had served in their roles for more than a year. The Deputy Director for Patient Care Services was the most tenured leader, permanently assigned in April 1996, and the Deputy Director was the newest member of the leadership team, assigned in June 2019. The Chief of Staff and the Director had served in their positions since October and November 2018, respectively. The Associate Director was assigned in January 2014.

The OIG reviewed employee satisfaction survey results and concluded that the Director and Associate Director appeared to have opportunities to improve employee satisfaction, while the Director and Deputy Director for Patient Care Services seemed to have opportunities to improve staff feelings of "moral distress" at work.[2] However, in general, employees appeared satisfied with the work environment and felt safe bringing forth issues and concerns to leadership. Selected patient experience survey results were notably higher than VHA inpatient and outpatient averages. However, outpatient Patient-Centered Medical Home survey results indicated opportunities to improve patient experience. In individual interviews, the executive leaders were able to describe actions taken during the previous 12 months to maintain or improve employee satisfaction and patient experiences.

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[2] "Survey Instruments," VA Workforce Surveys Portal, VHA Support Service Center, accessed May 3, 2021, http://aes.vssc.med.va.gov/SurveyInstruments/Pages/default.aspx. (This is an internal website not publicly accessible.) The 2019 All Employee Survey defines moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing."

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[3] However, the OIG noted that the healthcare system's process for identifying sentinel events could be strengthened.

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[4]

In individual interviews, the executive leaders, except for the Deputy Director for Patient Care Services, were able to speak about selected VHA data used by healthcare system and community living center SAIL measures and should continue to take actions to sustain and improve performance.[5]

COVID-19 Pandemic Readiness and Response

The results of the OIG's evaluation of the healthcare system's COVID-19 pandemic readiness and response were compiled and reported with other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[6]

Quality, Safety, and Value

The healthcare system complied with some of the requirements for quality, safety, and value oversight functions. However, the OIG identified weaknesses in the implementation of improvement actions and root cause analyses.

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

[4] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center , accessed March 6, 2020, https://vssc.med.va.gov. (This is an internal VA website not publicly accessible.)

[5] VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers,* June 1, 2017. Community living centers, previously known as nursing home care units, provide a skilled nursing environment and a variety of interdisciplinary programs for persons needing short- and long-stay services.

[6] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*, Report No. 21-01116-98, March 16, 2021.

Medical Staff Privileging

The OIG found compliance with the requirements for ongoing professional practice evaluations. However, the OIG noted deficiencies with focused professional practice evaluations and provider exit review processes.[7]

Medication Management

The healthcare system addressed some of the indicators of expected performance, including initial pain screening, documented justification for concurrent therapy with benzodiazepines, and a multidisciplinary pain management committee to oversee and monitor quality measures. However, areas for improvement included aberrant behavior risk assessments, urine drug testing, informed consent, and patient follow-up.

Mental Health

The healthcare system complied with requirements for the designation of a suicide prevention coordinator, tracking of high-risk veterans, patient contact for missed appointments, and completion of suicide safety plans. However, the OIG identified deficiencies with the timely completion of four mental health visits and staff training.

Care Coordination

The healthcare system generally complied with the requirement for the Life Sustaining Treatment Advisory Group. However, the OIG identified a concern with the completion of life-sustaining treatment decision progress notes.

Women's Health

The healthcare system complied with requirements for the provision of care, including a designated Women's Health Patient Aligned Care Team, women's health primary care providers, and available gynecologic care coverage. However, the OIG identified weaknesses with the Women Veterans Health Committee.

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

High-Risk Processes

The healthcare system met many of the requirements for the proper operations and management of reusable medical equipment. However, the OIG identified deficiencies with standard operating procedures, humidity maintenance, and staff training.

Conclusion

The OIG conducted a detailed inspection across nine key areas (two administrative and seven clinical), and subsequently issued 17 recommendations for improvement to the Director, Chief of Staff, and Deputy Director for Patient Care Services. The number of recommendations should not be used, however, as a gauge for the overall quality of care provided at this system. The intent is for system leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if not addressed, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 69–70, and the responses within the body of the report for the full text of the directors' comments.) The OIG has received evidence of compliance and considers recommendations 3, 4, 14, and 16 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities providing healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Portland Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so that informed decisions can be made to improve care.[1]

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[2] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[3] Figure 2 illustrates the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual review, paused physical inspection steps (especially those involved in the environment of care-focused review topic), and initiated a COVID-19 pandemic readiness and response evaluation.

As such, to examine risks to patients and the organization, the OIG focused on core processes in the following nine areas of administrative and clinical operations (see figure 2):[4]

1. Leadership and organizational risks

2. COVID-19 pandemic readiness and response[5]

3. Quality, safety, and value (QSV)

4. Medical staff privileging

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[1] VA administers healthcare services through a network of 18 regional offices nationwide referred to as the Veterans Integrated Service Network.

[2] Anam Parand et al., "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9, (September 5, 2014), https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae Sfantou et al., "Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4, (December 2017): 73, https://doi.org/10.3390/healthcare5040073.

[4] Virtual CHIP site visits address these processes during fiscal year 2020 quarter 4 (July 1 through September 30, 2020); they may differ from prior years' focus areas.

[5] "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," World Health Organization, accessed August 25, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 (coronavirus disease) is an infectious disease caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)."

5. Medication management (targeting long-term opioid therapy for pain)

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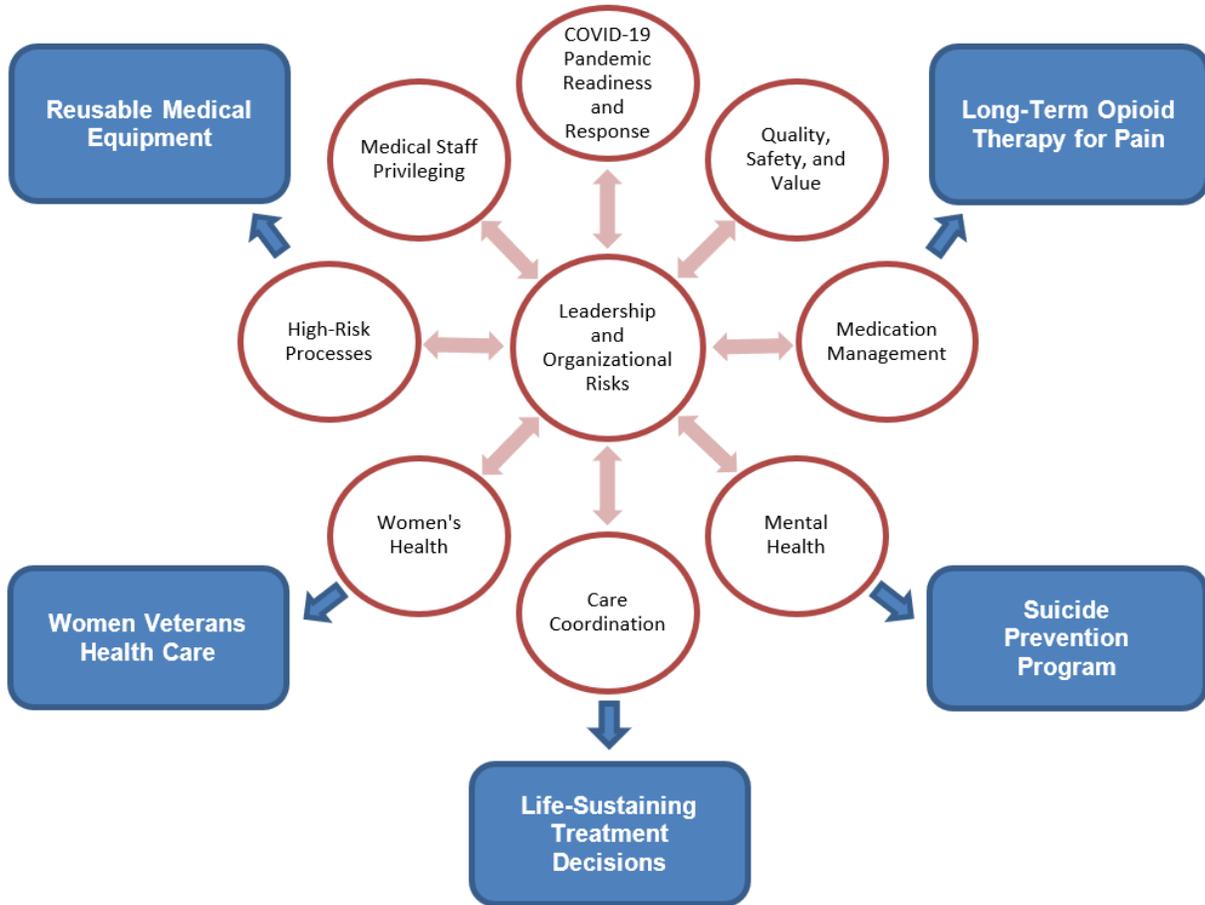9. High-risk processes (emphasizing reusable medical equipment)

Figure 2. Fiscal year (FY) 2020 comprehensive healthcare inspection of operations and services. *Source: VA OIG.*

Methodology

The VA Portland Health Care System includes multiple outpatient clinics in Oregon. Additional details about the types of care provided by the healthcare system can be found in appendixes B and C.

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality and clinical functions, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports.[6] The OIG team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The unannounced virtual review was initiated during the week of September 14, 2020. However, due to active wildfires and ongoing evacuations within close proximity of the VA Portland Health Care System, the OIG suspended the virtual review and rescheduled it for the following week. The OIG held interviews during the week of September 21, 2020, and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Thus, the inspection examined operations from December 5, 2016, through September 25, 2020, the last day of the unannounced multiday evaluation.[7] Following the virtual site visit, the OIG referred concerns beyond the scope of the inspection to the OIG's hotline management team for further review.

The results of the OIG's evaluation of the healthcare system's COVID-19 pandemic readiness and response were compiled and reported with other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[8]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[9] 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.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the healthcare system completes corrective actions. The System Director's responses to the report recommendations

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

[7] The range represents the time period from the prior Clinical Assessment Program site visit to the completion of the unannounced, multiday virtual CHIP visit in September 2020.

[8] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*, Report No. 21-01116-98, March 16, 2021.

[9] Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3).

appear within each topic area. The OIG accepted the action plans that system leaders developed based on the reasons for noncompliance.

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can affect the healthcare system's ability to provide care in the clinical focus areas.[10] To assess the healthcare system's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement

2. Employee satisfaction

3. Patient experience

4. Accreditation surveys and oversight inspections

5. Identified factors related to possible lapses in care and healthcare system response

6. VHA performance data (healthcare system)

7. VHA performance data (community living center (CLC))[11]

Executive Leadership Position Stability and Engagement

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

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[10] Laura Botwinick, Maureen Bisognano, and Carol Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare Improvement, Innovation Series White Paper, 2006.

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

Director

Chief of Staff
- Academic Affairs
- Community Care
- Group Practice Manager
- Hospital & Specialty Medicine
- Medical Practice Group
- Mental Health & Clinical Neurosciences
- Operative Care
- Primary Care
- Rehabilitation & Long Term Care
- Research & Development
- Transition & Care Management
- Virtual Care
- Women Veterans Healthcare Program

DDPCS
- Canteen
- Chaplain
- Critical Care Medicine
- Education
- Emergency Medicine
- Imaging
- Inpatient & Emergency Service
- Nursing Professional Service
- Pathology & Laboratory
- Pharmacy
- Social Work
- Sterile Processing
- Whole Health

Deputy Director
- Contracting
- Environmental Management
- Facilities Management
- Fiscal Services
- Human Resources
- Occupational Safety
- Office of Information & Technology
- Strategic Planning
- Supply Chain Management

Associate Director
- Audiology & Speech Pathology
- Business Office
- Compensation & Pension
- Employee Health
- Nutrition & Food Services
- Police Services
- Privacy Officers
- Prosthetics and Sensory Aids
- Veteran Experience
- Veteran Transportation Program
- Voluntary

- Compliance
- Equal Employment Opportunity/Minority Veterans
- Integrated Ethics
- Northwest Innovation Center
- Public Affairs
- Quality, Safety & Value
- Research Compliance
- System Improvement & Safety

Figure 3. Healthcare system organizational chart.

