DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

CHIP REPORT	REPORT #20-01259-196	AUGUST 2, 2021

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

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

Abbreviations

ADPCS	Associate Director for Patient Care Services
CBOC	community-based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
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 decisions
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
RCA	root cause analysis
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 Roseburg VA Health Care System, which includes the Roseburg VA Medical Center and three 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 Roseburg VA Health Care System during the week of September 21, 2020. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this healthcare system's performance within the identified focus 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)

[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)."

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 13 recommendations to the System Director, Chief of Staff, and Associate 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, Associate Director for Patient Care Services, and Associate Director. The healthcare system planned to implement a new committee reporting structure to manage organizational communications and accountability on October 1, 2020. Under the new structure, the Executive Leadership Board would oversee various councils and committees. The healthcare system leaders monitored patient safety and care through the Quality, Safety, and Value Council.

When the team conducted this inspection, the healthcare system's leaders had worked together for more than a year. The Associate Director for Patient Care Services was the most tenured leader, permanently assigned in December 2016. The Director and Chief of Staff were the newest members of the leadership team, assigned in March and April 2019, respectively. The Associate Director had served in the position since January 2018.

The OIG reviewed employee satisfaction and patient experience survey results. Employee satisfaction data revealed opportunities for the Director to improve staff feelings of moral distress at work.[2] Patients appeared generally satisfied with the care provided. However, survey data also highlighted various opportunities to improve the experiences of women veterans.

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]

[2] "2019 VA All Employee Survey (AES): Questions by Organizational Health Framework," VA Workforce Survey Portal, VHA Support Service Center, accessed June 7, 2021, http://aes.vssc.med.va.gov/documents/05_AES_Instrument_ItemThemes.pdf. (This is an internal VA website that is not publicly accessible.) The 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."

[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."

However, the OIG identified concerns with quality, safety, and value oversight. Those concerns involved root cause analysis action implementation and outcomes measurement.[4]

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.[5]

In individual interviews, the executive leaders spoke knowledgeably about employee satisfaction and patient experiences. However, the leaders have opportunities to improve their knowledge of VHA data and/or system-level factors contributing to specific poorly performing SAIL and Community Living Center SAIL measures.[6]

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.[7]

Quality, Safety, and Value

The healthcare system generally complied with requirements for the establishment of a governing body responsible for quality, safety, and value oversight functions and its review of aggregated data; and most patient safety elements reviewed. However, the OIG identified

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[4] 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."

[5] "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.)

[6] 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.

[7] 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.

weaknesses with the interdisciplinary review of utilization management data and root cause analyses.[8]

Medical Staff Privileging

The OIG found the healthcare system was generally compliant with focused professional practice evaluation processes. However, the OIG identified deficiencies with ongoing professional practice evaluation and provider exit review processes.[9]

Medication Management

The healthcare system addressed many indicators of expected performance, such as pain screening, documented justification for concurrent therapy with benzodiazepines, and the use of a multidisciplinary pain management committee to oversee and monitor quality measures. However, the OIG identified deficiencies with aberrant behavior risk assessments, urine drug testing, informed consent, and patient follow-up.

Mental Health

The OIG found the healthcare system complied with requirements for a designated suicide prevention coordinator, tracking and follow-up of high-risk veterans, and completion of at least five outreach activities per month and four appointments within the required time frame. However, the OIG identified concerns with suicide prevention training and suicide safety plans.

Care Coordination

Generally, the healthcare system complied with requirements for a life-sustaining treatment decisions committee, inclusion of required elements in life-sustaining treatment decisions documentation, and supervision of designees. However, the OIG found deficiencies with providers completing goals of care conversations and life-sustaining treatment decisions progress notes within the required timeframe.

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[8] VHA Directive 1117, *Utilization Management Program*, October 8, 2020. Utilization management involves the assessment of the "appropriateness, medical necessity, and the efficiency of health care services, according to evidence-based criteria." 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."

[9] 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."

Women's Health

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

High-Risk Processes

The healthcare system generally met the requirements for the proper operations and management of reusable medical equipment. However, the OIG identified weaknesses with the reusable medical equipment inventory file, standard operating procedures, and staff training. The OIG also found a reusable medical equipment-related root cause analysis performed in 2018 and noted that the analysis had been closed, even though two of the three actions had not been implemented and none of the outcomes measured had been assessed.

Conclusion

The OIG conducted a detailed inspection across nine key areas (two administrative and seven clinical) and subsequently issued 13 recommendations for improvement to the System Director, Chief of Staff, and Associate Director for Patient Care Services. However, the number of recommendations should not be used 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 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 70–71, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities providing healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Roseburg VA 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 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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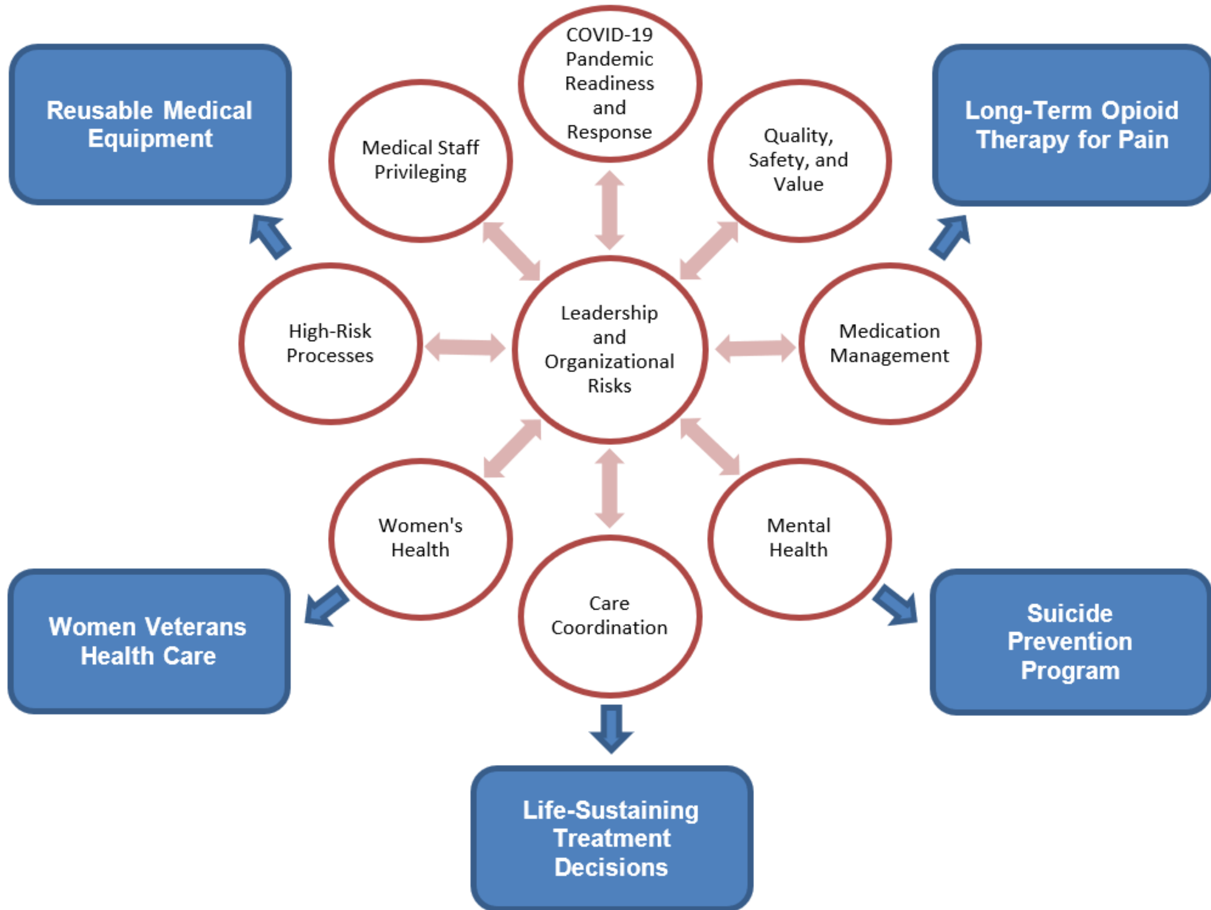

Figure 2. *Fiscal year (FY) 2020 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

Methodology

The Roseburg VA Health Care System includes the Roseburg VA Medical Center and three outpatient clinics in Oregon. Additional details about the types of care provided by the healthcare system are available 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 team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection examined operations from March 24, 2018, through September 25, 2020, the last day of the unannounced multiday evaluation.[7] During the virtual review, the OIG did not receive complaints beyond the scope of the inspection.

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 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.

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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 CHIP 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).

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 centers (CLCs))[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 system had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. The Chief of Staff and ADPCS oversaw patient care, which required managing service directors and chiefs of programs and practices.

[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.

