DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 19: VA Rocky Mountain Network in Glendale, Colorado

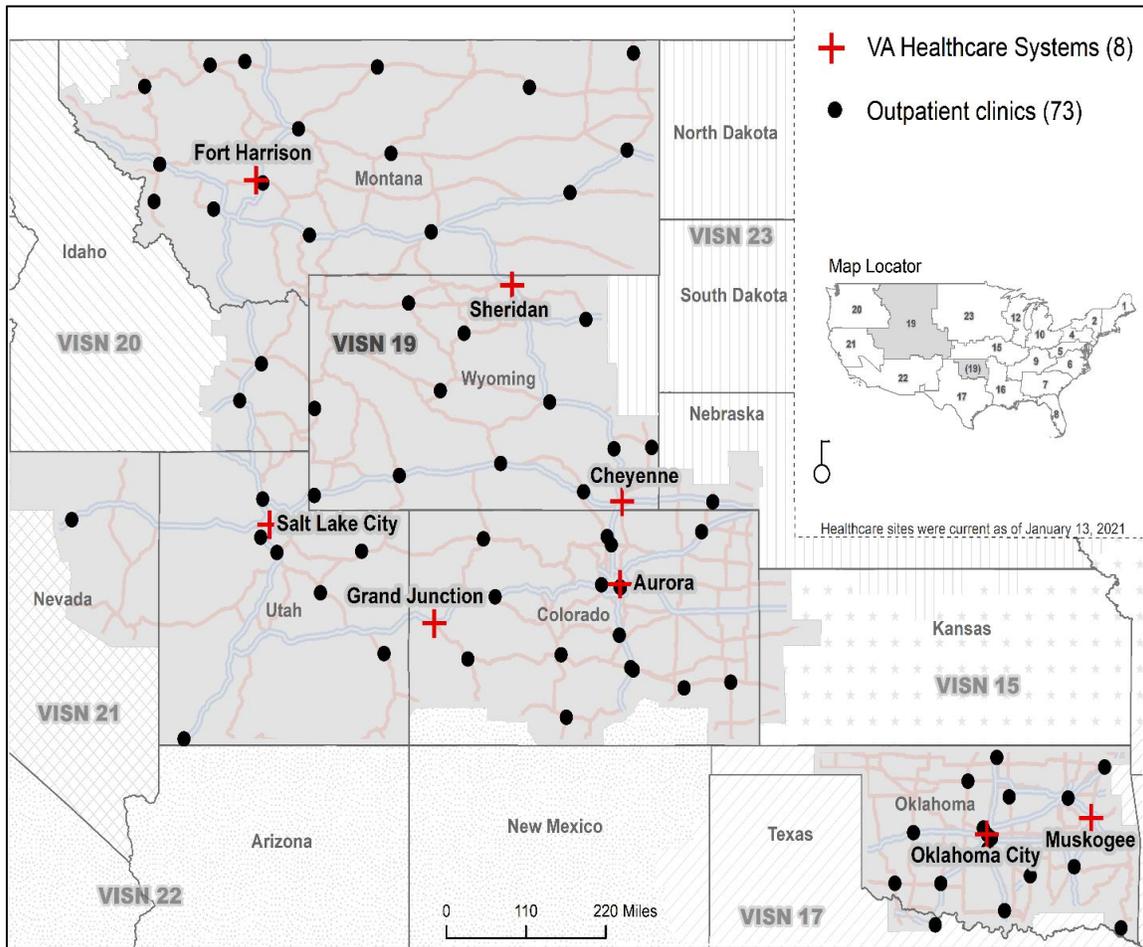***Figure 1.*** *Veterans Integrated Service Network 19: VA Rocky Mountain Network.*

Source: Veterans Affairs Site Tracking Database (accessed January 28, 2021).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	chief medical officer
CNO	chief nursing officer
FTE	full-time equivalent
FY	fiscal year
HCS	health care system
OIG	Office of Inspector General
QMO	quality management officer
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WVPM	women veterans program manager

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of leadership performance and oversight by the Veterans Integrated Service Network (VISN) 19: VA Rocky Mountain Network. The inspection covers key clinical and administrative processes 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 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 credentialing