Source: VA Portland Health Care System (received September 18, 2020).

At the time of the OIG virtual review, the executive team had served in their roles for more than a year. The DDPCS was the most tenured leader, permanently assigned in April 1996, while the Deputy Director was the newest member of the leadership team, assigned in June 2019. The Chief of Staff and the Director had served in their positions since October and November 2018, respectively. The Associate Director was assigned in January 2014 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	November 25, 2018
Chief of Staff	October 14, 2018
Deputy Director for Patient Care Services	April 28, 1996
Deputy Director	June 23, 2019
Associate Director	January 12, 2014

Source: VA Portland Health Care System Human Resources Officer (received September 14, 2020).

To help assess the healthcare system executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, DDPCS, and Associate Director regarding their knowledge of various

performance metrics and their involvement and support of actions to improve or sustain performance. The Deputy Director was on leave and not interviewed. The OIG also learned that the Deputy Director was recently appointed as the Director at another VA facility, effective October 2020.

The executive leaders, except for the DDPCS, were able to speak about VHA data and/or system-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. In individual interviews, the executive leadership team members were able to describe actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

The Director serves as the chairperson of the Executive Leadership Board, which has the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board oversees various working groups such as Healthcare Operations and the Medical Staff, Nursing Professional, and Organizational Health Councils.

These leaders monitor patient safety and care through the Quality, Safety and Value Council (formerly known as the Executive Quality Board). This council is responsible for tracking and trending quality of care and patient outcomes and reports to the Executive Leadership Board (see figure 4).
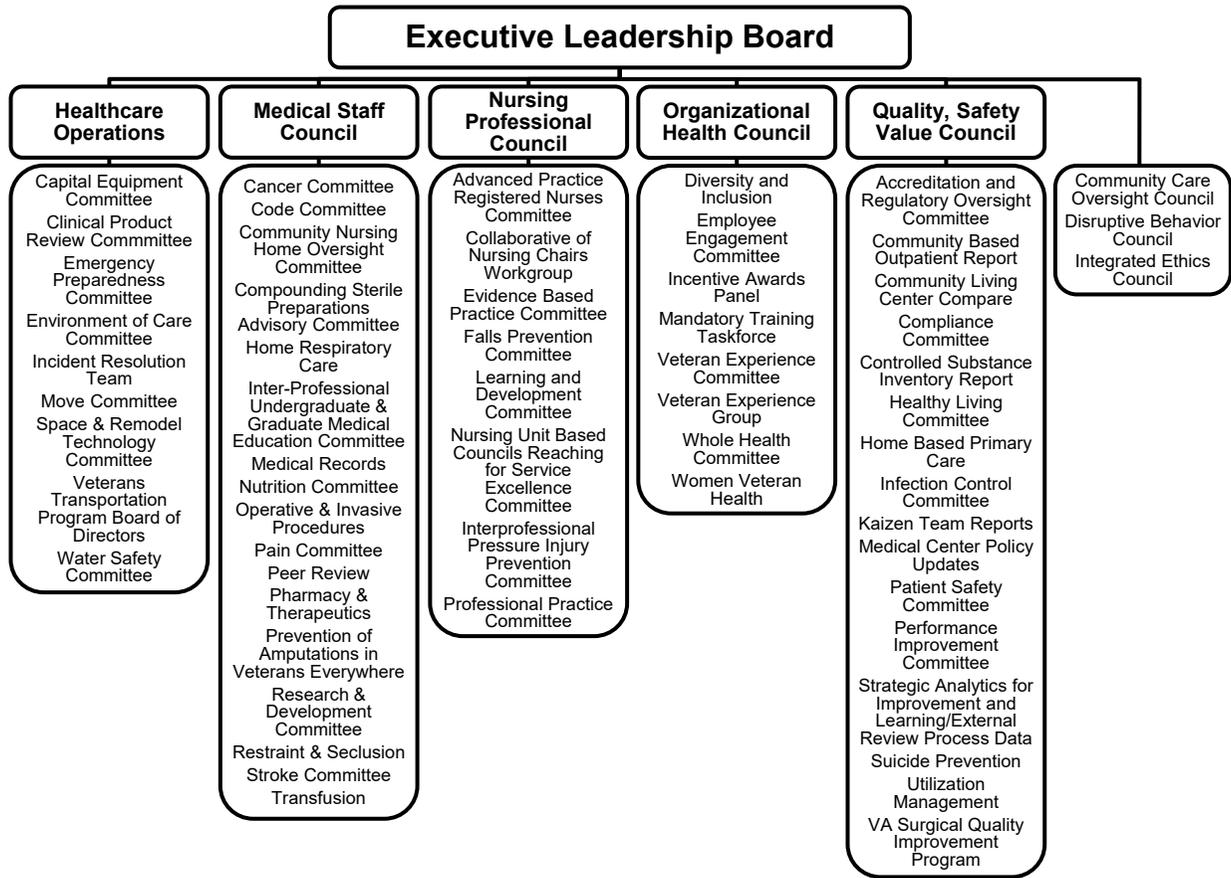
Executive Leadership Board

Healthcare Operations	Medical Staff Council	Nursing Professional Council	Organizational Health Council	Quality, Safety Value Council	
Capital Equipment Committee	Cancer Committee	Advanced Practice Registered Nurses Committee	Diversity and Inclusion	Accreditation and Regulatory Oversight Committee	Community Care Oversight Council
Clinical Product Review Committee	Code Committee	Collaborative of Nursing Chairs Workgroup	Employee Engagement Committee	Community Based Outpatient Report	Disruptive Behavior Council
Emergency Preparedness Committee	Community Nursing Home Oversight Committee	Evidence Based Practice Committee	Incentive Awards Panel	Community Living Center Compare	Integrated Ethics Council
Environment of Care Committee	Compounding Sterile Preparations Advisory Committee	Falls Prevention Committee	Mandatory Training Taskforce	Compliance Committee	
Incident Resolution Team	Home Respiratory Care	Learning and Development Committee	Veteran Experience Committee	Controlled Substance Inventory Report	
Move Committee	Inter-Professional Undergraduate & Graduate Medical Education Committee	Nursing Unit Based Councils Reaching for Service Excellence Committee	Veteran Experience Group	Healthy Living Committee	
Space & Remodel Technology Committee	Medical Records	Interprofessional Pressure Injury Prevention Committee	Whole Health Committee	Home Based Primary Care	
Veterans Transportation Program Board of Directors	Nutrition Committee	Professional Practice Committee	Women Veteran Health	Infection Control Committee	
Water Safety Committee	Operative & Invasive Procedures			Kaizen Team Reports	
	Pain Committee			Medical Center Policy Updates	
	Peer Review			Patient Safety Committee	
	Pharmacy & Therapeutics			Performance Improvement Committee	
	Prevention of Amputations in Veterans Everywhere			Strategic Analytics for Improvement and Learning/External Review Process Data	
	Research & Development Committee			Suicide Prevention	
	Restraint & Seclusion			Utilization Management	
	Stroke Committee			VA Surgical Quality Improvement Program	
	Transfusion				

***Figure 4.** Healthcare system committee reporting structure.*
Source: VA Portland Health Care System (received September 16, 2020).

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[12] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leadership.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2018, through

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[12] "AES Survey History," VA Workforce Surveys Portal, VHA Support Service Center, accessed May 3, 2021, http://aes.vssc.med.va.gov/Documents/04_AES_History_Concepts.pdf. (This is an internal website not publicly accessible.)

September 30, 2019.[13] Table 2 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the healthcare system average for the selected survey leadership questions was generally similar to the VHA average.[14] Survey scores for the Chief of Staff, DDPCS, and Deputy Director were consistently higher than those for VHA and the healthcare system. These leaders appeared to have created a positive workplace environment and were actively engaged with employees (for example, by conducting regular face-to-face meetings and sharing governance for some program areas). However, scores for the Director and Associate Director highlight opportunities for these leaders to improve employee attitudes. The Director attributed the significantly low servant leadership score to being new to the position at the time of the survey and making unpopular staffing decisions early on to implement changes. However, the Director remains optimistic that staff will adapt to the current leadership style and feel more comfortable communicating issues or concerns.

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	DDPCS Average	Deputy Director Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	72.6	74.1	58.6	82.6	85.0	92.0	70.5
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.4	3.2	3.2	3.6	3.9	4.0	2.8

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

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	DDPCS Average	Deputy Director Average	Assoc. Director Average
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.5	3.6	4.0	3.9	3.8	3.3
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.4	3.5	4.0	3.9	4.0	3.7

Source: VA All Employee Survey (accessed August 11, 2020).

*The Servant Leader Index "is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others' contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others' needs before their own."

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[15] The healthcare system average for the selected survey questions was similar to the VHA average. Leaders' survey results were generally similar to or better than those for VHA; however, the moral distress results for the Director and DDPCS were worse than the VHA average. Leaders appeared to have created a culture where employees feel safe bringing forth concerns and doing the right thing but have opportunities to improve employee feelings of moral distress at work.

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

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	DDPCS Average	Deputy Director Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.8	3.9	4.4	4.3	4.6	3.8
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.7	3.7	3.8	4.2	4.6	4.4	3.6
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)– 6 (Every Day)	1.4	1.6	2.1	1.6	1.8	0.8	1.1

Source: VA All Employee Survey (accessed August 11, 2020).

Patient Experience

To assess patient experiences with the healthcare system, which directly reflect on its leaders, the OIG team reviewed survey results that relate to the period of October 1, 2018, through September 30, 2019. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector.

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 4 provides relevant survey results for VHA and the healthcare system.[16] Patient survey results at this system were notably higher than VHA averages, except for the outpatient Patient-Centered Medical Home results. Patients generally appeared satisfied with the care provided.

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

Questions	Scoring	VHA Average	Healthcare System Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.3	75.6
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	87.6
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	77.3	76.2

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[16] Ratings are based on responses by patients who received care at this healthcare system.

Questions	Scoring	VHA Average	Healthcare System Average
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	78.0	81.2

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

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

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients' experiences by gender (see tables 5–7), including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG noted that male and female patients appeared satisfied with their Inpatient and Specialty Care experiences. However, leaders appeared to have opportunities to improve the Patient-Centered Medical Home experience.

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

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	82.8	91.7	85.8
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.8	83.1	91.2	88.2

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

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	68.7	61.8	76.1	64.1

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 6, 2020).

*The VHA averages are based on 48,259–48,798 male and 2,342–2,359 female respondents, depending on the question.

The healthcare system averages are based on 464–469 male and 24 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.2	43.3	52.1	32.8
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.9	49.7	59.9	56.3
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.6	65.7	70.6	63.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 6, 2020).

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

The healthcare system averages are based on 993–2,568 male and 70–165 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.5	44.7	53.7	71.7
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	55.0	54.9	59.6
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	70.4	70.1	71.2	74.3

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed May 6, 2020).

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

The healthcare system averages are based on 623–2,071 male and 33 or 121 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[18] Table 8 summarizes the relevant system inspections most recently performed by the OIG and The Joint

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[18] "Profile Definitions and Methodology: Joint Commission Accreditation," *American Hospital Directory*, accessed December 12, 2020, https://www.ahd.com/definitions/prof_accred.html. "The Joint Commission conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization."