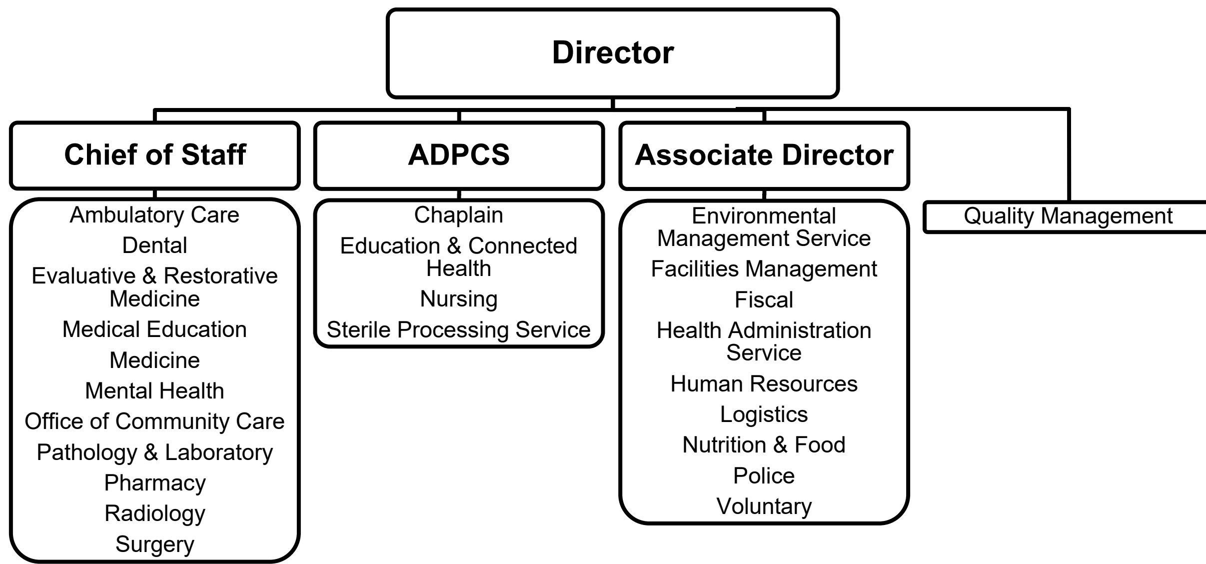

Figure 3. *Healthcare system organizational chart.*

Source: Roseburg VA Health Care System (received September 21, 2020).

At the time of the OIG virtual site visit, the executive team had served in their roles for 16 months (see table 1). Although not reflected by the healthcare system's organizational chart, the leaders considered the Chief of Quality Management a member of the executive leadership team.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	March 17, 2019
Chief of Staff	April 28, 2019
Associate Director for Patient Care Services	December 25, 2016
Associate Director	January 21, 2018

Source: Roseburg VA Health Care System Assistant Human Resources Officer (received September 25, 2020).

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

The executive leaders were generally knowledgeable within their scope of responsibilities. However, the leaders have opportunities to improve their awareness of VHA data and/or system-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) and CLC SAIL measures. In individual interviews, the executive leadership team members were able to speak in depth about employee satisfaction and patient experiences. These are discussed in greater detail below.

The healthcare system planned to implement a new committee reporting structure the week following the OIG virtual review. Figure 4 represents the committee reporting structure the healthcare system planned to implement on October 1, 2020. Under the revised structure, the Director would serve as the chairperson of the Executive Leadership Board, which would have the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board would also oversee various working groups such as the Executive Council of Medical Staff, Safety and Health Leadership Council, and Strategic Management and Resource Council.

System leaders monitored patient safety and care through the Quality, Safety, and Value Council, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Leadership Board (see figure 4).

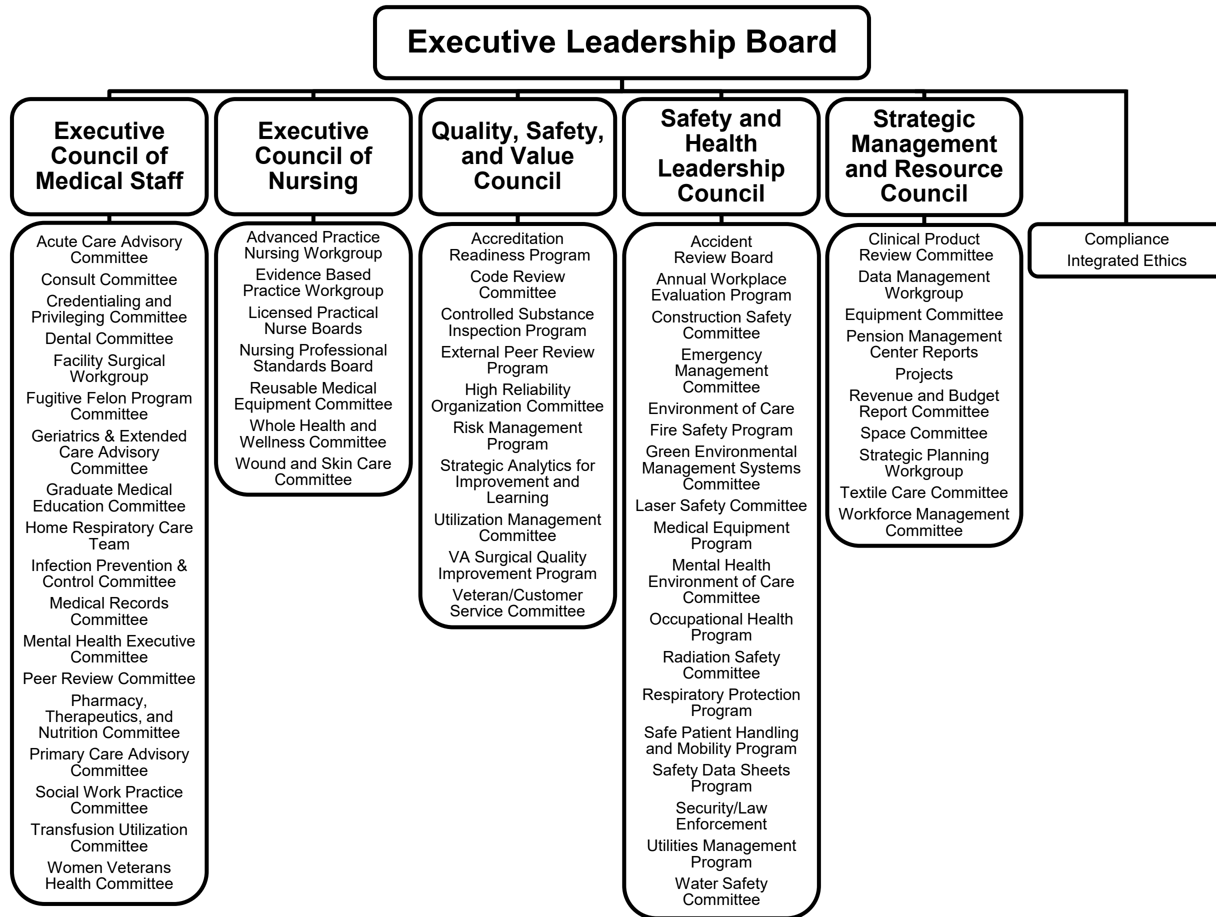

Figure 4. *Healthcare system committee reporting structure.*

Source: Roseburg VA Health Care System (received September 22, 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 leaders.

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

[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 averages for the selected survey leadership questions reviewed were lower than the VHA averages.[14] The ADPCS averages were generally similar to or lower than the VHA and healthcare system averages. The Chief of Staff scores were similar to or higher than VHA and the healthcare system averages, while the Director and Associate Director scores were consistently higher than those for VHA and the healthcare system.

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	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	72.6	71.3	91.0	75.0	73.0	86.4
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	4.7	3.5	3.3	4.1

[13] Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, 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	ADPCS 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	3.4	4.8	3.7	3.4	4.2
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	4.7	3.8	3.4	4.5

Source: VA All Employee Survey (accessed August 20, 2020).

**The Servant Leader Index is a summary measure based on respondents' assessments of their supervisors' listening, respect, trust, favoritism, and response to concerns.*

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[15] The healthcare system averages for the selected survey questions were similar to the VHA averages. Scores for the ADPCS were similar to those for VHA and the healthcare system, while scores for the Associate Director were consistently better. Average scores for the Director and Chief of Staff were generally better than VHA and healthcare system averages. However, opportunity exists for the Director to improve employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing).

[15] Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, 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	ADPCS 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	3.6	4.7	4.1	3.7	4.5
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	4.3	4.4	3.8	4.6
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	2.2	1.4	1.5	0.8

Source: VA All Employee Survey (accessed August 20, 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 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] The survey results indicated that patients were generally satisfied with the care provided. However, patients were less likely to recommend the hospital to friends and family compared to VHA patients in general. At the time of the virtual review, the healthcare system was changing its focus from providing acute inpatient medical care services to providing only inpatient hospice and palliative care services to better serve the needs of their local area.

System leaders spoke of actively engaging with patients to sustain and improve patient engagement and satisfaction. Examples included implementing a robust Environmental Management Service and strong patient advocate program, enhancing local communication through the Public Affairs office, and partnering with community hospitals to accept non-COVID-19 patients during the pandemic.

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	63.6
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	89.6
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	77.8

[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	78.1

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 results for male respondents were generally similar to the corresponding VHA averages. Female respondent scores highlighted various opportunities for improvement in outpatient primary and specialty care. System leaders did not address the gender-specific scores, but the OIG noted the system's general improvement actions previously discussed above.

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	85.2	–‡
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	86.4	–‡

[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	63.0	–‡

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 208–210 male and 4 female respondents, depending on the question.

‡Data are not available due to the small number of respondents.