4. Environment of care

5. Mental health (focusing on suicide prevention)

6. Care coordination (targeting inter-facility transfers)

7. Women's health (examining comprehensive care)

The OIG conducted this unannounced virtual review during the week of December 7, 2020. The OIG also performed virtual reviews of the following VISN 19 facilities during the weeks of November 30 and December 7, 2020:

- Cheyenne VA Medical Center (VAMC) (Wyoming)

- Eastern Oklahoma VA Health Care System (HCS) (Muskogee, Oklahoma)

- Montana VA HCS (Fort Harrison)

- Oklahoma City VA HCS (Oklahoma)

- Sheridan VAMC (Wyoming)

- VA Eastern Colorado HCS (Aurora)

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

- VA Salt Lake City HCS (Utah)

- VA Western Colorado HCS (Grand Junction)

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. The findings presented in this report are a snapshot of VISN 19 and facility performance within the identified focus areas at the time of the OIG review. The findings in this report may help VISN leaders identify areas of vulnerability 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 four recommendations to the Network Director and Chief Medical Officer. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual review, the VISN leadership team consisted of the Network Director, Deputy Network Director, Chief Medical Officer, Chief Nursing Officer, and Quality Management Officer. The VISN managed organizational communication and accountability through a committee reporting structure. Within this structure, the VISN's Executive Leadership Council oversaw various committees, including the Healthcare Operations; Healthcare Delivery; Quality, Safety and Value; and Organizational Health Committees.

When the team conducted this review, the Network Director and Chief Medical Officer had 37 and 34 years of VA experience, respectively. The Chief Medical Officer was assigned to the VISN in 2006, the Network Director in 2012, and the Deputy Network Director in 2014. In June 2020, the quality management officer position was permanently filled by the acting Quality Management Officer. In January 2020, the Chief Nursing Officer—a newly created position— was permanently assigned.

Selected survey scores related to employees' satisfaction with the VISN executive team leaders were generally higher than Veterans Health Administration (VHA) averages. However, the Deputy Network Director had opportunities to improve employee perceptions of leaders and the workplace. The OIG noted that aggregate VISN patient experience survey scores were similar to VHA averages.

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."[2]

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

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.[3]

The OIG's review of access metrics and clinical vacancies did not identify any substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibilities about selected SAIL and community living center metrics and should continue to take actions to sustain and improve performance measures contributing to quality ratings and care provided throughout the VISN. In individual interviews, the executive leadership team members were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

However, the OIG identified that VISN leaders had opportunities to improve their oversight of facility-level quality, safety, and value; registered nurse credentialing; care coordination; mental health, and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

COVID-19 Pandemic Readiness and Response

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 19 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[4]

Quality, Safety, and Value

The OIG found general compliance with requirements related to systems redesign and improvement and institutional disclosure reporting. However, the OIG identified a concern with peer review summary data analyses.

Medical Staff Credentialing

The OIG identified weaknesses in the review and approval of four physicians who had potentially disqualifying licensure actions prior to their VA appointment.

Women's Health

The OIG observed compliance with the appointment of a lead women veterans program manager, monthly calls with facility women veterans program managers and women's health

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

[4] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19*, Report No. 21-01699-175, July 7, 2021.

medical directors, completion of annual site visits, and analysis of access and satisfaction data. However, the OIG identified deficiencies with the provision of quarterly program updates to executive leaders and assessments of staff education gaps.

Conclusion

The OIG conducted a detailed inspection across seven key areas and subsequently issued four recommendations for improvement to the Network Director and Chief Medical Officer. However, the number of recommendations should not be used as a gauge for the overall quality of care provided within this VISN. The intent is for VISN leaders to use these recommendations to help guide improvements in operations and clinical care throughout the network of assigned facilities. The recommendations address issues that may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendix G, page 51, and the responses within the body of the report for the full text of the Network Director's comments.) The OIG considers recommendations 1–3 closed. The OIG will follow up on the planned actions for the open recommendation until it is completed.