Commission (TJC).[19] The system had a focused OIG inspection in March 2020 and the five recommendations for improvement remained open at the time of the OIG's review. The QSV Director reported continuing to work with system managers to address the five open recommendations.

At the time of the virtual review, the OIG team noted the system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[20] Additional results included the Long Term Care Institute's inspection of the system's CLC.[21]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Clinical Assessment Program Review of the VA Portland Health Care System, Portland, Oregon*, Report No. 16-00547-156, March 16, 2017)	December 2016	14	0
OIG (*Alleged Deficiencies in the Management of Staff Exposure to a Patient with COVID-19 at the VA Portland Health Care System in Oregon*, Report No. 20-02240-248, August 27, 2020)	March 2020	5	5*

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

[20] VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs*, May 9, 2017. The Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment is supported through a system-wide, long-term collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs. "About the College of American Pathologists," College of American Pathologists, accessed April 26, 2021, https://www.cap.org/about-the-cap. According to the College of American Pathologists, for 75 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." Additionally, as stated in VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
TJC Hospital Accreditation	September 2019	34	0
TJC Behavioral Health Care Accreditation		3	0
TJC Home Care Accreditation		6	0

Source: OIG and TJC (inspection/survey results verified with the Assistant Director, QSV on September 23, 2020).

*As of May 2021, all recommendations for improvement were closed.

Identified Factors Related to Possible Lapses in Care and Healthcare System Response

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. The OIG's review of the healthcare system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. However, the OIG noted a concern related to the potential for patient harm in the patient safety program.

Table 9 lists the reported sentinel events and disclosures from December 5, 2016 (the prior OIG comprehensive healthcare inspection), through September 23, 2020.[22] The OIG noted system leaders' and clinicians' efforts to be transparent by informing patients that an adverse event had occurred as evidenced by 55 institutional disclosures—28 of which were considered sentinel events—and taking corrective actions for improvement. However, the OIG determined that four disclosed adverse events should have been classified as sentinel events. This may have resulted in under-reporting of sentinel events at the healthcare system. Despite this, the OIG confirmed

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[22] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The OIG noted that the VA Portland Health Care System is a high complexity (1a) affiliated system as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." Lastly, in VHA Directive 1004.08, VHA defines a large-scale disclosure of adverse events (sometimes referred to as a "notification") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."

that program managers had conducted all required investigations, such as management and protected peer reviews.

Table 9. Summary of Selected Organizational Risk Factors
(December 5, 2016, through September 23, 2020)

Factor	Number of Occurrences
Sentinel Events	28
Institutional Disclosures	55
Large-Scale Disclosures	0

Source: VA Portland Health Care System's Patient Safety/Risk Awareness Operations Manager and Risk Managers (received September 23, 2020).

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[23]

Figure 5 illustrates the system's quality of care and efficiency metric rankings and performance compared with other VA facilities as of March 31, 2020. Of note, figure 5 uses blue and green data points to indicate high performance for the VA Portland Health Care System (for example, in the areas of emergency department (ED) throughput, specialty care (SC) care coordination, adjusted length of stay (LOS), and care transition). Metrics that need improvement are denoted in orange and red (for example, healthcare associated (HC assoc) infections, rating (of) primary care (PC) provider, patient-centered medical home (PCMH) same day appointment (appt), and mental health population (MH popu) coverage).[24]

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[23] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center, accessed March 6, 2020, https://vssc.med.va.gov. (This is an internal VA website not publicly accessible.)

[24] For information on the acronyms in the SAIL metrics, please see appendix E.
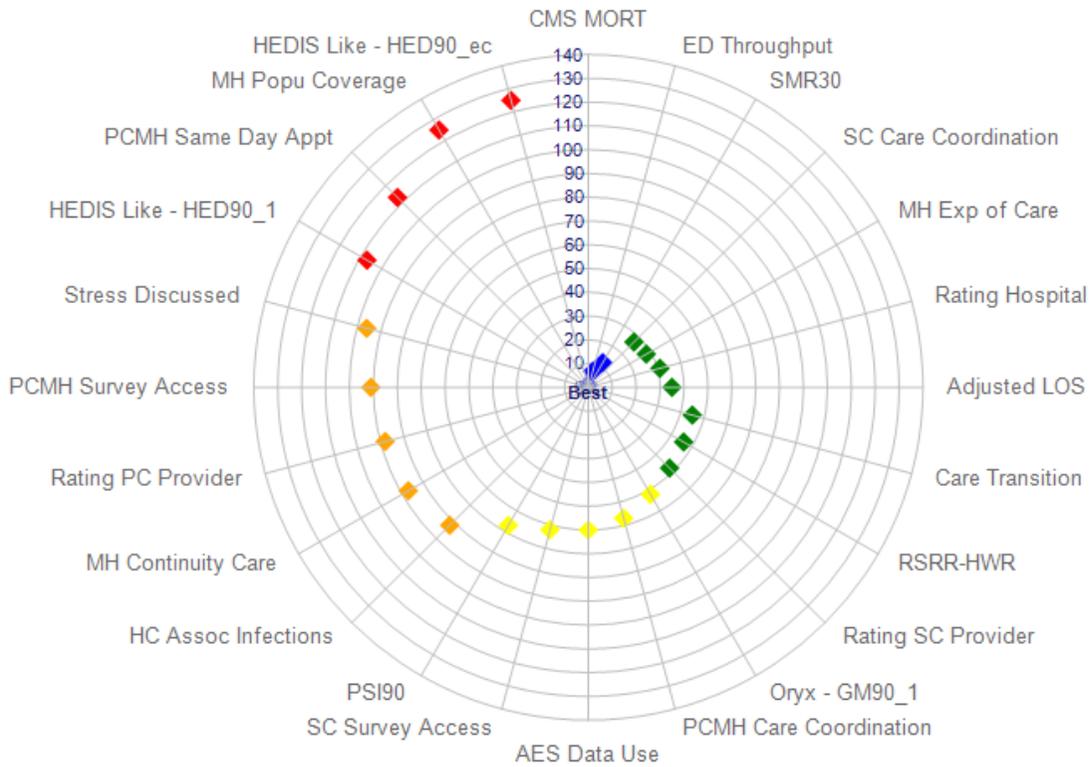
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Figure 5. *System quality of care and efficiency metric rankings, FY 2020 quarter 2 (as of March 31, 2020).*

Source: VHA Support Service Center.

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

Veterans Health Administration Performance Data for Community Living Centers

The CLC SAIL Value Model is a tool to "summarize and compare the performance of CLCs in the VA." The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[25]

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[25] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, July 23, 2020. "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

Figure 6 illustrates the system's CLC quality rankings and performance compared with other VA CLCs as of March 31, 2020. Figure 6 uses blue data points to indicate high performance for the Portland CLC (for example, in the areas of physical restraints–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), and discharged to community (SS)). Metrics that need improvement are denoted in orange and red (for example, outpatient emergency department (ED) visit (SS), catheter in bladder (LS)), and moderate-severe pain (LS)).[26]
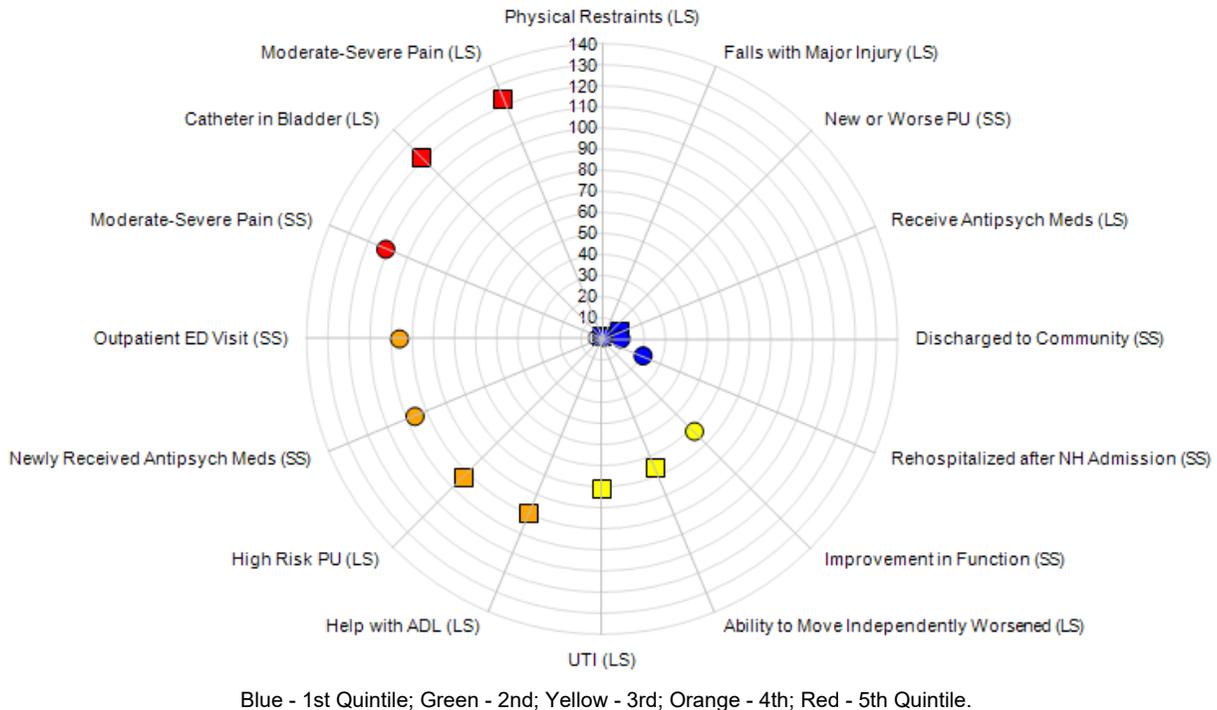

Blue - 1st Quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th Quintile.

Figure 6. Portland CLC quality measure rankings, FY 2020 quarter 2 (as of March 31, 2020).

LS = Long-Stay Measure   SS = Short-Stay Measure

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Conclusion

The system's executive leadership team appeared stable, with all positions permanently assigned at the time of the OIG's virtual inspection. Selected employee satisfaction survey results revealed opportunities for the Director and Associate Director to improve employee satisfaction, and the Director and DDPCS to improve staff feelings of moral distress at work. However, in general, employees appeared satisfied with the work environment and felt safe bringing forth issues and concerns to leadership. The OIG noted that patients appeared satisfied with their Inpatient and Specialty Care experiences. However, leaders have opportunities to improve the Patient-

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

Centered Medical Home experience. The OIG's review of the system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. However, the OIG noted concerns with the healthcare system's identification of sentinel events. In individual interviews, the executive leaders were able to describe actions taken during the previous 12 months to maintain or improve employee satisfaction and patient experiences. In addition, the executive leaders, except for the DDPCS, were able to speak about selected VHA data used by SAIL and CLC SAIL measures and should continue to take actions to improve performance.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[27] VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.[28]

During this time, VA continued providing for veterans' healthcare needs and engaged its fourth mission, "the provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have VA eligibility for such care and services."[29] "In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans."[30]

Due to VHA's mission-critical work in supporting both veteran and civilian populations during the pandemic, the OIG conducted an evaluation of the pandemic's impact on the system and its leaders' subsequent response. The OIG analyzed performance in the following domains:

- Emergency preparedness

- Supplies, equipment, and infrastructure

- Staffing

- Access to care

- CLC patient care and operations

The OIG also surveyed healthcare system staff to solicit their feedback and potentially identify any problematic trends and/or issues that may require follow-up. The results of the OIG's evaluation of the healthcare system's COVID-19 pandemic readiness and response were compiled and reported with other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[31]

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[27] "WHO Director General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, accessed March 23, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

[28] VHA Office of Emergency Management, *COVID-19 Response Plan*, March 23, 2020.