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	54.8	40.3
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	58.4	61.3
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	69.0	56.2

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 408–1,045 male and 33–60 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	52.1	46.0
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	53.6	28.8
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	73.0	62.0

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 352–975 male and 20–47 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 by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[18] Table 8 summarizes the relevant system inspections

[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."

most recently performed by the OIG and The Joint Commission (TJC).[19] At the time of the OIG virtual review, the system had closed all recommendations for improvements issued since the previous comprehensive healthcare inspection conducted in March 2018.

The OIG team also 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 CLCs.[21]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
VA OIG (*Comprehensive Healthcare Inspection Program Review of the Roseburg VA Health Care System, Oregon,* Report No.18-00620-277, September 17, 2018)	March 2018	7	0
TJC Hospital Accreditation TJC Behavioral Health Care Accreditation TJC Home Care Accreditation	November 2018	21 7 9	0 0 0

Source: OIG and TJC (inspection/survey results received from the Deputy Chief Quality Management on September 21, 2020).

[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 CARF [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."

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.

Table 9 lists the reported sentinel events and disclosures from March 24, 2018 (the prior OIG comprehensive healthcare inspection), through September 21, 2020.[22]

Table 9. Summary of Selected Organizational Risk Factors (March 24, 2018, through September 21, 2020)

Factor	Number of Occurrences
Sentinel Events	5
Institutional Disclosures	7
Large-Scale Disclosures	0

Source: Roseburg VA Health Care System's acting Patient Safety Manager and Risk Manager (received September 21, 2020).

The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to improve the perceptions of the facility through active stakeholder and community engagement). However, the OIG had concerns regarding quality, safety, and value oversight related to root cause analysis action implementation. The OIG found that a root cause analysis related to reusable medical equipment

[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 Roseburg VA Health Care System is a low complexity (3) 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."

(RME) had been closed without implementation of all identified action items. In discussion with the acting Patient Safety Manager, it was reported to the OIG that other root cause analyses had been closed without the implementation of identified actions and monitoring for improvement. The acting Patient Safety Manager stated that this was a result of staff turnover and the inability to determine what needed to be done due to vague actions and outcome measures. Closing root cause analyses without implementing actions and measuring outcomes prevents the healthcare system from addressing system vulnerabilities and could result in exposing veterans to potential and preventable adverse events.

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 healthcare system's quality of care and efficiency metric rankings and performance compared with other VA facilities as of March 31, 2020. Figure 5 uses blue and green data points to indicate high performance for the Roseburg VA Health Care System (for example, in the areas of hospital-wide readmission rate (RSRR-HWR) and acute care 30-day standardized mortality ratio (SMR30)). Metrics that need improvement are denoted in orange and red (for example, care transition, adjusted length of stay (LOS), and health care (HC) associated (assoc) infections).[24]

[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.

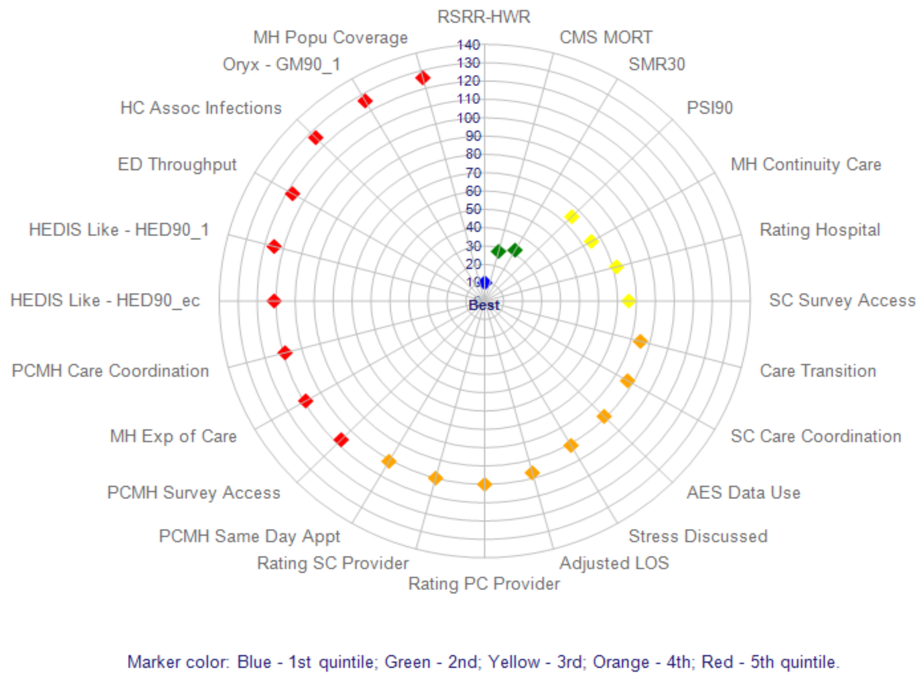

Figure 5. *System quality of care and efficiency metric rankings for FY 2020 quarter 2 (as of March 31, 2020).*

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]

Figures 6 illustrates the healthcare system's CLC quality rankings and performance compared with other VA CLCs as of March 31, 2020. Figure 6 uses blue and green data points to indicate high performance for the Roseburg CLC (for example, in the areas of physical restraints–long-stay (LS), outpatient emergency department (ED) visit–short-stay (SS), and catheter in bladder (LS)). Metrics that need improvement are denoted in orange and red (for example, high risk

[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."

pressure ulcer (PU) (LS), urinary tract infections (UTI) (LS), falls with major injury (LS), and moderate-severe pain (SS)).[26]

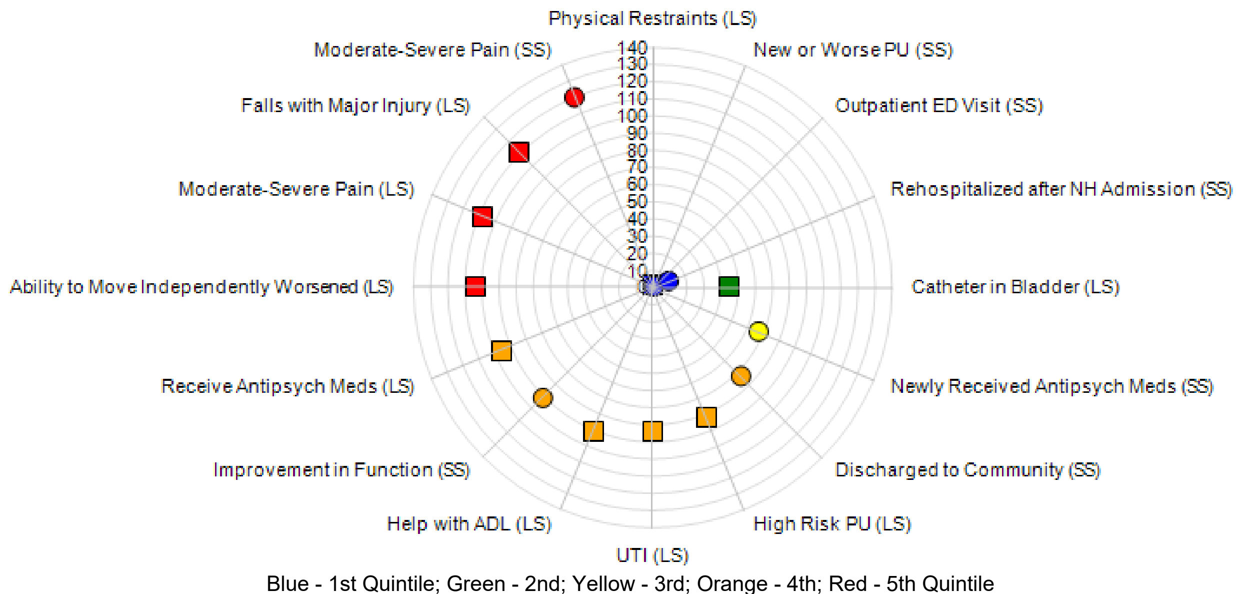

Figure 6. *Roseburg CLC quality measure rankings for FY 2020 quarter 2 (as of March 31, 2020).*

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 had served in their roles for 16 months at the time of the OIG virtual review. Survey items related to employee satisfaction with executive leaders revealed opportunities for the Director to improve staff feelings of moral distress at work. Patient experience survey data indicated general satisfaction with the care provided but also highlighted various opportunities to improve the outpatient experiences of women veterans. 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 identified concerns regarding the closure of root cause analyses without implementation of actions or measurement of outcomes. This may have prevented the healthcare system from eliminating or controlling system vulnerabilities, potentially exposing veterans to preventable adverse events.

In individual interviews, the executive leaders spoke knowledgeably about employee satisfaction and patient experiences. However, the leaders have opportunities to improve their awareness of VHA data and/or system-level factors contributing to specific poorly performing SAIL and CLC SAIL measures.

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

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 effect 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 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 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, 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

[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 OIG assessed the healthcare system's 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 generally complied with requirements for the establishment of a governing body responsible for QSV oversight functions and its review of aggregated data, as well as most patient safety elements reviewed. However, the OIG identified weaknesses with the interdisciplinary review of UM data and root cause analyses.