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Contents

Purpose and Scope

The purpose of this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to evaluate leadership performance and oversight by Veterans Integrated Service Network (VISN) 19: VA Rocky Mountain Network. This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so that informed decisions can be made to improve care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[1] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[2]

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual review and initiated a pandemic readiness and response evaluation. As such, to examine risks to patients and the organization, the OIG focused on core processes in the following eight areas of administrative and clinical operations:[3]

1. Leadership and organizational risks

2. COVID-19 pandemic readiness and response[4]

3. Quality, safety, and value (QSV)

4. Medical staff credentialing

5. Environment of care

6. Mental health (focusing on suicide prevention)

7. Care coordination (targeting inter-facility transfers)

8. Women's health (examining comprehensive care)

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[1] 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.

[2] Danae Sfantou et al., "Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4, (October 14, 2017): 73, https://doi.org/10.3390/healthcare5040073.

[3] Virtual CHIP site visits address these processes during fiscal year 2021 (October 1, 2020, through September 30, 2021); they may differ from prior years' focus areas.

[4] "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)."

Methodology

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

The inspection examined operations from December 5, 2016, through December 11, 2020, the last day of the unannounced week-long virtual review.[5]

The OIG also performed inspections of the following VISN 19 facilities during the weeks of November 30 and December 7, 2020:

- Cheyenne VA Medical Center (VAMC) (Wyoming)

- Eastern Oklahoma VA Health Care System (HCS) (Muskogee, Oklahoma)

- Montana VA HCS (Fort Harrison)

- Oklahoma City VA HCS (Oklahoma)

- Sheridan VAMC (Wyoming)

- VA Eastern Colorado HCS (Aurora)

- VA Salt Lake City HCS (Utah)

- VA Western Colorado HCS (Grand Junction)

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 19 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[6]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[7] 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 VISN leaders complete

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[5] The range represents the time from the last clinical assessment program review of the VA Salt Lake City Health Care System to the completion of the unannounced week-long virtual CHIP visit on December 11, 2020 (see appendix D).

[6] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19*, Report No. 21-01699-175, July 7, 2021.

[7] Pub. L., No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3).

corrective actions. The Network Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that VISN leaders developed based on the reasons for noncompliance.

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can affect the ability to provide care in the clinical focus areas.[8] To assess this VISN's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement

2. Employee satisfaction

3. Patient experience

4. Access to care

5. Clinical vacancies

6. Oversight inspections

7. VHA performance data

Additionally, the OIG briefed VISN managers on identified trends in noncompliance for facility virtual CHIP visits performed during the weeks of November 30, 2020, and December 7, 2020.

Executive Leadership Position Stability and Engagement

A VISN consists of a geographic area that encompasses a population of veteran beneficiaries. The VISN is defined based on VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary, and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VAMCs, clinics, and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is designed to be the basic budgetary and planning unit of the veterans' healthcare system.[9]

The VISN oversees eight healthcare systems and 73 outpatient and community-based outpatient clinics. According to data from the VA National Center for Veterans Analysis and Statistics, VISN 19 had a veteran population of nearly 975,000 at the end of fiscal year (FY) 2020 and a projected population of over 960,000 by the end of FY 2021. The VISN's FY 2020 medical care budget of $4,122,423,032 represented an increase of 25 percent over that from the previous FY.

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

[9] *The Curious Case of the VISN Takeover: Assessing VA's Governance Structure, Hearing Before the House Committee on Veterans' Affairs,* 115th Cong. (2018) (statement of Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration).