[29] 38 U.S.C § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission for the provision of hospital care and medical services during certain disasters and emergencies: "During and immediately following a disaster or emergency…VA under 38 U.S.C §1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

[30] VA OIG, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness, March 19–24, 2020,* Report No. 20-02221-120, March 26, 2020.

[31] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*, Report No. 21-01116-98, March 16, 2021.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.[32] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[33] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[34]

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

- Review of aggregated QSV data

- Recommendation and implementation of improvement actions

- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the healthcare system's processes for conducting protected peer reviews of clinical care.[35] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[36] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[37] The OIG team examined the completion of the following elements:

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[32] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

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

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

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

[36] VHA Directive 1190.

[37] VHA Directive 1190.

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

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

- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[38]

- Completion of final reviews within 120 calendar days

- Implementation of improvement actions recommended by the Peer Review Committee

- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Next, the inspection team assessed the healthcare system's utilization management (UM) program, a key component of VHA's framework for quality, safety, and value, which provides vital tools for managing the quality and the efficient use of resources.[39] It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[40] Inspectors reviewed several aspects of the UM program:

- Completion of at least 80 percent of all required inpatient reviews

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

- Interdisciplinary review of UM data

- Implementation and monitoring of improvement actions recommended by the interdisciplinary UM group

Finally, the OIG reviewers assessed the healthcare system's reports of patient safety incidents with related root cause analyses.[41] Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root

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[38] VHA Directive 1190.

[39] VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019, UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." (This directive was rescinded and replaced with VHA Directive 1117, *Utilization Management Program*, October 8, 2020.)

[40] VHA Directive 1117(2).

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

cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the healthcare system.[42] The healthcare system was assessed for its performance on several dimensions:

- Annual completion of a minimum of eight root cause analyses[43]

- Inclusion of required content in root cause analyses

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

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

- Submission of an annual patient safety report to healthcare system leaders

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents.[44]

Quality, Safety, and Value Findings and Recommendations

The healthcare system complied with some of the requirements for quality, safety, and value. However, the OIG identified deficiencies in the implementation of improvement actions and root cause analyses.

VHA programs, including hospitals, are "required to achieve and maintain The Joint Commission accreditation." [45] TJC standards state that facilities are to establish a governing body to provide oversight and support for quality and safety processes.[46] TJC standards also state that facilities are to measure and analyze performance using data so that improvement "effectiveness can be sustained, assessed, and measured."[47]

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[42] VHA Handbook 1050.01.

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

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

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

[46] The Joint Commission, *Standards Manual*, LD.01.01.01, September 2020. "The hospital has a leadership structure." The Joint Commission, *Standards Manual,* LD.01.03.01, September 2020. "The governing body is ultimately accountable for the safety and quality of care, treatment, and services."

[47] The Joint Commission, *Standards Manual*, LD.03.02.01, September 2020. "The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality." The Joint Commission, *Standards Manual*, LD.03.05.01, September 2020. "Leaders manage change to improve the performance of the hospital."

The Executive Quality Board serves as the governing body with oversight of QSV functions. The OIG reviewed Executive Quality Board meeting minutes during calendar year 2019 and found no evidence that the board followed up on recommended improvement actions to ensure implementation and sustained improvement.[48] This may have prevented quality of care and patient safety process improvements at the healthcare system. The QSV Director reported believing that healthcare system program managers implemented action items but could not provide evidence that the Executive Quality Board or the Quality, Safety and Value Council followed up to ensure implementation and sustained improvement.

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures the Quality, Safety and Value Council's recommended improvement actions are fully implemented and monitored.

Healthcare system concurred.

Target date for completion: 6/30/2021

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. The Quality, Safety and Value Council reviewed its process and developed an action tracking log. As of November 2020, 100% of action plans reported to and recommended by the council were added to the action tracking log and will be tracked to completion. As of May 2021, the action tracking log implementation of recommended improvement actions has been sustained for six consecutive months.

VHA requires the System Director ensures that an interdisciplinary group review UM data.[49] TJC standards also state that facilities are to improve performance using data to ensure "effectiveness can be sustained, assessed, and measured."[50] The OIG reviewed quarterly UM Committee meeting minutes from January through October 2019 and found no evidence that recommended improvement actions were fully implemented. This may have prevented UM process improvements to ensure patients received the right care, in the right setting, at the right time, and for the right reasons. The UM Manager reported believing that improvement actions were fully implemented but did not provide any evidence of implementation.

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[48] According to the QSV Director, the Executive Quality Board was renamed the Quality, Safety and Value Council, effective April 2020.

[49] VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019. (This directive was rescinded on October 8, 2020, and replaced with VHA Directive 1117. Directive 1117(2) was in place for the time frame of the minutes reviewed in this report. Both directives contain the same or similar language regarding the review of UM data by the UM Committee.)

[50] *Standards Manual*, LD.03.02.01, September 2020. *Standards Manual*, LD.03.05.01, September 2020.

Recommendation 2

2. The System Director evaluates and determines any additional reasons for noncompliance and ensures the Utilization Management Committee's recommended improvement actions are fully implemented.

Healthcare system concurred.

Target date for completion: 12/1/2021

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. The VA Portland Healthcare System Utilization Management (UM) Committee has adopted a standardized minutes template that more easily identifies action plans, due dates, and ongoing compliance data. All UM metrics not meeting compliance will have specific and measurable action plans with due dates, and documented review of the metric and intervention. This new format will guide the committee to evaluate actions and interventions for effectiveness and reevaluate those found needing more work. The UM minutes will be monitored for clearly defined plans and follow up actions until compliance is achieved quarterly.

VHA requires root cause analyses to include an "analysis of the underlying systems through a series of "why" questions to determine where redesigns might reduce risk."[51] The OIG found that none of the five root cause analyses selected for review included a systems analysis. This likely affected the evaluation of patient safety events and limited reviewers' ability to identify vulnerabilities and implement process improvements to prevent patient harm. The Patient Safety/Risk Manager Operations Manager stated that staff and leaders asked "why" questions during team meetings and believed documenting one identified reason met the standard.

Recommendation 3

3. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that root cause analyses include all required review elements.[52]

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[51] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

[52] The OIG reviewed evidence sufficient to demonstrate that the healthcare system had completed improvement actions and therefore closed the recommendation before publication of the report.

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. Each root cause analyses included the required elements, but they were not documented in a standardized manner. Audit of documentation has indicated sustained improvement of RCAs [root cause analyses] including all the required review elements >90% compliance for six consecutive months from November 2020 to April 2021. Audit documentation for evidence of compliance of the above is available to support facility proposal for early closure of this recommendation.

VHA also requires full implementation of recommended improvement actions resulting from root cause analyses.[53] The OIG determined that all five root cause analyses reviewed lacked evidence that action items were fully implemented. This could have resulted in missed opportunities to prevent patient harm events. The Patient Safety/Risk Manager Operations Manager reported believing that the receipt of clinical managers' emails stating that action items were completed, without supporting data, was sufficient evidence of full implementation.

Recommendation 4

4. The System Director evaluates and determines any additional reasons for noncompliance and ensures all root cause analysis actions are fully implemented.[54]

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. A tracking system was developed to monitor root cause analysis actions and outcome measures to completion. As of October 2020, all root cause analysis actions and outcome measures have been added to the tracking system and are tracked to completion. This action has been sustained for six consecutive months from October 2020 to March 2021. Audit documentation for evidence of compliance of the above is available to support facility proposal for early closure of this recommendation.

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[53] VHA Handbook 1050.01.

[54] The OIG reviewed evidence sufficient to demonstrate that the healthcare system had completed improvement actions and therefore closed the recommendation before publication of the report.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[55]

Clinical privileges need to be specific and based on the individual practitioner's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[56]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance." The FPPE process occurs when a provider is hired at the facility and granted initial privileges and before any new clinical privileges are granted. Additionally, VA facilities must continuously monitor the performance of their providers. VHA requirements state that "the on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered."[57] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
    - Establishment of criteria in advance
    - Use of minimum criteria for selected specialty LIPs[58]
    - Clear documentation of the results and time frames
    - Evaluation by another provider with similar training and privileges

- OPPEs
    - Application of criteria specific to the service or section
    - Use of minimum criteria for selected specialty LIPs[59]
    - Evaluation by another provider with similar training and privileges

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

[56] VHA Handbook 1100.19.

[57] VHA Handbook 1100.19.

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

[59] VHA Acting DUSHOM Memorandum, *Requirements for Peer Review of Solo Practitioners*.

The OIG determined whether service chiefs recommended continuing the LIPs' current privileges based in part on the results of OPPE activities and if the healthcare system's Executive Committee of the Medical Staff decided to recommend continuing privileges based on FPPE and OPPE results.

VA must put processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former licensed practitioner's clinical practice, VA has an obligation to notify state licensing boards (SLBs) and subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[60] Further, "VA medical facility Directors must designate an individual, and backup, to be responsible for the SLB reporting process. This individual will be the subject matter expert (SME) for the facility…and ensure oversight of the exit review process, including receipt, review, and maintenance of the Provider Exit Review Forms."[61] The OIG reviewers assessed whether the healthcare system's staff

- Designated an individual and backup responsible for the SLB reporting process,

- Completed forms within the required time frame and with required oversight, and

- Reported results to SLBs when indicated.

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

- Ten LIPs who completed an FPPE in calendar year 2019

- Ten LIPs privileged during calendar year 2019

- Twenty LIPs who left the healthcare system in calendar year 2019

Medical Staff Privileging Findings and Recommendations

The OIG found compliance with the above requirements for OPPEs but identified deficiencies with FPPE and provider exit review processes.

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[60] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005. (This handbook was rescinded on January 28, 2021, and replaced with VHA Directive 1100.18. The two documents contain similar language related to state licensing board requirements.)

[61] VHA Notice 2018-05, *Amendment to VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards*, February 5, 2018. (VHA Directive 1100.18 requires the "Credentialing and Privileging program manager to be responsible for the [state licensing board] reporting process and oversight of timely completion of exit reviews." The new directive also revises the requirement for exit review forms to be completed within seven calendar days to seven business days.)

VHA requires service chiefs ensure FPPE criteria are "defined in advance using objective criteria accepted by the practitioner."[62] The OIG did not find written documentation of LIPs' advance acceptance of FPPE criteria for 9 of 10 practitioner profiles reviewed. However, the healthcare system took steps to address the deficiency. It provided the OIG with memoranda signed by service chiefs attesting to LIPs' acceptance of FPPE criteria in advance and the adoption of a new process to ensure documentation in LIP profiles. Therefore, the OIG did not issue a recommendation.

At the time of the virtual review, VHA required provider exit review forms, which document the review of providers' clinical practices, to "be completed within 7 calendar days of the departure of a licensed health care professional from a VA facility."[63] For the 20 providers who departed the healthcare system in calendar year 2019, the OIG found that 8 exit review forms were not completed within 7 calendar days, and 1 was completed prior to the last day the LIP provided care to patients.

As of January 28, 2021, VHA requires the facility director to ensure that provider exit review forms are completed within seven business days.[64] Based on the updated requirement, six exit review forms were not completed within the new time frame. Delay or advance completion of exit forms could have resulted in untimely or missed SLB reporting of healthcare professionals. Credentialing and privileging program staff cited the belief that the exit form could be completed in advance of an LIP leaving the healthcare system and stated that service lines had inconsistent processes for notifying credentialing and privileging staff of exiting providers, which resulted in delayed completion of some forms.

Recommendation 5

5. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that provider exit review forms are completed within seven business days of licensed healthcare professionals' departure from the healthcare system.

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

[63] VHA Notice 2018-05, *Amendment to VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards*, February 5, 2018. (VHA Handbook 1100.18, was rescinded on January 28, 2021, and replaced with VHA Directive 1100.18.)

[64] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

Healthcare system concurred.