At the time of the OIG's virtual review, VHA required the system director to ensure an interdisciplinary group reviewed UM data. This group was required to include, but was not limited to, "representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR [chief business office revenue-utilization review]."[45] The OIG requested Utilization Management/Flow Committee meeting minutes for calendar year 2019. While staff provided minutes for May through December 2019, they were unable to locate the documentation for January through April 2019. The OIG found that representatives from social work and mental health did not consistently attend meetings. As a result, the committee conducted reviews and analyzed data without the input of key staff. On October 8, 2020, VHA updated the requirement for the review of UM data to be performed by "a multidisciplinary

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

[43] VHA Handbook 1050.01, "The requirement for a total of eight 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 site visits, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

[45] VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019. (This directive was rescinded and replaced with VHA Directive 1117, *Utilization Management Program*, October 8, 2020.)

committee, which may include representatives from" various services.[46] Therefore, the OIG made no recommendation.

For root cause analyses to be considered thorough, VHA requires inclusion of "potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist."[47]. In two of five root cause analyses evaluated, the OIG did not find evidence that potential process or system improvements were identified. This could have negatively affected the evaluation of patient safety events and system vulnerabilities and prevented process improvements from being implemented to avoid future patient harm events. The acting Patient Safety Manager reported that some of the cases selected for review were the first conducted after assuming the role. The acting Patient Safety Manager also reported not receiving training on the root cause analysis process and believing that some sections of WebSPOT (a component of the VHA Patient Safety Information System) did not need completion.[48]

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures the Patient Safety Manager or designee includes all required review elements in root cause analyses.

[46] VHA Directive 1117, *Utilization Management Program*, October 8, 2020.

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

[48] VHA Handbook 1050.01.

Healthcare system concurred.

Target date for completion: September 1, 2021

Healthcare system response: No additional reasons for noncompliance were identified when developing the action plan. To provide additional training for root cause analyses (RCA) to ensure all required review elements are contained, the VISN Patient Safety Officer assisted with conducting an RCA at the end of September 2020 to provide training to existing Quality Management staff. All subsequent RCAs will clearly identify the system vulnerability and potential improvements found in the final understanding of events, the root cause statements will reflect the vulnerability and the action items will address that vulnerability. To ensure these items are addressed, every RCA is audited/reviewed monthly by a designee in quality management to identify any potential gaps or recommend improvements prior to reporting out on the RCA to the executive leadership team. This audit also confirms that relevant literature is included in the documentation and that the RCA team included an Evidence Based Practice mentor either on the team or utilized them as a resource/consultant to address the lack of consideration of relevant literature finding on two RCAs.

A process and tracking tool has been put in place to ensure action items from RCAs were implemented. The Patient Safety Manager tracks the pending and any overdue action items and outcome measures and facilitates communication and closure with the point of contact and/or person assigned to the task. Compliance target is 90% or greater performance for a period of six consecutive months.

The tracking of all of the RCA findings are reported monthly at Quality, Safety, and Value Council meetings and executive leadership is alerted of any assistance needed by the Patient Safety Manager for overdue actions and outcome measures to help facilitate closure.

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).[49]

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.[50]

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

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[52]
  - 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[53]
  - Evaluation by another provider with similar training and privileges

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

[50] VHA Handbook 1100.19.

[51] VHA Handbook 1100.19.

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

[53] 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.[54] 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."[55] 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:

- Nine solo/few practitioners who underwent initial or reprivileging during calendar year 2019[56]
- Three LIPs who completed an FPPE in calendar year 2019
- Ten LIPs privileged during calendar year 2019
- Thirteen LIPs who left the healthcare system in calendar year 2019

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[54] 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.)

[55] 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.)

[56] VHA Acting DUSHOM Memorandum, *Requirements for Peer Review of Solo Practitioners*. This memorandum refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers few practitioners as being less than three providers in the facility that are privileged in a particular specialty.

Medical Staff Privileging Findings and Recommendations

The OIG found the healthcare system was generally compliant with FPPE processes. However, the OIG identified deficiencies with OPPE and provider exit review processes.

VHA requires that privileges are facility- and practitioner-specific, and service chiefs must establish additional criteria for clinical privileges that are service-specific. Per VHA, these criteria-based privileges are used for ongoing monitoring of practitioners.[57] For 7 of 18 practitioners—including 6 solo/few practitioners—reprivileged in calendar year 2019, the OIG found that OPPE criteria were not service-specific. This resulted in incomplete data to support decisions to continue the practitioners' clinical privileges. The Associate Chief of Staff for Medical Surgery reported that, with the exception of gastroenterology providers who have national standards, the same OPPE criteria were used throughout the surgical service line because other specialties did not have national standards. The acting Chief of Staff reported that the solo cardiologist reviewed had a low volume of patient visits and acknowledged the cardiology visits should have been evaluated using cardiology criteria.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that service chiefs evaluate practitioners based on service-specific criteria.

[57] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: September 30, 2021

Healthcare system response: No additional reasons for noncompliance were identified when developing the action plan. A Standard Operating Procedure (SOP) was developed to ensure that standard procedures for Ongoing Professional Practice Evaluation (OPPE) were clearly defined and available to the Service Chiefs and their Administrative Officers for review and direction. Reference to service-specific OPPE forms is included in the Procedures section. Beginning November 9, 2020, the Executive Council of Medical Staff (ECMS) minutes show Focused Professional Practice Evaluation (FPPE) and OPPE criteria were presented to the board for review and approval. Minutes reflect the actions taken and the updated service-specific OPPE forms are in use.

The SOP was provided for review and approval to the (ECMS) on April 21, 2021, and is uploaded to the facility SharePoint. Compliance target is 90% or greater performance for a period of six consecutive months. OPPEs presented to the ECMS in March 2021 demonstrated service-specific criteria were used to review 100% of providers (111/111).

OPPE review forms are included in the ECMS minutes twice a year where the ECMS board and the Director are provided with an overview of the OPPE data.

VHA requires that LIPs are evaluated on an ongoing basis by providers with similar training and privileges.[58] The OIG found that 2 of 17 LIP profiles lacked evidence that providers with similar training and privileges completed the evaluations. This resulted in two solo/few LIPs providing patient care without a thorough evaluation of their competencies, which could affect quality of care and jeopardize patient safety. The Associate Chief of Staff for Medical Surgery reported conducting the reviews for the two providers to ensure completion in a timely manner and noted that it was difficult to find an outside provider to complete the reviews. The OIG identified similar concerns with the FPPE process during the prior CHIP visit.[59]

Recommendation 3

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

[58] VHA Handbook 1100.19. VHA Acting DUSHOM Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

[59] VA OIG, *Comprehensive Healthcare Inspection Program Review of the Roseburg VA Health Care System, Oregon,* Report No. 18-00620-277, September 17, 2018.

Healthcare system concurred.

Target date for completion: September 30, 2021

Healthcare system response: No additional reasons for noncompliance were identified when developing the action plan. OPPE presentation forms now attest that review for OPPE was completed by a qualified peer of similar education and training. An SOP was created to ensure that the procedures for OPPE were clearly defined and available to the Service Chiefs and their Administrative Officers for review and direction. Specific reference to OPPEs being completed by providers with similar training and education is stated in the SOP. The SOP was provided for review and approval to the Executive Council of Medical Staff (ECMS) on 4/21/21 and is uploaded to the facility SharePoint.

OPPE forms are included in the ECMS minutes twice a year where the ECMS and the Director are provided with an overview of the OPPE data. Compliance target is 90% or greater performance for a period of six consecutive months. Reports presented in March 2021 were recorded at 100% as noted in the minutes. The updated forms attesting that the OPPE is reviewed by a provider with similar training and privileges is included as of March 2021.

VHA requires an executive committee of the medical staff (known as the Executive Council of Medical Staff at this healthcare system) to review and evaluate LIPs' reprivileging requests. Committee meeting minutes must indicate the materials reviewed and rationale for the conclusion. The committee then submits their recommendation to the Director, who is the approving authority.[60] The OIG did not find evidence that the Executive Council of Medical Staff evaluated reprivileging requests for 15 of 18 practitioners. This function was performed by a professional standards board (known as the Executive Council of Medical Staff Credentialing and Privileging Committee), which was not identified in the Medical Staff Bylaws as a committee authorized to make recommendations to the Director. Failure to appropriately document committee reviews and recommendations resulted in incomplete evidence to support the Director's approval for continuing clinical privileges. The Medical Staff Coordinator reported that after the Executive Council of Medical Staff Credentialing and Privileging Committee voted to recommend continuing privileges, the committee sent their minutes and attachments to Executive Council of Medical Staff members for voting. The OIG was not provided evidence of the electronic vote in the Executive Council of Medical Staff minutes prior to LIPs' reprivileging. The OIG identified similar concerns with the FPPE process during the prior CHIP visit.[61]

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[60] VHA Handbook 1100.19.

[61] VA OIG, *Comprehensive Healthcare Inspection Program Review of the Roseburg VA Health Care System, Oregon*, Report No. 18-00620-277.

Recommendation 4

4. The Chief of Staff evaluates and determines the reasons for noncompliance and makes certain the Executive Council of Medical Staff reviews and evaluates licensed independent practitioners' reprivileging requests and documents the review in the meeting minutes.

Healthcare system concurred.

Target date for completion: September 30, 2021

Healthcare system response: No other reasons for noncompliance were identified when developing the action plan. The Chief of Staff Office, in cooperation with the Medical Staff Office, ensures that Licensed Independent Practitioner's (LIPs) re-privileging requests are reviewed in the Executive Council of the Medical Staff (ECMS) meetings. Provider recommendations are brought forth by the service chief and the committee reviews, discusses and votes on re-privileging recommendations. All actions are documented in the meeting minutes. The medical staff office records the reappraisal requests in the ECMS minutes.