VISN 19 has a leadership team consisting of the Network Director, Deputy Network Director, Chief Medical Officer (CMO), Chief Nursing Officer (CNO, also referred to as the Nurse Executive), and Quality Management Officer (QMO). The CMO oversees facility-level patient care programs. Figure 2 illustrates the VISN's reported organizational structure.[10]
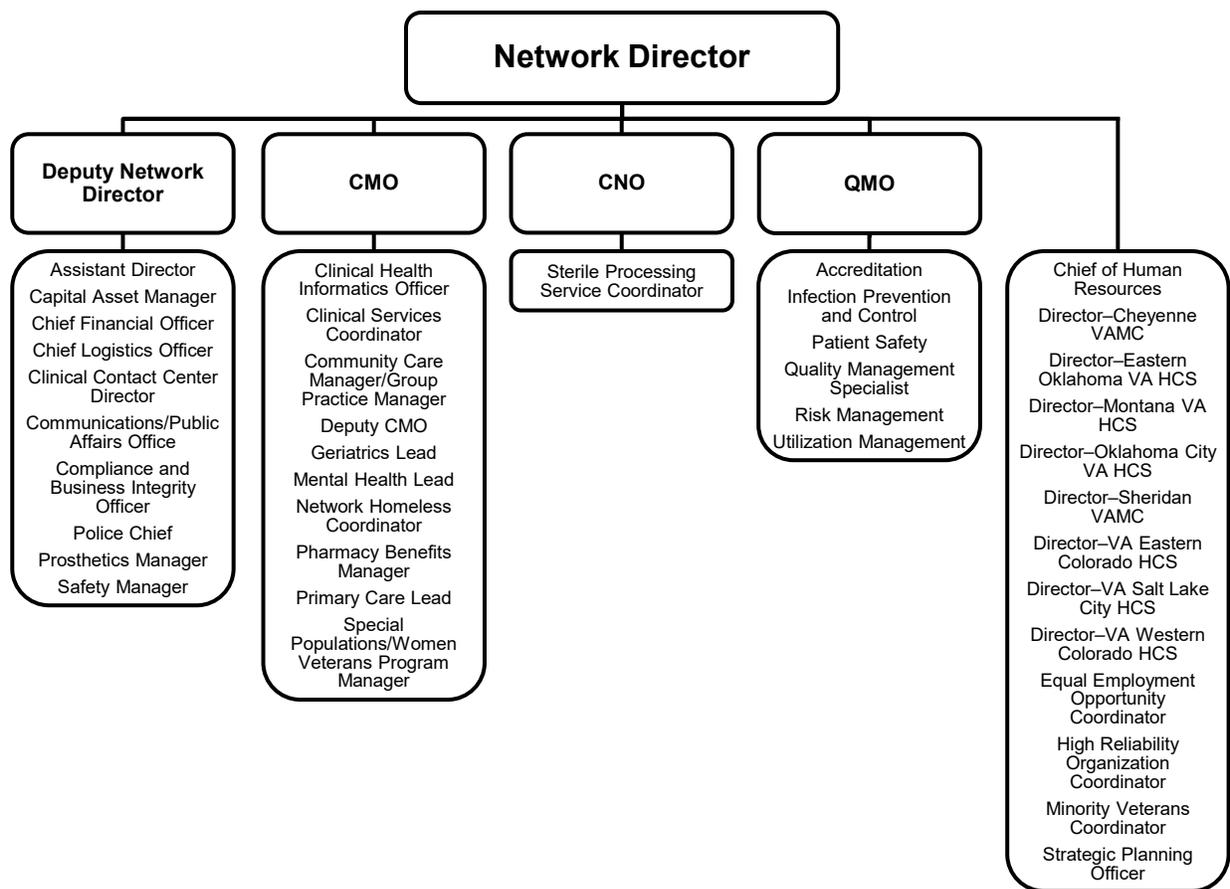
Figure 2. *VISN 19 organizational chart.*

Source: VA Rocky Mountain Network (received December 10, 2020).

At the time of the OIG inspection, the VISN's leadership team had worked together for approximately six months. However, three of the five leadership team members had worked together since 2014—the CMO was assigned in 2006, the Network Director in 2012, and the Deputy Network Director in 2014. In June 2020, the QMO position was filled by the acting QMO. In January 2020, the CNO—a newly created position—was permanently assigned (see table 1).[11]

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[10] For this VISN, the Network Director is responsible for the directors of the Cheyenne VAMC, Eastern Oklahoma VA HCS, Montana VA HCS, Oklahoma City VA HCS, Sheridan VAMC, VA Eastern Colorado HCS, VA Salt Lake City HCS, and VA Western Colorado HCS.

[11] Across VHA, there were four other CNOs serving at the VISN level.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network Director	March 11, 2012
Deputy Network Director	June 29, 2014
Chief Medical Officer	January 1, 2006
Chief Nursing Officer	January 19, 2020
Quality Management Officer	June 21, 2020

Source: VA Rocky Mountain Network (received December 7, 2020).