Target date for completion: 06/30/2021

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. On October 1, 2020, the Medical Professional Service implemented a new process for provider exit reviews. Instead of sending the form to the Service Chief prior to the provider leaving, the form is now sent on the day or day after the provider leaves. The Medical Profession Service monitors to ensure the provider review is completed by the Service Chief within seven business days of departure. The Medical Professional Service will monitor until 90% compliance is maintained for six consecutive months.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[65] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[66] Long-term opioid use is of particular concern in the veteran population where there is a high incidence of posttraumatic stress disorder, major depressive disorder, alcohol use, substance abuse, and suicide attempts.[67] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[68]

VHA requires routine assessments of pain and the completion of an opioid risk assessment before initiating patients on long-term opioid therapy and recommends against the therapy for patients with untreated substance use disorders. VHA also recommends avoiding drugs capable of inducing fatal interactions, such as opioids with benzodiazepines.[69] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[70] To achieve VHA's vision of providing patient-driven healthcare, providers are also required to obtain informed consent from patients and to provide education about the risks, benefits, and alternatives prior to initiating long-term opioid therapy.[71] VHA recommends evaluating patients receiving continued opioid therapy for improvement of pain and opioid-related adverse events at least every three months and more frequently as doses increase.[72]

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

- Completion of initial screening for pain

- Assessment of aberrant behavior risk

- Avoidance of concurrent therapy with benzodiazepines

- Completion of urine drug testing with intervention, when indicated

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[65] "Information Sheet on Opioid Overdose," World Health Organization, accessed November 6, 2019, https://www.who.int/substance_abuse/information-sheet/en/.

[66] "Opioid Overdose, Understanding the Epidemic," Centers for Disease Control and Prevention, accessed November 6, 2019, https://www.cdc.gov/drugoverdose/epidemic.

[67] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*, Version 3.0. February 2017.

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

[69] "Benzodiazepines, Street Names: Benzos, Downers, Nerve Pills, Tranks," U.S. Drug Enforcement Administration, accessed December 20, 2020, https://www.deadiversion.usdoj.gov/drug_chem_info/benzo.pdf. Benzodiazepines "are a class of drugs that produce central nervous system (CNS) depression and that are most commonly used to treat insomnia and anxiety."

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

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

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

- Documentation of informed consent

- Timely follow-up with patients included required elements

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures include, but are not limited to, "adherence to published clinical practice guidelines, timeliness of pain treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment…patient satisfaction, physical and psychosocial functioning, and quality of life."[73] The OIG examined indicators for program oversight and evaluation:

- Performance of pain management committee activities

- Monitoring of quality measures

- Following the quality improvement process

The OIG interviewed key employees and managers and reviewed relevant documents and the electronic health records of 48 randomly selected outpatients who had newly-dispensed (no VA dispensing in previous six months) long-term opioids for pain, daily or intermittently for 90 or more calendar days through VA from July 1, 2018, through June 30, 2019. The team considered whether providers acted in accordance with guidelines for the provision of pain management and the healthcare system's oversight process for evaluating pain management outcomes and quality.

Medication Management Findings and Recommendations

The healthcare system addressed some of the indicators of expected performance, including initial pain screening, documented justification for concurrent therapy with benzodiazepines, and a multidisciplinary pain management committee. However, the OIG found deficiencies with aberrant behavior risk assessments, urine drug testing, informed consent, and patient follow-up.

VA/DoD clinical practice guidelines recommend that providers complete an aberrant behavior risk assessment that includes a history of substance abuse, psychological disease, and aberrant drug-related behaviors prior to initiating long-term opioid therapy.[74] The OIG determined that providers did not document aberrant drug-related behaviors in 48 percent of the patient electronic health records reviewed. This may have resulted in providers prescribing opioids to patients at high-risk for misuse. The Clinical Director, Primary Care Division attributed the noncompliance to unclear guidance from VHA to follow the VA/DoD clinical practice guideline.

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

[74] VA Educational Guide, *Pain Management, Opioid Safety*, July 2014. Examples of aberrant drug related behaviors include "lost prescriptions, multiple requests for early refills, unauthorized dose escalation, apparent intoxication, [and] frequent accidents." *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain.*

Recommendation 6

6. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that providers complete an aberrant behavior risk assessment that includes a history of aberrant drug-related behaviors prior to initiating long-term opioid therapy.

> Healthcare system concurred.
>
> Target date for completion: 12/1/2021
>
> Healthcare system response: The reasons for noncompliance were considered when developing the action plan. A new process for the prescribing and monitoring of opioid therapy has been developed. Opioids will only be available to order in outpatient settings by completing a templated note. This required note includes a mandatory field for documentation of any aberrant drug-related behaviors. The Opioid Safety Review Board will monitor until 90% compliance is maintained for six consecutive months.

VA/DoD clinical practice guidelines also recommend that providers conduct a "UDT [urine drug test] prior to initiating or continuing LOT [long-term opioid therapy] and periodically thereafter."[75] The OIG determined that providers did not conduct initial urine drug testing for 40 percent of the patients reviewed. This resulted in providers' inability to identify whether the patients had substance use disorders, determine potential diversion, or ensure patients adhered to the prescribed medication regimen. As reported previously, the Clinical Director, Primary Care Division attributed the noncompliance to unclear VHA guidance to follow the VA/DoD clinical practice guideline.

Recommendation 7

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

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

Healthcare system concurred.

Target date for completion: 12/1/2021

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. A new process for the prescribing and monitoring of opioid therapy has been developed. Opioids will only be available to order in outpatient settings by completing a templated note. This required note will prompt providers to conduct a urine drug test as recommended for patients on long-term opioid therapy. The Opioid Safety Review Board will monitor until 90% compliance is maintained for six consecutive months.

VHA requires providers to obtain and document informed consent prior to the initiation of long-term opioid therapy. VHA also recommends that informed consent conversations cover the risks and benefits of opioid therapy, as well as alternative therapies.[76] The OIG determined that providers did not document informed consent prior to initiating long-term opioid therapy for 27 percent of patients reviewed. Therefore, patients may have received treatment without knowledge of the associated risks, including opioid dependence, tolerance, addiction, and fatal overdose. The Clinical Director, Primary Care Division stated that providers were aware of the requirement but did not complete informed consent due to competing demands, lack of attention to detail, or misunderstanding of the need to complete a new informed consent with an opioid medication change.

Recommendation 8

8. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that providers obtain and document informed consent for patients prior to initiating long-term opioid therapy.

Healthcare system concurred.

Target date for completion: 12/1/2021

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. A new process for the prescribing and monitoring of opioid therapy has been developed. Opioids will only be available to order in outpatient settings by completing a templated note. This required note will prompt providers to obtain and document informed consent for patients prior to initiating long-term opioid therapy. The Opioid Safety Review Board will monitor until 90% compliance is maintained for six consecutive months.

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[76] VHA Directive 1005(1), *Informed Consent for Long-Term Opioid Therapy for Pain*, May 6, 2014, amended November 13, 2018. (This directive was in place for the time frame of the electronic health records reviewed in this report. It was rescinded and replaced with VHA Directive 1005 on May 13, 2020. Both directives contain the same or similar language regarding the informed consent process.)

VA/DoD clinical practice guidelines recommend that providers follow up with patients within three months after initiating long-term opioid therapy and assess patients' adherence to their pain management plan of care and the effectiveness of interventions.[77] The OIG found that providers completed three month follow-up as required but did not assess adherence to pain management plans of care for 39 percent of patients. Additionally, providers did not assess the effectiveness of interventions for 28 percent of the patients reviewed. Failure to assess adherence and intervention effectiveness may have resulted in missed opportunities to evaluate the risks and benefits of continued opioid therapy. Again, the Clinical Director, Primary Care Division attributed the noncompliance to unclear guidance from VHA to follow the VA/DoD clinical practice guideline.

Recommendation 9

9. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers conduct follow-up assessments that include adherence to the pain management plan of care and effectiveness of the interventions.

Healthcare system concurred.

Target date for completion: 12/1/2021

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. A new process for the prescribing and monitoring of opioid therapy has been developed. Opioids will only be available to order in outpatient settings by completing a templated note. This required note will require providers to document follow-up assessments that include adherence to the pain management plan of care and the effectiveness of interventions. The Opioid Safety Review Board will monitor until 90% compliance is maintained for six consecutive months.

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

Mental Health: Suicide Prevention Program

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[78] The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018. However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[79]

VHA has identified suicide prevention as a top priority and implemented various evidence-based approaches to reduce the veteran suicide rate. In addition to expanded mental health services and community outreach, VHA has developed comprehensive screening and assessment processes to identify at-risk patients.[80]

VHA requires that each medical center and very large community-based outpatient clinic have a full-time suicide prevention coordinator (SPC) to track and follow up with high-risk veterans, develop a process for responding to referrals from hotlines such as the Veteran Crisis Line, and conduct community outreach activities.[81] The OIG examined various requirements related to SPCs:

- Assignment of a full-time SPC

- Tracking and follow-up of high-risk veterans

  o Patients' completion of four appointments within the required time frame

  o Safety plan completion within the required time frame

  o Mental health teams' contacts with patients for missed appointments

- Provision of suicide prevention training for nonclinical employees at new employee orientation

- Completion of at least five outreach activities per month

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

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[78] "Preventing Suicide," Centers for Disease Control and Prevention, accessed December 9, 2020, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.

[79] VA Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report,* November 2020.

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

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

in his or her electronic health record "as soon as possible but no later than 1 business day after such determination by the SPC."[82] According to VHA, "Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death…The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions."[83] The HRS PRF is reviewed at least every 90 days and depending on changes to the suicide risk status, will remain active or be removed.[84] Additionally, VHA requires designated high-risk patients to have a completed suicide safety plan and four face-to-face visits with an acceptable provider within the first 30 days of designation.[85]

The OIG noted that from July 1, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA required that "Any patient determined to be High Risk for Suicide [by the licensed independent provider] must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination."[86] However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management changed the requirement for the HRS PRF placement to be "as soon as possible but no later than 1 business day after determination by the SPC."[87] VHA further provided additional clarifying information:

- The "SPC exclusively controls the HRS-PRF and must limit their use to patients who meet the criteria of being placed on the facility high-risk suicide list."

- "The time frame of placing the flag begins once the SPC makes the determination that an HRS-PRF is warranted."

- The SPC's determination process "may be beyond 24 hours after a referral, due to case consultation and review."[88]

The OIG is concerned that the updated requirement may result in delayed placement of HRS PRFs for at-risk patients. Without defined time frames for SPC determination that the HRS PRF

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

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

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

[85] VA Manual, *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version,* August 20, 2008. A safety plan is a "written list of coping strategies and sources of support that patients can use during or preceding suicidal crises." Face-to-face visits may be performed as telephone visits if requested by the patient. The requirement for four face-to-face visits within 30 days of designation can be found in *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide*.

[86] VHA DUSHOM Memorandum, *High Risk for Suicide Patient Record Flag Changes*.

[87] VHA DUSHOM Memorandum, *Update to High Risk for Suicide Patient Record Flag Changes*.

[88] VHA, response to questions by VA OIG Office of Healthcare Inspections from February 12, 2020, received February 19, 2020.

is warranted, patients identified as at-risk for suicide could have flags placed in their charts several days after referral. For example, the current requirement would allow for a patient to be identified as high risk for suicide and referred to the SPC on Monday, the SPC to assess the patient for risk and determine the need for an HRS PRF on the following Friday, and the SPC to place an HRS PRF on the subsequent Monday (a week after referral).