Compliance target is 90% or greater performance for a period of six consecutive months. Audit data reflect 100% compliance for six consecutive months. Recording of re-privileging requests will continuously be recorded in the meeting minutes of the committee.

At the time of the OIG virtual site visit, VHA required that "Provider Exit Review forms must be completed within 7-calendar days of departure of a licensed health care professional" and that SLB reporting is initiated when a licensed health care professional has been identified as performing substandard care.[62] For 13 providers who departed the healthcare system during calendar year 2019, the OIG found that 3 provider exit review forms were not completed within 7 calendar days. However, as of January 28, 2021, VHA requires the system director to ensure provider exit review forms are completed within seven business days of departure.[63] Based on the updated requirement, two exit review forms were not completed within the new time frame. Further, the OIG noted that six providers' exit review forms were completed before departure, with two providers continuing to provide care after exit form completion. This could have resulted in delayed or lack of reporting of healthcare professionals to SLBs when indicated. The Medical Staff Coordinator did not explain why the forms were not completed as required but reported sending exit review forms to the service chiefs on notification that the provider was

[62] VHA Notice 2018-05, *Amendment to VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards*, February 5, 2018. VHA Directive 1100.18, which replaced VHA Handbook 1100.18 on January 28, 2021, updated the requirement for exit review forms to be completed within seven calendar days to seven business days.

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

leaving, tracking the completion of forms, and sending reminders to the services to complete the form if needed.

Recommendation 5

5. The System Director evaluates and determines 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.

Healthcare system concurred.

Target date for completion: November 30, 2021

Healthcare system response: No additional reasons for noncompliance were identified when developing the action plan. An SOP was created to ensure that the procedures for Exit Review Memos were clearly defined and available to the Service Chiefs and their Administrative Officers for review and direction. Both Licensed Independent Practitioner (LIP) and Non-LIP Exit Review memo compliance for timely completion of exit review forms is reported to the Executive Council of Medical Staff (ECMS) on a monthly basis. Compliance target is 90% or greater performance for a period of six consecutive months. Audit data has been collected and demonstrates continuous compliance over a 6-month period (92-100%).

The reporting of this metric will continue to be recorded in the ECMS minutes monthly. Fallouts will be reviewed to determine the cause and an action plan will be created to follow-up on the remediation of the issue.

The compliance data is reported monthly in the ECMS meeting.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[64] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[65] 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.[66] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[67]

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.[68] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[69] 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.[70] 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.[71]

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

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

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

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

[68] "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."

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

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

[71] *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.”[72] 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 17 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 OIG found the healthcare system addressed many of the indicators of expected performance, including pain screening, documented justification for concurrent therapy with benzodiazepines, and the use of a multidisciplinary pain management committee to oversee and monitor quality measures. However, the OIG found deficiencies with aberrant behavior risk assessments, urine drug testing, informed consent, and patient follow-up after therapy initiation.

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.[73] The OIG determined that providers failed to document aberrant behavior risk assessments for 29 percent of the patients, based on the electronic health records reviewed.[74] This may have resulted in providers prescribing opioids for patients at high risk for misuse. The Associate Chief of Staff for

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

[73] *Pain Management, Opioid Safety, VA Educational Guide*, 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,* Version 3.0. February 2017.

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

Ambulatory Care and the Chief of Pharmacy reported the involvement of multiple providers from different services in the care of the patient and turnover of primary care providers as reasons for noncompliance.

Additionally, VA/DoD clinical practice guidelines recommend that providers "obtain UDT [urine drug testing] prior to initiating or continuing LOT [long-term opioid therapy] and periodically thereafter."[75] The OIG found that providers did not ensure completion of initial urine drug testing for 41 percent of the patients reviewed.[76] This resulted in providers' inability to identify whether patients had substance use disorders, determine potential diversion, or ensure patients adhered to the prescribed medication regimen. The Chief of Pharmacy reported that providers ordered urine drug tests; however, the tests were not completed prior to medications being prescribed. The Associate Chief of Staff for Ambulatory Care also identified that providers may have renewed the medication without the urine drug tests to prevent patients' pain and withdrawal, especially if the patient was not demonstrating signs of aberrant behavior.

VHA requires providers to obtain and document informed consent for therapeutic treatments that have a "significant risk of complication or morbidity," including long-term opioid therapy, prior to initiation.[77] The OIG determined that providers failed to document informed consent prior to initiating long-term opioid therapy for 53 percent of the patients reviewed.[78] This could have resulted in patients receiving treatment without knowledge of the risks associated with long-term opioid therapy, including dependence, tolerance, addiction, and unintentional fatal overdose. As reported previously, the Associate Chief of Staff for Ambulatory Care and the Chief of Pharmacy attributed the noncompliance to the involvement of multiple providers from different services in the care of the patient and the turnover of primary care providers.

VA/DoD clinical practice guidelines recommend providers follow up with patients within three months after initiating long-term opioid therapy.[79] The OIG found that providers did not follow up within 3 months after initiating long-term opioid therapy for 24 percent of the patients reviewed.[80] Failure to conduct follow-ups can result in missed opportunities to assess patients' adherence to the therapy plan, effectiveness of treatment, and risks of continued opioid therapy. The Associate Chief of Staff for Ambulatory Care and the Chief of Pharmacy attributed noncompliance to multiple providers from different services being involved in the care of the patient and the turnover of primary care providers.

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

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

[77] VHA Directive 1005.

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

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

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

The OIG made no recommendations due to the small sample of patients identified for these review elements.

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.[81] 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.[82] VHA has identified suicide prevention as a top priority and implemented various evidence-based approaches to reduce the veteran suicide rate. In addition to expanded mental health services and community outreach, VHA has developed comprehensive screening and assessment processes to identify at-risk patients.[83]

VHA requires that each medical center and very large 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.[84] The OIG examined various requirements related to SPCs:

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

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

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

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

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

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

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

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

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

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

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

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

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

88 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*.

89 VHA DUSHOM Memorandum, *High Risk for Suicide Patient Record Flag Changes*.

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

91 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."[92]

Inspectors examined the completion of several requirements:

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

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

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

[93] Operation S.A.V.E. is a VA gatekeeper training program provided by suicide prevention coordinators to veterans and those who serve veterans. The acronym "S.A.V.E" summarizes the steps needed to take in recognizing and responding to a veteran in suicidal crisis. The training was designed for 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.

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

[95] 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 20 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, and completion of at least five outreach activities per month and four appointments within the required time frame. 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[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"[96]—the OIG determined that 45 percent of HRS PRFs were not placed within 24 hours of referral to the SPC.[97] Based on the current requirement that the SPC is 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 3 days (observed range was 0–13 days).[98]

Further, the OIG noted concerns with reviewing HRS PRFs within the required time frame. Per VA, all patients with an HRS PRF should be reevaluated at least every 90 days.[99] The OIG determined that 75 percent of patients with an HRS PRF were not reevaluated at least every 90 days.[100] 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 10 percent of the patients within the new time frame (observed range was 6–101 days).[101]

Additionally, the OIG noted concerns with suicide prevention training and suicide safety plans.

VHA requires the SPC to provide Operation S.A.V.E. training in person to all nonclinical employees during new employee orientation.[102] The OIG found that education staff, not the SPC, provided the Operation S.A.V.E. training in all four new employee orientation sessions reviewed. Training conducted by staff without the specialized knowledge and

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

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

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

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

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

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

[102] VHA DUSHOM Memorandum, *Suicide Awareness Training*, April 11, 2017.

experience of the SPC could hinder nonclinical employees' recognition of and response to a veteran in suicidal crisis. The acting New Employee Orientation Facilitator was not aware that training must be provided by the SPC.

Recommendation 6

6. The System Director evaluates and determines any additional reasons for noncompliance and ensures the Suicide Prevention Coordinator provides in-person Operation S.A.V.E. training at new employee orientation.

Healthcare system concurred.

Target date for completion: November 30, 2021

Healthcare system response: No additional reasons for noncompliance were identified when developing the action plan. The Roseburg VA Health Care System has been in compliance with the National Policy Guideline from October 15, 2020, indicating Operation S.A.V.E. Trainings were to be assigned virtually in VA Talent Management System (TMS) to all new employees by the facility's Education Department. Compliance target is 90% or greater performance for a period of six consecutive months. The compliance report for this training was sent to the employee's manager by the Education Department monthly, and overall compliance for the facility was reported in the monthly Mental Health Executive Committee (MHEC) Meeting, with recorded 100% compliance since October 2020, meeting the goal of 100% compliance for Operation S.A.V.E. Training completion. The Facility will continue to follow National Policy Guidelines, and this process, and will resume in-person Operation S.A.V.E. Trainings when appropriate, or as indicated by COVID-19 Pandemic protocol and guidelines. At this time, New Employee Orientation continues to operate virtually and there is no current projected day to resume in-person.

VHA requires "that for patients with a new or reactivated HRS-PRF, the safety plan should be completed within 7 days before or after the current HRS-PRF date."[103] The OIG found that safety plans were not completed within 7 days before or after the high-risk designation for 11 percent of the patients reviewed.[104] When safety plans are not completed in a timely manner, patients may not be able to find critical resources when needed. The Chief Social Worker for Mental Health stated that the service line was less than 50 percent staffed during the time of the review, which contributed significantly to the noncompliance. The Associate Chief of Staff, Mental Health also reported difficulty with staff recruitment and retention.