To help assess VISN executive leaders' engagement, the OIG interviewed the Network Director, Deputy Network Director, CMO, QMO, and CNO 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, about VHA data and/or factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. Leaders also had a sound understanding of Community Living Center (CLC) SAIL metrics. In individual interviews, the executive leadership team members were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. Details regarding these actions are below.

The leaders were members of the VISN's Executive Leadership Council, which was responsible for processes that enhance network performance by

- providing organizational values and strategic direction,

- developing policy and making decisions,

- managing compliance and financial performance,

- balancing values for patients and other stakeholders,

- regularly reviewing organizational performance and capabilities,

- identifying priorities for improvement and opportunities for innovation, and

- developing and communicating organizational goals and objectives across the network.

The Network Director served as the chairperson of the Executive Leadership Council, which had oversight of the Healthcare Operations, Healthcare Delivery, QSV, and Organizational Health Committees (see figure 3).

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                    │  Executive Leadership Council    │
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Healthcare Operations Committee	Healthcare Delivery Committee	Quality, Safety & Value Committee	Organizational Health Committee
Business Office	Access	Accreditation/OIG	Compliance
Capital Assets	Controlled Substances Task Force	Diffusion of Excellence	Customer Service/Patient Experience
Compliance and Integrity	Geriatrics and Extended Care	Infection Prevention	Disruptive Behavior
Contracting	Mental Health Services	Oversight	Education
Data Management	Pain	Patient Safety	Employee Engagement & Satisfaction
Emergency Management	Pharmacy and Therapeutics	Performance Measures/Strategic Analytics for Improvement and Learning	High Reliability
Financial Quality Assurance Manager	Primary Care Steering	Risk Management	Human Centered Design/Innovation
Healthcare Technology	Sterile Processing	Utilization Management	Integrated Ethics
Office of Information and Technology	Surgical Operative Care		Just Culture
Prosthetics	Virtual Modalities		Minority Veterans Program
Resources	Women's Health		Public Affairs/Communication
Safety, Environment of Care, and Green Environmental Management Systems			Strategic Analytics for Improvement and Learning Coordinators
Strategic Planning			System Redesign
Supply Chain			Voluntary Services
Veterans Experience			Whole Health
Workforce			

Figure 3. *VISN 19 committee reporting structure.*

Source: VA Rocky Mountain Network (received December 10, 2020).

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[12] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[13] 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 VISN leaders.

To assess employee attitudes toward VISN leaders, the OIG reviewed VHA All Employee Survey satisfaction results from October 1, 2018, through September 30, 2019.[14] Table 2 summarizes those results. The OIG found the VISN office and leaders' average scores for the

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

[13] "AES Survey History."

[14] Ratings are based on responses by employees who report to or are aligned under the Network Director, Deputy Network Director, and CMO. Data were not available for the CNO and QMO.

selected survey leadership questions were generally higher than the VHA averages. However, the Deputy Network Director had opportunities to improve servant leader behaviors and leadership respect scores.[15]

Table 2. Survey Results on Employee Attitudes toward VISN 19 Leadership (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	VISN 19 Office Average	Network Director Average	Deputy Network Director Average	CMO Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	72.6	80.2	85.0	65.7	87.7
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.4	4.0	4.1	4.3	4.1
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	4.1	4.3	3.9	4.3
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	4.0	4.0	3.4	4.2

Source: VA All Employee Survey (accessed November 4, 2020).

**The Servant Leader Index is a summary 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. Except for the Deputy Network Director's scores related to psychological safety, the leaders' averages were generally better than the VHA averages. Overall, VISN leaders appeared to maintain an environment where employees felt safe bringing forth issues and

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[15] 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. The QMO did not have enough direct employee reports to calculate a score, so the QMO staff were rolled into the Director's totals. The CNO had not been on duty long enough to participate in the survey.

concerns. Executive leaders shared survey results with staff and created employee workgroups to identify improvement goals for the coming year.