On March 27, 2020, VHA also updated existing policy requirements to allow the review of an HRS PRF to "occur no earlier than 10 days before and no later than 10 days after the 90-day due date."[89]

Inspectors examined the completion of several requirements:

- Review of HRS PRFs within the required time frame

- Completion of at least four mental health visits within 30 days of HRS PRF placement

- Appropriate follow-up for no-show high-risk appointments

- Completion of suicide safety plans with the required elements within the required time frame

All VHA employees must complete suicide risk and intervention training within 90 days of entering their position. Clinical staff (including physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and Vet Center counselors) must complete Suicide Risk Management Training for Clinicians, and nonclinical staff must complete Operation S.A.V.E. training.[90] VHA also requires that all staff receive annual refresher training.[91] In addition, SPCs are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[92]

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

- Relevant documents;

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

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

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

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

- The electronic health records of 38 outpatients whose electronic health records were flagged as high risk for suicide from July 1, 2018, to June 30, 2019; and

- Staff training records.

Mental Health Findings and Recommendations

The OIG found the healthcare system complied with requirements for a designated SPC, tracking and follow-up of high-risk veterans, patient contact for missed appointments, and suicide safety plans. However, the OIG found deficiencies.

With VHA's original requirement that was in place when these patients received care—that "Any patient determined to be High Risk for Suicide must have a HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"[93]—the OIG estimated that 68 percent of HRS PRFs were not placed within 24 hours of referral to the SPC.[94] Based on the current updated requirement that the SPC be responsible for determining placement of the HRS PRF (without a defined timeframe for doing so), the OIG further calculated that the average time from referral to HRS PRF placement for the patients reviewed was 8 days (observed range was 0–28 days).[95]

Further, the OIG noted concerns with reviewing HRS PRFs within the required time frame. VHA required that the System Director ensures all patients with an HRS PRF be reevaluated at least every 90 days.[96] The OIG estimated that 55 percent of patients with an HRS PRF were not reevaluated every 90 days.[97] However, based on the updated requirement that HRS PRFs be reviewed up to 10 days prior to or after the due date for reevaluation, the OIG found that clinical staff did not review 21 percent of patients within the new time frame (observed range was 18–165 days).[98]

Additionally, the OIG noted concerns with the completion of four mental health visits and staff training records.

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

[94] The OIG estimated that 95 percent of the time, the true compliance rate is between 17.1 and 46.9 percent, which is statistically significantly below the 90 percent benchmark.

[95] VHA, response to questions by VA OIG Office of Healthcare Inspections from February 12, 2020, received February 19, 2020; VHA DUSHOM Memorandum, *Update to High Risk for Suicide Patient Record Flag Changes*, January 16, 2020.

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

[97] The OIG estimated that 95 percent of the time, the true compliance rate is between 28.9 and 60.5 percent, which is statistically significantly below the 90 percent benchmark.

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

VHA requires a veteran to have four follow-up visits with a qualified provider within 30 days of HRS PRF placement. The follow-up visits should be face-to-face unless the veteran requests a telephonic visit, and there must be documentation identifying the patient's preference for a telephone call.[99] The OIG estimated that providers did not conduct four mental health visits for 29 percent of patients reviewed.[100] This resulted in insufficient follow-up of high-risk patients. The Mental Health Director of Nursing and Patient Care Line Manager reported that telephonic contacts met the follow-up visit requirement, but they were unaware that documentation of the patient's preference for telephonic visits was necessary.

Recommendation 10

10. The Chief of Staff evaluates and determines the reasons for noncompliance and ensures that providers conduct four follow-up visits, either face-to-face or telephonic with documented consent, within the required time frame.

Healthcare system concurred.

Target date for completion: 5/30/2021

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. In October 2020, The Mental Health Director of Nursing and Patient Care Line Manager reviewed this requirement with the Suicide Prevention Coordinator team. The primary issue was the lack of consent for telephonic follow-up visits. A new contact Electronic Health Record Template was implemented to address documenting telephone consent. 90% compliance with follow-up visits has been maintained since November 2020. Monitoring will continue until six consecutive months of compliance is achieved.

VHA also requires that all employees complete annual suicide prevention refresher training.[101] The OIG found that 9 of 20 employees did not complete annual refresher training within one year of initial training. Lack of training could have prevented employees from providing optimal care to veterans who were at risk for suicide. The Education Division Director/Designated Learning Officer attributed the noncompliance to competing patient care priorities.

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[99] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care Suicide Prevention Coordinator Guide*, January 5, 2018.

[100] The OIG estimated that 95 percent of the time, the true compliance rate is between 56.3 and 85.3 percent, which is statistically significantly below the 90 percent benchmark.

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

Recommendation 11

11. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that employees complete annual suicide prevention refresher training.

Healthcare system concurred.

Target date for completion: 9/30/2021

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. The Education Service provided training to supervisors to increase knowledge on tracking completion of employee training in the Talent Management System (TMS). The Suicide Prevention Team supervisor reviewed TMS reports to identify staff that had not completed training and notified their supervisor. The Suicide Prevention Team will monitor training completion until 90% compliance has been maintained for six consecutive months.

Care Coordination: Life-Sustaining Treatment Decisions

Life-sustaining treatments (LSTs) are intended to extend the life of a patient expected to die soon without medical intervention. LSTs may include artificial nutrition, hydration, and mechanical ventilation. VHA issued the life-sustaining treatment decision (LSTD) handbook to standardize practices related to discussing and documenting goals of care and LSTDs. Per VHA, the goal is to encourage personalized, proactive, patient-driven treatment plans for veterans with serious illness by "eliciting, documenting, and honoring patients' values, goals, and preferences."[102]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD handbook by July 12, 2018.[103] Implementation requirements included initiating conversations about the goals of care. A goals of care conversation is a discussion between a healthcare provider and a patient or surrogate to help define the patient's values, goals, and preferences for care and, based on the discussion, make choices about starting, limiting, or ceasing LSTs.[104] VHA requires practitioners to initiate goals of care conversations with high-risk patients— including hospice patients or their surrogates—within a time frame that meets the medical needs of the patient or at the time of a triggering event.[105]

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

- Decision-making capacity,

- Identification of a surrogate if the patient loses decision-making capacity,

- Patient or surrogate understanding of the patient's condition,

- Goals of care,

- Plan of care for the use of LST, including whether cardiopulmonary resuscitation will be attempted in the event of cardiac arrest, and

- Informed consent for the LST plan.

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

[103] VHA Handbook 1004.03(1). The medical facility must fully implement handbook requirements within 18 months of publication.

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

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

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

- Decision-making capacity,

- Goal(s) of care,

- Plan of care for the use of LST, and

- Informed consent for the LST plan.

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

The healthcare system was assessed for its adherence to requirements for goals of care conversations:

- Completion of LSTD notes

- Timely documentation of LSTD

- Inclusion of required elements in LSTD documentation

- Completion of LSTD note/orders by an authorized provider or delegation to a designee met all requirements

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[106] Inspectors examined if the healthcare system established an LSTD committee that was comprised of a multidisciplinary membership, which included representation from the Ethics Consultation Service, and reviewed proposed LST plans.

To determine whether the healthcare system complied with the OIG-selected requirements related to LSTD for hospice patients, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 41 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

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[106] VHA Handbook 1004.03(1).

Care Coordination Findings and Recommendations

The healthcare system generally complied with the requirement for the Life Sustaining Treatment Advisory Group. However, the OIG identified a deficiency with the completion of LSTD progress notes.

VHA requires that providers complete LSTD progress notes prior to hospice referrals.[107] The OIG estimated that providers did not complete an LSTD progress note prior to hospice referral for 90 percent of patients, based on the electronic health records reviewed.[108] Failure to complete LSTD progress notes may prevent patients from having their "values, goals, and preferences" identified and met.[109] The acting Chief Health Informatics Officer reported that providers did not consistently complete LSTD progress notes because they were awaiting VHA guidance on the implementation of an updated standardized note template. Issues cited included the LST note template's fixed/non-editable configuration, redundancy of content questions, and order workflow.

Recommendation 12

12. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures providers complete life-sustaining treatment decisions progress notes prior to hospice referrals.

Healthcare system concurred.

Target date for completion: 10/1/2021

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. After receiving additional guidance from the national program office, the VA Portland Healthcare System (VAPORHCS) implemented the use of the Life Sustaining Treatment (LST) Note on September 10, 2019. VAPORHCS has trained all providers that refer to hospice services to ensure completion of the standardized LST progress notes prior to hospice referral. In addition to education, a reminder to the hospice consult was added to prompt the provider at the time the consult is entered. Compliance will be monitored until 90% sustained compliance is achieved for 6 consecutive months.

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[107] VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017. (This handbook was amended March 19, 2020, to VHA Handbook 1004.03(1). Handbook 1004.03 was in place for the time frame of the progress notes reviewed in this report. Both handbooks contain the same or similar language regarding provider completion of the LSTD progress note.)

[108] The OIG estimated that 95 percent of the time, the true compliance rate is between 2.3 and 20.0 percent, which is statistically significantly below the 90 percent benchmark.

[109] VHA Handbook 1004.03(1).

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[110] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans are anticipated to increase.[111] To help the VA better understand the needs of the growing women veterans population, efforts have been made by VHA to identify and address the urgent needs "by examining health care use, preferences, and the barriers Women Veterans face in access to VA care."[112] Additionally, a VA report in 2016 on suicide among veterans pointed out concerning trends in suicide among women veterans and discussed "the importance of understanding suicide risk among women veterans and developing gender-tailored suicide prevention strategies."[113]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment. Facilities must, therefore, ensure availability of appropriate resources, services, and staffing ratios.[114] VHA also requires delivery of quality care to all women veterans accessing VA emergency services. In addition, VHA requires facilities to establish a multidisciplinary women veterans health committee that "develops and implements a Women's Health Program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans."[115]

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

- Provision of care requirements
  - Designated Women's Health Patient Aligned Care Team established
  - Primary Care Mental Health Integration services available

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[110] "Veteran Population," Table 1L: VetPop2016 Living Veterans by Age Group, Gender, 2015–2045, National Center for Veterans Analysis and Statistics, accessed November 14, 2019, https://www.va.gov/vetdata/Veteran_Population.asp.

[111] "Veteran Population," National Center for Veterans Analysis and Statistics, accessed on September 16, 2019, https://www.va.gov/vetdata/docs/Demographics/VetPop_Infographic_2019.pdf.

[112] Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care Final Report*, April 2015.

[113] Claire Hoffmire, "Concerning Trends in Suicide Among Women Veterans Point to Need for More Research on Tailored Interventions," Suicide Prevention, *Forum*, Spring 2018, https://www.hsrd.research.va.gov/publications/forum/spring18/default.cfm?ForumMenu=Spring18-5.

[114] VHA Directive 1330.01(3), *Health Care Services for Women Veterans,* February 15, 2017, amended June 29, 2020.

[115] VHA Directive 1330.01(3).

      o   Gynecologic care coverage available 24/7

      o   Facility women's health primary care providers designated

      o   Community-based outpatient clinic women's health primary care providers designated

- Oversight of program and monitoring of performance improvement data

      o   Women Veterans Health Committee established

           -   Quarterly meetings held

           -   Core members attend

           -   Quality assurance data collected and tracked

           -   Reports made to clinical executive leaders

- Assignment of required staff

      o   Women Veterans Program Manager

      o   Women's Health Medical Director or clinical champion

      o   Maternity Care Coordinator

      o   Women's health clinical liaison at each community-based outpatient clinic

Women's Health Findings and Recommendations

The healthcare system complied with requirements for the provision of care indicators and each of the selected staffing elements reviewed. However, the OIG identified weaknesses with the Women Veterans Health Committee.