[103] VHA, suicide subject matter expert response to timing of safety plan completion, received July 8, 2019.

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

VA also requires that safety plans include language for "recognizing warning signs, using internal coping strategies, utilizing social contact…contacting family members or friends…contacting professionals and agencies, and reducing the potential for use of lethal means."[105] The OIG found that 53 percent of safety plans for patients with a HRS PRF did not contain contact numbers of family or friends. Additionally, 47 percent of safety plans did not include an assessment of available lethal means and information about how to keep the environment safe.[106]

For safety plans completed on or after September 1, 2018, VHA requires an assessment of patients' access to firearms and opioids and education on safety and overdose risks.[107] The OIG found that 27 percent of safety plans for patients with an HRS PRF did not include an assessment of patients' access to firearms. The OIG also found that 73 percent lacked an assessment of patients' access to opioids and contained no evidence of education on safety and overdose risks.[108] Failure to complete safety plans with all required elements may pose a significant danger to vulnerable patients.

The Associate Chief of Staff of Mental Health reported a large population of homeless patients who were unable to provide contact information for family or friends. The SPC reported that providers had saved a previous version of the safety plan, which did not include assessment of patients' access to firearms and opioids, and the providers continued to use the outdated version after the healthcare system updated to the new national template.

The OIG made no recommendations due to the small sample of patients identified for these review elements.

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

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

[107] VHA DUSHOM Memorandum, *Suicide Prevention Safety Plan National CPRS Note Templates Implementation*, June 1, 2018.

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

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 decisions (LSTD) handbook to standardize practices related to discussing and documenting goals of care and LSTD. Per VHA, the goal is to encourage personalized, proactive, patient-driven treatment plans for veterans with serious illness by "eliciting, documenting, and honoring patients' values, goals, and preferences."[109]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD handbook by July 12, 2018.[110] 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.[111] 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.[112]

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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[109] 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.

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

[111] 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.

[112] 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.[113] 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 31 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

Care Coordination Findings and Recommendations

The healthcare system generally complied with requirements for an LSTD committee, inclusion of required elements in LSTD documentation, and supervision of designees. However, the OIG

[113] VHA Handbook 1004.03(1).

found deficiencies with providers completing goals of care conversations and documenting LSTD in a timely manner.

VHA requires that the Chief of Staff and ADPCS are responsible for ensuring that providers complete and "document the patient's goals of care and LST plan using the standardized progress note template entitled 'Life-Sustaining Treatment'."[114] The OIG estimated that providers did not complete goals of care conversations for 26 percent of patients, based on the electronic health records reviewed.[115] Failure to complete goals of care conversations may prevent patients from having their "values, goals, and preferences regarding the initiation, limitation or discontinuation of LSTs" identified and met.[116] The Associate Chief of Staff for Ambulatory Care did not provide a reason beyond stating that education for providers was completed last year, and a standard operating procedure, as well as education for nurses and patients, were in development.

Recommendation 7

7. The System Director evaluates and determines the reasons for noncompliance and ensures providers complete and document goals of care conversations.

[114] VHA Handbook 1004.03 was amended to VHA Handbook 1004.03(1) on March 19, 2020. The requirements remained the same or similar.

[115] The OIG estimated that 95 percent of the time, the true compliance rate is between 58.0 and 88.9 percent, which is statistically significantly below the 90 percent benchmark.

[116] VHA Handbook 1004.03(1).

Healthcare system concurred.

Target date for completion: July 31, 2021

Healthcare system response: No additional reasons for noncompliance were identified when developing the action plan. The VA Primary Care Providers (PCP) and the Office of Community Care Referral Management Nurse will coordinate efforts to identify Veterans with new hospice referrals.

Veterans referred for hospice or their designated surrogate will have opportunity to engage in a Goals of Care Conversation (GOCC). The VA PCP and the VA hospice team are to be contacted upon initiation of a hospice referral. They can then contact the Veteran or surrogate to confirm and document the GOCC and life sustaining treatment (LST) choices. This process is being implemented currently with a review period of January 1, 2021, through July 1, 2021.

Monthly reviews of 100% (to a max of 30 cases per month) hospice referrals by VA providers and completed LST templates have been reviewed since January 2021.

Currently, 100% of inpatient hospice referrals have documented LST orders prior to admission or following admission to a hospice unit. This review will continue for six consecutive months with a target of 90% compliance.

Audit data is and will continue to be provided monthly to the Geriatric Extended Care Advisory Committee. [The] report [is] presented to the Executive Council of Medical Staff monthly.

VHA requires that the Chief of Staff and ADPCS are responsible for ensuring providers complete goals of care conversations with hospice patients and document LSTD before entering a referral to VA or non-VA hospice.[117] The OIG estimated that providers did not complete goals of care conversations prior to a hospice referral for 45 percent of patients, based on the electronic health records reviewed.[118] Failure to initiate timely goals of care conversations may hinder providers' ability to honor patients' self-determined preferences, autonomy, and patient wishes prior to or during a life-threatening clinical event. The Nurse Practitioner stated the healthcare system had identified improvement opportunities prior to the OIG virtual review and changes were being made, including the development of a standard operating procedure and education.

[117] VHA Handbook 1004.03 was amended to VHA Handbook 1004.03(1) on March 19, 2020. The requirements remained the same or similar.

[118] The OIG estimated that 95 percent of the time, the true compliance rate is between 33.3 and 76.5 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 8

8. The System Director evaluates and determines the reasons for noncompliance and ensures providers complete and document goals of care conversations within the required time frame.

Healthcare system concurred.

Target date for completion: July 31, 2021

Healthcare system response: No additional reasons for noncompliance were identified when developing the action plan. The admitting Medical Officer of the Day and/or the Nurse Practitioner complete inpatient hospice LST notes prior to referral or following admission to a hospice unit. A Standard Operating Procedure regarding this process has been completed and is in effect.

All inpatient hospice Veterans have completed LST notes.

This process began January 1, 2021, and has been ongoing since then.

Monthly chart reviews of up to 10 completed LST notes/orders for Veterans admitted to the VA inpatient hospice are occurring (unit capacity is 10 beds). Compliance is 100% and has been sustained since January 2021.

This audit data is and will continue to be provided monthly to the Geriatric Extended Care Advisory Committee. [The] report [is] presented to the Executive Council of Medical Staff monthly.

Women's Health: Comprehensive Care

Women represented 9.8 percent of the veteran population as of September 30, 2018.[119] 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.[120] 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."[121] 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."[122]

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.[123] 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."[124]

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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[119] "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.

[120] "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.

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

[122] 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.

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

[124] VHA Directive 1330.01(3).

    - Gynecologic care coverage available 24/7
    - Facility women’s health primary care providers designated
    - Community-based outpatient clinic (CBOC) women’s health primary care providers designated
- Oversight of program and monitoring of performance improvement data
    - Women Veterans Health Committee established
        - Quarterly meetings held
        - Core members attend
        - Quality assurance data collected and tracked
        - Reports made to clinical executive leaders
- Assignment of required staff
    - Women Veterans Program Manager
    - Women’s Health Medical Director or clinical champion
    - Maternity Care Coordinator
    - Women’s health clinical liaison at each CBOC

Women’s Health Findings and Recommendations

The healthcare system complied with requirements for most of the provision of care indicators and staffing elements reviewed. However, the OIG identified weaknesses with CBOC-designated women’s health primary care providers and the Women Veterans Health Committee.

VHA requires that each CBOC has at least two designated women’s health primary care providers to ensure adequate coverage is available during provider leave.[125] The OIG found that one CBOC (Brookings) did not have any women’s health primary care providers, which could negatively affect the delivery of comprehensive healthcare services to women veterans. The Associate Chief of Staff of Ambulatory Care reported the clinic’s remote location made it difficult to recruit providers, and it was believed the nurse practitioner hired for the clinic was a women’s health provider; however, this was not the case.

[125] 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 staff was reviewed for this report. The directive 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 designation of women’s health primary care providers.

Recommendation 9

9. The System Director evaluates and determines any additional reasons for noncompliance and ensures that each community-based outpatient clinic has at least two designated women's health primary care providers.

Healthcare system concurred.

Target date for completion: October 1, 2021

Healthcare system response: No additional reasons for noncompliance were identified when developing the action plan. It is the responsibility of the Associate Chief of Staff for Ambulatory Care to hire medical providers willing to service all Veterans. This is monitored by the Women's Veteran Program Manager. Any discrepancies or non-compliance is reported directly to the Chief of Staff and through the Executive Council of Medical Staff (ECMS) quarterly. New functional statements have been created using gender inclusive language. These new functional statements have been implemented since March 1, 2021. A new SOP was written on February 26, 2021, outlining women's health coverage in the absence of a Women's Health Provider. The new Women's Health Coverage SOP has been shared with all primary care providers, managers and executive leadership. We are in the process of implementing a cross coverage plan based on the new Women's Health Coverage SOP.

It is anticipated that we will have two women's health (WH) Providers by the target date for completion. A new Women's Health Provider has been recruited for the Brookings Community Based Outpatient Clinic (CBOC) and will start July 2021. We are currently providing women's health care coverage in the community and through telehealth services.

VHA requires the system director to ensure there is a women veterans health committee in place which meets quarterly, reports to executive leaders, and has core members.[126] The membership must include a women veterans program manager, 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."[127]

[126] 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.)

[127] VHA Directive 1330.01(2). (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.)

The OIG reviewed the Women Veterans Health Committee minutes for meetings held between July 1 and December 31, 2019, and found that a women's health medical director and a representative from the medical and/or surgical subspecialty did not attend any meetings. This resulted in a lack of expertise and oversight, and may have prevented the identification and implementation of improvements for the Women's Health Program. The Women Veterans Program Manager attributed noncompliance to staffing issues, including the vacant women's health medical director position, which had remained unfilled since 2016.

Recommendation 10

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

Healthcare system concurred.

Target date for completion: October 1, 2021

Healthcare system response: No additional reasons for noncompliance were identified when developing the action plan. Women Veteran[s] Health Committee attendance is monitored and reported to executive committee medical staff quarterly by the Women Veterans Program Manager. Attendance reminders are sent out by the Women Veterans Program Manager in advance to every Women Veterans Health Committee meeting.

Any required committee member unable to attend the Women Veterans Health Committee is required to send a delegate per the Women Veterans Health Committee Charter. If a committee member and or delegate is not present at the Women Veterans Health Committee, the noncompliance will be reported to the department supervisor by the Women Veterans Program Manager within three business days. Continued noncompliance defined by two missed committee meetings will be escalated and reported to the Chief of Staff for resolution. Compliance of the Women Veterans Health Committee Charter is monitored by the Women Veterans Program Manager and reported to executive leadership quarterly.

Compliance has been achieved for three consecutive months with a compliance percentage of 90% or greater. It is anticipated that six consecutive months' worth of compliance data will be submitted by the target date for completion.

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."[128] The goal of SPS is to "provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[129] 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[130]
- 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[131]

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.[132] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[133]

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.[134]

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

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

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

[131] VHA Directive 1116(2).

[132] 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.

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

[134] 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.[135]

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

High-Risk Processes Findings and Recommendations

The healthcare system generally met the requirements for the proper operations and management of RME. However, the OIG identified deficiencies with required administrative processes and

[135] VHA Directive 1116(2).

staff training. The OIG also found a 2018 root cause analysis regarding RME that had been closed, even though two of the three actions were not implemented and none of the outcomes measured had been assessed.

VHA requires that "The Chief, SPS must maintain a file (electronic or paper copy) for all reusable devices. This file must contain the manufacturer's IFU [instructions for use] for the proper method of sterilization for each item."[136] The OIG found that the healthcare system's RME inventory file did not accurately reflect the current inventory for one of the selected pieces of equipment (Olympus Rhino-Laryngo Videoscope ENF-VH). Inventory management staff verified the healthcare system had not purchased the device. Beyond reporting that the device was not at the facility, the Acting SPS Program Director Roseburg and Eugene was unable to provide a reason why there was an SOP on record for a device not in inventory at the system. The OIG made no recommendation.

VHA also requires that "all 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."[137] All four SOPs reviewed were labeled as Version 1. The SOPs did not contain any revision information; therefore, the OIG was unable to determine if SOPs were reviewed every three years. These administrative oversights could result in improper cleaning of reusable equipment. The SPS lead staff member stated version numbers had not been modified when updating SOPs. The SPS lead also stated that staff were unaware of a process to track revision history.

Recommendation 11

11. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that standard operating procedures are reviewed at least every three years and updated when there is a change in process or manufacturer's instructions for use.

[136] VHA Directive 1116(2).

[137] VHA Directive 1116(2).

Healthcare system concurred.

Target date for completion: July 1, 2021

Healthcare system response: No additional reasons for noncompliance were identified when developing the action plan. A process was implemented in December 2020 to review every Instruction for Use (IFU) for updates at least annually. Every month, 32 of 187 IFUs are reviewed for updates. The date of last review is documented on the master inventory list. If there is a change to the IFU, the SOP is marked for revision and converted to the new SOP format. Audit tracking shows 100% compliance for four months with data still being reviewed until the six months' worth of data is collected demonstrating at least 90% compliance each month. The Sterile Processing Services (SPS) has reported compliance to the Reusable Medical Equipment (RME) Committee since December 2020. Progress is reported in the Reusable Medical Equipment Committee. The RME minutes are reported to the Executive Council of Nursing and the Quality, Safety and Value Council.

Per the March 23, 2016 directive, VHA requires that "all new SPS employees must complete the SPS Level 1 training program within 90 days of hire."[138] Of the 10 selected SPS employees, 8 of whom were hired after March 23, 2016, the OIG found that 1 employee had not completed the training and 2 did not complete the training within 90 days of hire. This could have resulted in improperly cleaned equipment and potentially compromised patient safety. The SPS lead staff member was unable to provide a reason for noncompliance, citing that the process is for all new staff to have the Level 1 training done during their first week.

Recommendation 12

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

[138] VHA Directive 1116(2).

Healthcare system concurred.

Target date for completion: November 30, 2021

Healthcare system response: No additional reasons for noncompliance were identified when developing the action plan. Sterile Processing Services (SPS) leadership worked with the Education Department to assign new SPS staff all Level 1 modules with a due date of 75 days post-hire. This allows for a 15-day buffer period at which point the staff member would be pulled from other duties until all Level 1 modules are completed. There has been one new staff member since the preliminary finding was assigned, and all Level 1 modules were completed within 54 days. Status of future hire completion of Level 1 training will continue to be reported to the Reusable Medical Equipment (RME) Committee for tracking of compliance (reporting began in December 2020). Completion of Level 1 SPS staff training was monitored from December 2020 through May 2021 with an expected compliance rate of at least 90%. This monitoring demonstrates 100% compliance during the review period. Progress is reported in the Reusable Medical Equipment Committee. The RME minutes are reported to the Executive Council of Nursing and the Quality, Safety and Value Council.

Additionally, VHA requires SPS employees to receive monthly "in-service education sessions focusing on the technical aspects of SPS."[139] The OIG found no evidence of monthly continuing education for 9 of 10 selected SPS employees from October through December 2019. This could result in a knowledge gap in the technical aspects of reprocessing duties. Beyond reporting that training was not conducted consistently at the Roseburg site and was not provided for one month at the Eugene site because SPS leaders were unavailable, SPS staff were unable to provide a reason for noncompliance.

Recommendation 13

13. The Associate Director of Patient Care Services determines the reasons for noncompliance and ensures that all employees who reprocess reusable medical equipment receive monthly continuing education.

[139] VHA Directive 1116(2).

Healthcare system concurred.

Target date for completion: November 30, 2021

Healthcare system response: No additional reasons for noncompliance were identified when developing the action plan. An annual training plan was created for both Sterile Processing Services (SPS) locations. Attendance roster and training outline is kept for documentation. Any staff member not in attendance for the monthly training session will meet with the Lead or Supervisor upon return for make-up training. Completion of staff training was monitored beginning in December 2020 with an expected compliance rate of at least 90%. Monitoring from December 2020 through May 2021 demonstrates at least 90% compliance. Progress is reported in the Reusable Medical Equipment Committee and to leadership via the Executive Council of Nursing and the Quality, Safety, and Value Council.

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	Thirteen 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 ADPCS. 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	• Patient Safety Manager or designee includes all required review elements in root cause analyses.	• None
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• Service chiefs evaluate practitioners based on service-specific criteria. • Providers with similar training and privileges complete OPPE of licensed independent practitioners. • Provider exit review forms are completed within seven business days of licensed healthcare professionals' departure from the healthcare system.	• Executive Council of Medical Staff reviews and evaluates licensed independent practitioners' reprivileging requests and documents the review in the meeting minutes.
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• None	• None
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	• None	• Suicide Prevention Coordinator provides in-person Operation S.A.V.E. training at new employee orientation.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
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 and document goals of care conversations. • Providers complete and document goals of care conversations within the required time frame.	• None
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• Each CBOC has at least two designated women's health primary care providers.	• Required members consistently attend Women Veterans Health Committee meetings.
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Quality assurance • Staff training	• Standard operating procedures are reviewed at least every three years and updated when there is a change in process or manufacturer's instructions for use.	• New SPS employees complete Level 1 training within 90 days of hire. • Employees who reprocess reusable medical equipment receive monthly continuing education.

Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) affiliated healthcare system reporting to VISN 20.[1]

Table B.1. Profile for Roseburg VA Health Care System (653) (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	$224,739,344	$227,111,677	$238,589,122
Number of: • Unique patients	28,950	28,720	28,943
• Outpatient visits	344,212	338,242	345,601
• Unique employees	935	943	973
Type and number of operating beds: • Community living center	50	50	50
• Domiciliary	22	22	22
• Medicine	12	12	12
• Mental health	10	10	10
Average daily census: • Community living center	43	44	45
• Domiciliary	12	12	15
• Medicine	5	5	6
• Mental health	7	5	6

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.