VHA requires the Women Veterans Health Committee to report to executive leaders and have a core membership. That membership must include a women veterans program manager; a women's health medical director; and "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care; and a member from executive leadership."[116]

From August through December 2019, the OIG did not find evidence of meeting attendance by four core members of the Women Veterans Health Committee (emergency department, radiology, laboratory, or an executive leader), based on meeting minutes reviewed. This resulted

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[116] VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017, amended July 24, 2018. (This directive was in place for the time frame of the minutes reviewed in this report. It was amended on June 29, 2020 (1330.01(3)), and again on January 8, 2021 (1330.01(4)). All three directives contain the same or similar language regarding the Women Veterans Health Committee.)

in a lack of expertise and oversight in data review and analysis as the committee planned and carried out improvements for quality and equitable care for women veterans. The Women Veterans Program Manager and the Women's Health Medical Director attributed the noncompliance to scheduling conflicts for the required members.

Additionally, the Women Veterans Program Manager reported that the Women Veterans Health Committee did not report to executive leaders. Failure to report activities to executive leaders has the potential to impede oversight and support of the Women's Health Program. The Women Veterans Program Manager was aware of the requirement and stated that a gap occurred when the committee transitioned its reporting from the Veteran Experience Committee to the Organizational Health Council.

Recommendation 13

13. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that required members attend Women Veterans Health Committee meetings.

Healthcare system concurred.

Target date for completion: 6/30/2021

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. The Women Veterans Program Manager ensures that the Women Veterans Health Committee has required representation at its meetings. The Program Manager/designee will monitor for required attendance at the bimonthly Women Veterans Health Committee meetings. Ninety percent of members required per VHA Directive 1331.01(02) will attend each meeting. Monitoring will continue until compliance has been maintained for two consecutive quarters.

Recommendation 14

14. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Women Veterans Health Committee reports to executive leaders.[117]

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[117] The OIG reviewed evidence sufficient to demonstrate that the healthcare system had completed improvement actions and therefore closed the recommendation before publication of the report.

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. The Women Veterans Health Committee (WVHC) reported to the Organizational Health Council (OHC), an executive level council, on a quarterly basis beginning October 2020. Women Veterans Program Manager (WVPM) has reviewed OHC minutes and WVHC has reported timely to executive leaders for two consecutive quarters demonstrating consistent communication. Documentation of the above as evidence of compliance is available to support facility proposal for early closure of this recommendation.

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have Sterile Processing Services (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment."[118] The goal of SPS is to "provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[119] To ensure this, VHA requires facilities to conduct the following activities:

- Maintain a current inventory list of all RME

- Have standard operating procedures (SOPs) that are based on current manufacturers' guidelines and reviewed at least triennially

- Use CensiTrac® Instrument Tracking System for tracking reprocessed instruments[120]

- Perform annual risk analysis and report results to the VISN SPS Management Board

- Monitor data for reprocessing and storing RME

- Conduct annual airflow/ventilation system inspections[121]

VHA requires strict controls that closely monitor climate, storage, and sterilization parameters and additionally requires that quality assurance documentation of this monitoring be maintained for a minimum of three years.[122] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[123]

In addition, RME reprocessing areas must be clean, restricted, and airflow-controlled. All areas where RME reprocessing occurs must have safety data sheets, an unobstructed eyewash station, personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[124]

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

[119] Julie Jefferson, Martha Young. *APIC Text of Infection Control and Epidemiology.* Association for Professionals in Infection Control and Epidemiology, 2019. "Chapter 108: Sterile Processing."

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

[121] VHA Directive 1116(2).

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

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

[124] VHA Directive 1116(2).

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued annual and essential staff competency assessments, and monthly continuing education. This ensures that staff have sufficient aptitude, knowledge, and skills to effectively and safely reprocess and sterilize RME.[125]

To determine whether the healthcare system complied with OIG-selected requirements, the inspection team examined relevant documents and training records and interviewed key managers and staff on the following:

- Requirements for administrative processes
  - RME inventory file is current
  - SOPs are based on current manufacturers' guidelines and reviewed at least triennially
  - CensiTrac® system used
  - Risk analysis performed and results reported to the VISN SPS Management Board
  - Airflow checks made
  - Eyewash station checked
  - Daily cleaning schedule maintained
  - Required temperature and humidity maintained
- Monitoring of quality assurance
  - High-level disinfectant solution tested
  - Bioburden tested
- Completion of staff training, competency, and continuing education
  - Required training completed in a timely manner
  - Competency assessments performed
  - Monthly continuing education received

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[125] VHA Directive 1116(2).

High-Risk Processes Findings and Recommendations

The healthcare system met many of the requirements for the proper operations and management of RME. However, the OIG identified deficiencies with SOPs, humidity maintenance, and staff training.

VHA requires the Chief of SPS to ensure "SOPs are kept up-to-date, reviewed at least every 3 years and updated when there is a change in process or a change in manufacturer's IFU [Instructions For Use]." [126] The OIG found that one SOP (Olympus endoscope) was updated in March 2020 but had not been reviewed and approved by the SPS Chief. Failure to review and approve changes to the SOP could result in inadequate reprocessing, damage to the scope, and significant patient safety risks. The SPS Assistant Chief reported that staffing challenges and competing priorities resulted in the lack of SOP review and approval by the SPS Chief.

Recommendation 15

15. The Deputy Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures standard operating procedures are kept up-to-date and reviewed at least every three years.

Healthcare system concurred.

Target date for completion: 11/30/2021

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. In October 2020, the Chief of Sterile Processing Service (SPS) assigned an employee to create a new Reusable Medical Equipment (RME) Standard Operating Procedure (SOP) Master list, and review and update any expired SOPs to reflect alignment with current Instructions For Use (IFUs). Updates to the SOPs are reviewed with the IFU by the Chief of SPS and an Infection Prevention Nurse. The SOPs will continue to be updated and reviewed annually, and any new [SOPs] or updates needed will be completed and documented in the Reusable Medical Equipment (RME) master list. The Chief of SPS will monitor to ensure compliance.

VHA requires the Health System Director to ensure a relative humidity range of 20 to 60 percent in clean and sterile storage areas.[127] The OIG determined that the humidity reading in the Endoscopy Clinic clean storage room was outside of the required parameters. Failure to achieve air quality standards can lead to the spread of healthcare-associated infections. The Facilities Management Service Chief reported implementing corrective actions to address the deficiency

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

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

and attributed the noncompliance to a delay in purchasing a device to control temperature and humidity.

Recommendation 16

16. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that the Endoscopy Clinic clean storage room maintains the required relative humidity range.[128]

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. The Facilities Management Service Chief added a new terminal unit with heating coil and new thermostat to the Endoscopy Clinic clean storage room on 10/22/2020, to maintain the required relative humidity range. Compliance has been continuously monitored by the Energy Center since this update. Ongoing review of the humidity reports show >90% compliance for six consecutive months. Documentation of the above as evidence of compliance is available to support facility proposal for early closure of this recommendation.

Since March 23, 2016, VHA has required that "all new SPS employees must complete the SPS Level 1 training program within 90 days of hire."[129] Of the six selected SPS employees hired after March 23, 2016, the OIG found that five did not complete Level 1 training within 90 days of hire. This could have resulted in improper cleaning of the RME and compromised patient safety. The previous SPS Chief and the current Assistant Chief explained that they were unable to provide a reason for noncompliance because they were not in SPS leadership roles at the time the selected staff were hired and trained.

Recommendation 17

17. The Deputy Director for Patient Care Services determines the reasons for noncompliance and ensures that all new Sterile Processing Services employees complete Level 1 training within 90 days of hire.

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[128] The OIG reviewed evidence sufficient to demonstrate that the healthcare system had completed improvement actions and therefore closed the recommendation before publication of the report.

[129] VHA Directive 1116(2).

Healthcare system concurred.

Target date for completion: 8/1/2021

Healthcare system response: The reasons for noncompliance were considered when developing the action plan. In April 2020, the Sterile Processing Service Chief confirmed current Sterile Processing Services (SPS) employees had completed Level 1 training and established a process for new employees to have Level 1 training integrated into the service level orientation. An SPS Talent Management System (TMS) Administrator reviews and verifies monthly that all Level 1 trainings are completed within 90 days. Monitoring will continue until compliance of 90 percent or higher is sustained for a minimum of six consecutive months.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Healthcare Processes	Requirements	Conclusion
Leadership and Organizational Risks	- Executive leadership position stability and engagement - Employee satisfaction - Patient experience - Accreditation surveys and oversight inspections - Factors related to possible lapses in care and healthcare system response - VHA performance data (system) - VHA performance data for CLCs	Seventeen OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the Director, Chief of Staff, and DDPCS. See details below.
COVID-19 Pandemic Readiness and Response	- Emergency preparedness - Supplies, equipment, and infrastructure - Staffing - Access to care - CLC patient care and operations - Staff feedback	The results of the OIG's evaluation of the healthcare system's COVID-19 pandemic readiness and response were compiled and reported with other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• QSV Council's recommended improvement actions are fully implemented and monitored. • UM Committee's recommended improvement actions are fully implemented. • Root cause analysis actions are fully implemented.	• Root cause analyses include all required elements.
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• None	• Provider exit review forms are completed within seven business days of licensed healthcare professionals' departure from the healthcare system.
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• Providers complete an aberrant behavior risk assessment that includes a history of aberrant drug-related behaviors prior to initiating long-term opioid therapy. • Providers conduct urine drug testing as recommended for patients on long-term opioid therapy. • Providers obtain and document informed consent for patients prior to initiating long-term opioid therapy. • Providers conduct follow-up assessments that include adherence to the pain management plan of care and effectiveness of the interventions.	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Tracking and follow-up of high-risk veterans • Provision of suicide prevention care • Completion of suicide prevention training requirements	• Providers conduct four follow-up visits, either face-to-face or telephonic with documented consent, within the required time frame.	• Employees complete annual suicide prevention refresher training.
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • LSTD progress note documentation • LSTD note/orders completed by an authorized provider or delegated appropriately	• Providers complete LSTD progress notes prior to hospice referrals.	• None
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• None	• Required members attend Women Veterans Health Committee meetings. • The Women Veterans Health Committee reports to executive leaders.
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Quality assurance • Staff training	• The Endoscopy Clinic clean storage room maintains the required relative humidity range.	• Standard operating procedures are kept up-to-date and reviewed at least every 3 years. • New Sterile Processing Services employees complete Level 1 training within 90 days of hire.

Appendix B: Healthcare System Profile

The table below provides general background information for this highest complexity (1a) affiliated healthcare system reporting to VISN 20.[1]

Table B.1. Profile for VA Portland Health Care System (648)
(October 1, 2016, through September 30, 2019)

Profile Element	Healthcare System Data FY 2017*	Healthcare System Data FY 2018	Healthcare System Data FY 2019‡
Total medical care budget	$800,580,393	$911,467,336	$885,351,771
Number of:			
• Unique patients	95,093	96,718	98,409
• Outpatient visits	948,323	965,209	972,848
• Unique employees	3,455	3,602	3,682
Type and number of operating beds:			
• Community living center	72	72	76
• Domiciliary	35	35	35
• Medicine	88	88	88
• Mental Health	21	21	21
• Surgery	58	58	58
Average daily census:			
• Community living center	66	72	77
• Domiciliary	30	30	30
• Medicine	67	69	70
• Mental Health	14	13	13

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[1] Associated with a medical residency program. The VHA medical centers are classified according to a facility complexity model; a designation of "1a" indicates a facility with "high volume, high risk patients, most complex clinical programs, and large research and teaching programs."

Profile Element	Healthcare System Data FY 2017*	Healthcare System Data FY 2018	Healthcare System Data FY 2019‡
• Surgery	33	28	25

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse.

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

*October 1, 2016, through September 30, 2017.

October 1, 2017, through September 30, 2018.

‡October 1, 2018, through September 30, 2019.