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

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)

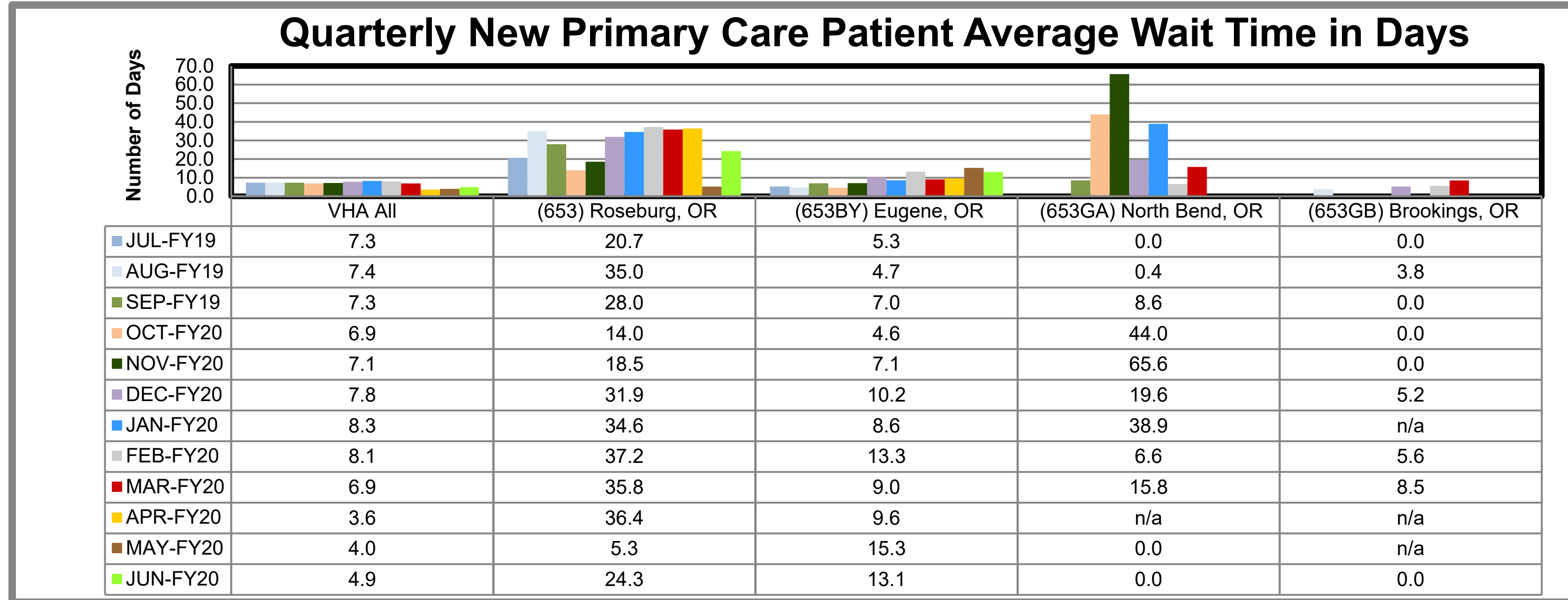
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
North Bend, OR	653GA	5,235	2,359	Cardiology Dermatology Pulmonary/ Respiratory disease	EKG	Pharmacy Weight management
Brookings, OR	653GB	4,951	2,956	Dermatology Pulmonary/ Respiratory disease	–	Pharmacy Weight management
Eugene, OR	653QA	–	9,155	–	–	–

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

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

[1] Includes outpatient clinics in the community that were in operation as of August 27, 2019. VHA Directive 1230(4), *Outpatient Scheduling Processes And Procedures*, July 15, 2016, amended June 17, 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. Electrocardiogram (EKG) diagnostic and pharmacy and weight loss management ancillary services were provided.

Appendix D: Patient Aligned Care Team Compass Metrics

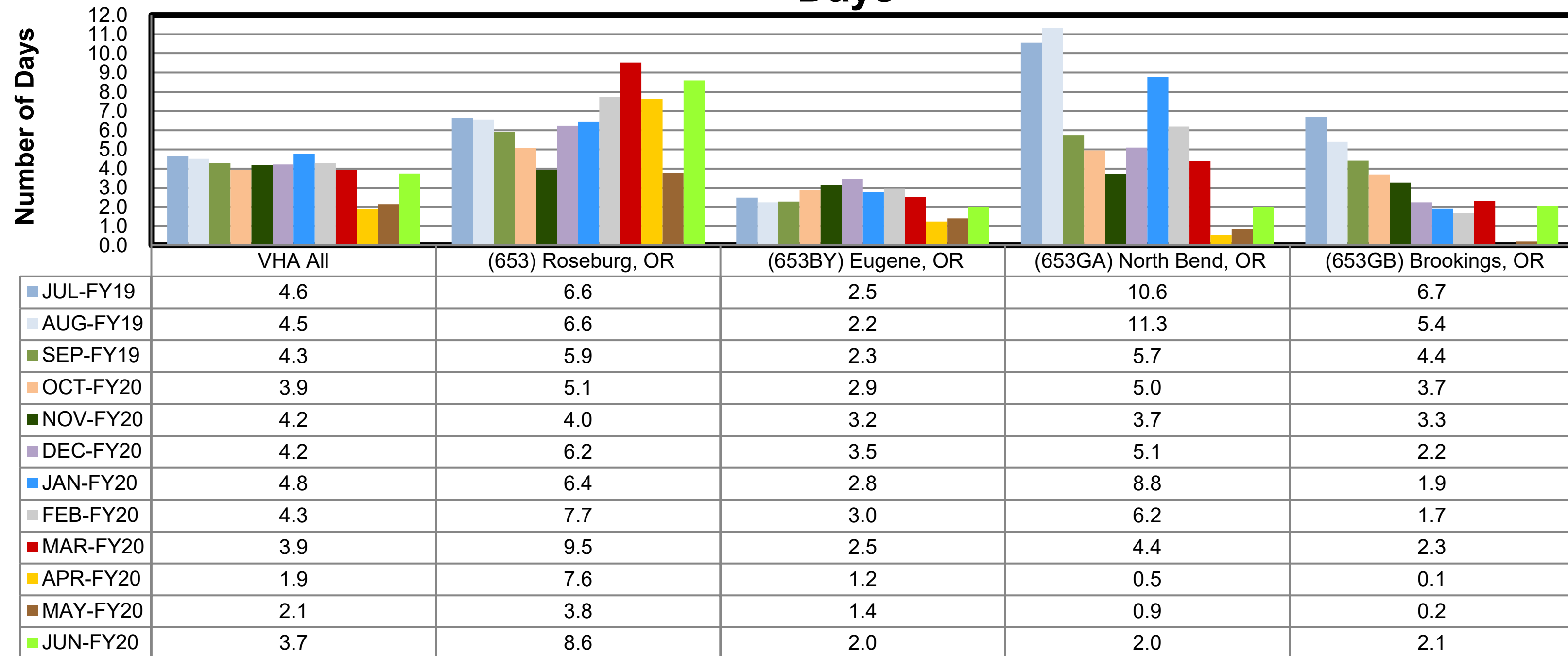


	VHA All	(653) Roseburg, OR	(653BY) Eugene, OR	(653GA) North Bend, OR	(653GB) Brookings, OR
JUL-FY19	7.3	20.7	5.3	0.0	0.0
AUG-FY19	7.4	35.0	4.7	0.4	3.8
SEP-FY19	7.3	28.0	7.0	8.6	0.0
OCT-FY20	6.9	14.0	4.6	44.0	0.0
NOV-FY20	7.1	18.5	7.1	65.6	0.0
DEC-FY20	7.8	31.9	10.2	19.6	5.2
JAN-FY20	8.3	34.6	8.6	38.9	n/a
FEB-FY20	8.1	37.2	13.3	6.6	5.6
MAR-FY20	6.9	35.8	9.0	15.8	8.5
APR-FY20	3.6	36.4	9.6	n/a	n/a
MAY-FY20	4.0	5.3	15.3	0.0	n/a
JUN-FY20	4.9	24.3	13.1	0.0	0.0

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 Roseburg and North Bend CBOCs. Note: The OIG omitted (653QA) Eugene, OR as no data were reported.

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 possibly create date. The absence of reported data is indicated by "n/a."



	VHA All	(653) Roseburg, OR	(653BY) Eugene, OR	(653GA) North Bend, OR	(653GB) Brookings, OR
JUL-FY19	4.6	6.6	2.5	10.6	6.7
AUG-FY19	4.5	6.6	2.2	11.3	5.4
SEP-FY19	4.3	5.9	2.3	5.7	4.4
OCT-FY20	3.9	5.1	2.9	5.0	3.7
NOV-FY20	4.2	4.0	3.2	3.7	3.3
DEC-FY20	4.2	6.2	3.5	5.1	2.2
JAN-FY20	4.8	6.4	2.8	8.8	1.9
FEB-FY20	4.3	7.7	3.0	6.2	1.7
MAR-FY20	3.9	9.5	2.5	4.4	2.3
APR-FY20	1.9	7.6	1.2	0.5	0.1
MAY-FY20	2.1	3.8	1.4	0.9	0.2
JUN-FY20	3.7	8.6	2.0	2.0	2.1

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. Note: The OIG omitted (653QA) Eugene, OR as no data were reported.

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 (AES) 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: June 4, 2021

From: Director, Northwest Network (10N20)

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

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

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

1. Thank you for the opportunity to provide an initial response to the findings from the Comprehensive Healthcare Inspection of the Roseburg VA Health Care System in Oregon.

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

(Original signed by:)

Teresa D. Boyd, DO

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: May 28, 2021

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

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

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

(Original signed by:)

Keith M. Allen

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