Appendix C: VA Outpatient Clinic Profiles

The VA outpatient clinics in communities within the catchment area of the healthcare system provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table C.1. provides information relative to each of the clinics.[1]

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Bend, OR	648GA	15,046	3,735	Dermatology Eye Gastroenterology Pulmonary/ Respiratory disease Urology	EKG	Nutrition Pharmacy Social work Weight management
Salem, OR	648GB	15,805	4,713	Dermatology Eye Plastic Podiatry	Radiology	Nutrition Pharmacy Weight management
Warrenton, OR	648GD	3,091	1,386	Dermatology	–	Pharmacy

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[1] The OIG omitted (648GK) Lincoln City, OR as no data were reported. VHA Directive 1230(3), *Outpatient Scheduling Processes And Procedures*, July 15, 2016, amended January 7, 2021. An encounter is a "professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition." Specialty care services refer to non-primary care and non-mental health services provided by a physician. Diagnostic services include electrocardiogram (EKG), and radiology. Ancillary services include dental, nutrition, pharmacy, social work, and weight management.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Fairview, OR	648GE	14,648	6,754	Dermatology	–	Nutrition Pharmacy Social work Weight management
Hillsboro, OR	648GF	16,934	7,306	Dermatology Eye Neurology Orthopedics	Radiology	Dental Nutrition Pharmacy Social work Weight management
West Linn, OR	648GG	15,034	2,174	Dermatology Neurology	–	Nutrition Pharmacy Social work Weight management
Newport, OR	648GH	2,976	816	Eye Neurology	–	Pharmacy
Portland, OR	648GI	1,643	1	Dermatology	–	Nutrition
The Dalles, OR	648GJ	4,952	969	Dermatology	–	Nutrition Pharmacy Social work

Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

Appendix D: Patient Aligned Care Team Compass Metrics

New Primary Care Patient Average Wait Time in Days

	VHA Total	(648) Portland, OR	(648A4) Portland Vancouver, WA	(648GA) Bend, OR	(648GB) Salem, OR	(648GD) North Coast, OR	(648GE) Fairview, OR	(648GF) Hillsboro, OR	(648GG) West Linn, OR	(648GH) Newport, OR	(648GI) Portland 1st Avenue, OR	(648GJ) The Dalles, OR (Loren R. Kaufman)
JUL-FY19	7.3	12.0	39.5	16.2	0.0	72.7	12.3	24.4	11.9	26.8	16.4	15.3
AUG-FY19	7.4	16.6	25.0	8.7	5.0	37.4	6.1	22.8	10.7	n/a	21.0	18.3
SEP-FY19	7.3	19.0	19.4	7.8	3.4	3.0	5.8	19.4	9.8	33.1	11.0	10.3
OCT-FY20	6.9	24.3	15.7	6.1	11.7	3.2	3.5	14.2	6.6	125.8	18.0	7.8
NOV-FY20	7.1	18.9	12.1	8.1	1.5	9.7	5.6	8.7	3.8	30.5	10.7	6.8
DEC-FY20	7.8	28.5	5.7	4.3	0.0	8.5	2.4	8.8	2.9	15.7	14.7	9.4
JAN-FY20	8.3	28.7	6.6	4.6	0.0	5.8	4.2	11.7	4.5	17.9	17.6	2.1
FEB-FY20	8.1	26.8	12.1	8.1	4.2	11.2	7.0	12.1	9.1	21.9	31.0	3.3
MAR-FY20	6.9	28.5	17.6	9.7	0.3	8.4	9.3	14.8	7.0	14.3	9.8	6.9
APR-FY20	3.6	5.4	2.3	0.0	0.0	0.0	4.2	5.0	3.1	n/a	21.3	0.0
MAY-FY20	4.0	0.2	1.6	0.0	0.0	1.0	3.5	2.5	4.7	n/a	29.4	0.0
JUN-FY20	4.9	0.6	0.7	26.9	1.2	96.0	6.7	4.5	3.7	n/a	14.6	0.9

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019.

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the healthcare system's explanation for the increased wait times for the Portland (Vancouver), North Coast, and Newport clinics. The OIG omitted (648GK) Lincoln City, OR.

Data Definition: "The average number of calendar days between a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL)), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Prior to FY 2015, this metric was calculated using the earliest possible create date. The absence of reported data is indicated by "n/a."

Established Primary Care Patient Average Wait Time in Days

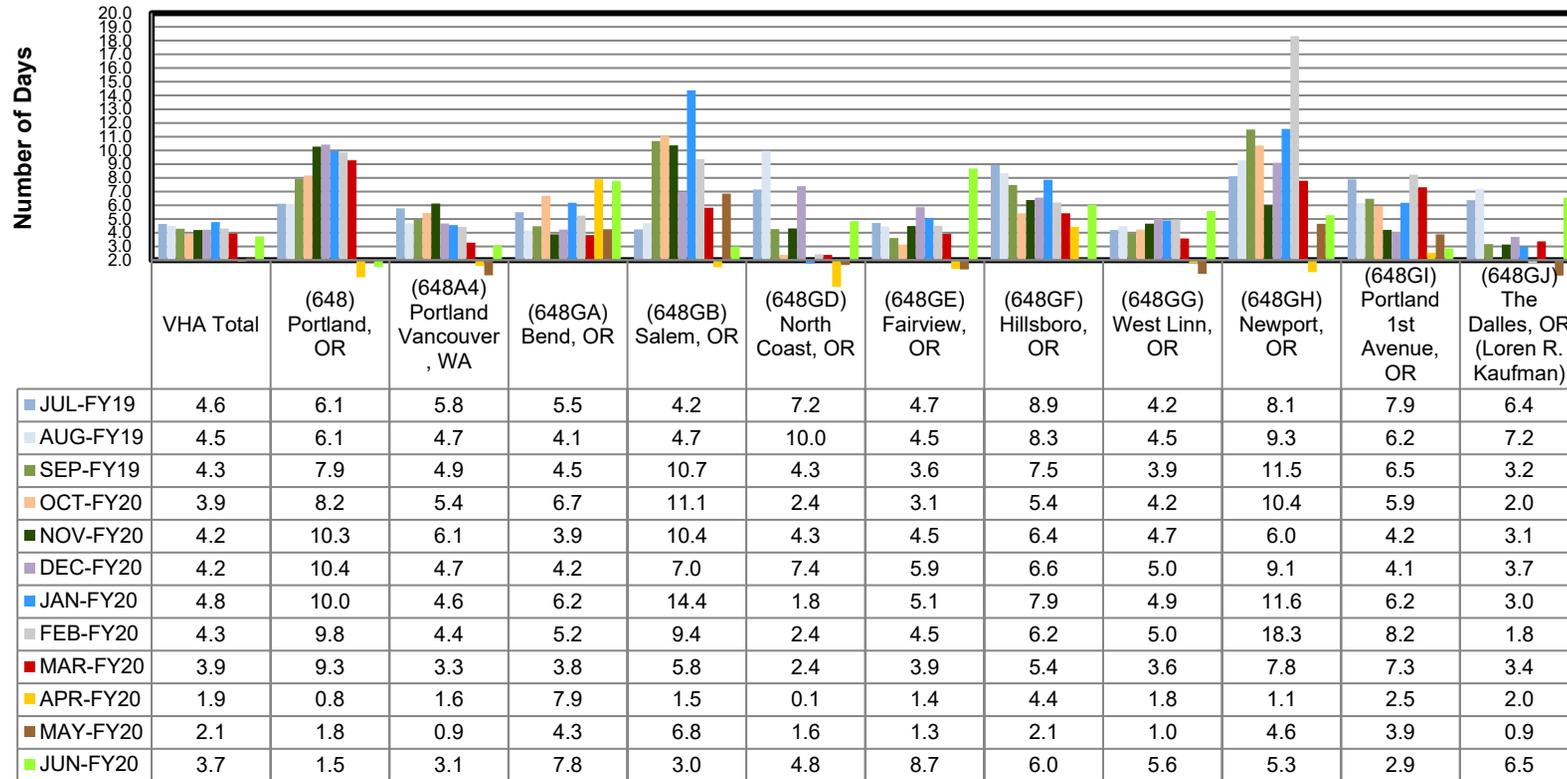|	VHA Total	(648) Portland, OR	(648A4) Portland Vancouver, WA	(648GA) Bend, OR	(648GB) Salem, OR	(648GD) North Coast, OR	(648GE) Fairview, OR	(648GF) Hillsboro, OR	(648GG) West Linn, OR	(648GH) Newport, OR	(648GI) Portland 1st Avenue, OR	(648GJ) The Dalles, OR (Loren R. Kaufman)
JUL-FY19	4.6	6.1	5.8	5.5	4.2	7.2	4.7	8.9	4.2	8.1	7.9	6.4
AUG-FY19	4.5	6.1	4.7	4.1	4.7	10.0	4.5	8.3	4.5	9.3	6.2	7.2
SEP-FY19	4.3	7.9	4.9	4.5	10.7	4.3	3.6	7.5	3.9	11.5	6.5	3.2
OCT-FY20	3.9	8.2	5.4	6.7	11.1	2.4	3.1	5.4	4.2	10.4	5.9	2.0
NOV-FY20	4.2	10.3	6.1	3.9	10.4	4.3	4.5	6.4	4.7	6.0	4.2	3.1
DEC-FY20	4.2	10.4	4.7	4.2	7.0	7.4	5.9	6.6	5.0	9.1	4.1	3.7
JAN-FY20	4.8	10.0	4.6	6.2	14.4	1.8	5.1	7.9	4.9	11.6	6.2	3.0
FEB-FY20	4.3	9.8	4.4	5.2	9.4	2.4	4.5	6.2	5.0	18.3	8.2	1.8
MAR-FY20	3.9	9.3	3.3	3.8	5.8	2.4	3.9	5.4	3.6	7.8	7.3	3.4
APR-FY20	1.9	0.8	1.6	7.9	1.5	0.1	1.4	4.4	1.8	1.1	2.5	2.0
MAY-FY20	2.1	1.8	0.9	4.3	6.8	1.6	1.3	2.1	1.0	4.6	3.9	0.9
JUN-FY20	3.7	1.5	3.1	7.8	3.0	4.8	8.7	6.0	5.6	5.3	2.9	6.5

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019.

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (648GK) Lincoln City, OR.

Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES Data Use	Composite measure based on three individual All Employee Survey data use and sharing questions	A higher value is better than a lower value
Care transition	Care transition (inpatient)	A higher value is better than a lower value
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
ED Throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like – HED90_1	Healthcare Effectiveness Data and Information Set (HEDIS) composite score related to outpatient behavioral health screening, prevention, immunization, and tobacco	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS composite score related to outpatient care for diabetes and ischemic heart disease	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx – GM90_1	ORYX inpatient composite of global measures	A higher value is better than a lower value

Measure	Definition	Desired Direction
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center.

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

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: May 24, 2021

From: Director, Northwest Network (10N20)

Subj: Comprehensive Healthcare Inspection of the VA Portland Health Care System in Oregon

To: Director, Office of Healthcare Inspections (54CH01)

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

1. Thank you for the opportunity to provide a status report to the findings from the Comprehensive Healthcare Inspection of the VA Portland Healthcare System in Oregon.

2. I concur with the findings and recommendations, as well as the submitted action plans.

(Original signed by:)

John A. Mendoza for

Teresa D. Boyd, DO

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: May 13, 2021

From: Director, VA Portland Health Care System (648/00)

Subj: Comprehensive Healthcare Inspection of the VA Portland Health Care System in Oregon

To: Director, Northwest Network (10N20)

1. Thank you for the opportunity to provide a response to the findings from the Comprehensive Healthcare Inspection of the VA Portland Healthcare System in Oregon.

2. I concur with the findings and recommendations and will ensure that actions to correct these findings are completed as described in the response.

(Original signed by:)

Darwin G. Goodspeed, FACHE

Director, VA Portland Healthcare System

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