Table 3. Survey Results on Employee Attitudes toward the VISN 19 Workplace (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	VISN 19 Office Average	Network Director Average	Deputy Network Director Average	CMO 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	4.1	4.0	3.6	4.7
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	4.0	3.9	3.5	4.5
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	1.3	0.9	1.0	0.9

Source: VA All Employee Survey (accessed November 4, 2020).

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[16] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients felt secure and respected.[17]

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[16] "Stand Up to Stop Harassment Now!" Department of Veterans Affairs, accessed December 8, 2020, https://vaww.insider.va.gov/stand-up-to-stop-harassment-now/; Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*, October 23, 2019.

[17] "Stand Up to Stop Harassment Now!"

Table 4 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The scores for the Network Director, Deputy Network Director, and CMO were similar to or higher than the VHA averages. The leaders appeared to promote an environment where discrimination was not tolerated, and staff felt safe bringing up problems and tough issues.

Table 4. Survey Results on Employee Attitudes toward Workgroup Relationships (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	VISN 19 Office Average	Network Director Average	Deputy Network Director Average	CMO Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	4.1	3.9	3.7	4.6
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.0	4.2	4.4	4.0	4.6
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	4.0	3.9	3.7	4.6

Source: VA All Employee Survey (accessed November 4, 2020).

Patient Experience

To assess patient attitudes toward their healthcare experiences, the OIG reviewed patient experience survey results from October 1, 2019, through July 31, 2020. 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 three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 5 provides relevant survey results for VHA and VISN 19.[18] The VISN averages for the

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[18] Ratings are based on responses by patients who received care within the VISN.

selected survey questions were similar to the VHA averages. VISN 19 facility scores for the selected survey questions are in appendix C.

Table 5. Survey Results on Patient Attitudes within VISN 19 (October 1, 2019, through July 31, 2020)

Questions	Scoring	VHA Average	VISN 19 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.	69.6	70.3
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	82.8	80.4
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	84.2

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 5, 2020).

Access to Care

A VA priority is achieving and maintaining an optimal workforce to ensure timely access to the best care and benefits for our nation's veterans. VHA has a goal of providing patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[19] VHA has used various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates.[20] Wait time measures based on "create date" have the advantage of not relying on the accuracy of the "preferred date" entered

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[19] VHA Directive 1230(4), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended June 17, 2021. The "Clinically Indicated Date (CID) is the date an appointment is deemed clinically appropriate by a VA health care provider. The CID is contained in a provider entered Computerized Patient Record System (CPRS) order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request…The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity."

[20] "Completed appointments cube data definitions," VA Business Intelligence Office, accessed March 28, 2019, https://bioffice.pa.cdw.va.gov/. (This is an internal VA website not publicly accessible.)

into the scheduling system and are particularly applicable for new primary care patients where the care is not initiated by referral, or consultation, and includes a "clinically indicated date." The disadvantage to "create date" metrics is that wait times do not account for specific patient requests or availability. Wait time measures based on patient preferred dates consider patient preferences but rely on appointment schedulers accurately recording the patients' wishes into the scheduling software.[21]

When patients could not be offered appointments within 30 days of clinically indicated or preferred dates, patients became eligible to receive non-VA (community) care through the VA Choice program—eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.[22] However, with the passage of the VA MISSION Act of 2018 on June 6, 2018, and subsequent enactment on June 6, 2019, eligibility criteria for obtaining care in the community now include average drive times and appointment wait times:[23]

- Average drive time
  - 30-minute average drive time for primary care, mental health, and noninstitutional extended care services
  - 60-minute average drive time for specialty care
- Appointment wait time
  - 20 days for primary care, mental health care, and noninstitutional extended care services, unless the veteran agrees to a later date in consultation with a VA health care provider
  - 28 days for specialty care from the date of request, unless the veteran agrees to a later date in consultation with a VA health care provider

To examine access to primary and mental health care within VISN 19, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics for the most recently completed quarter. Tables 6 and 7 provide wait time statistics for completed primary care and mental health appointments from July 1 through September 30, 2020.[24]

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[21] Office of Veterans Access to Care, *Specialty Care Roadmap*, November 27, 2017.

[22] VHA Directive 1700, *Veterans Choice Program*, October 25, 2016.

[23] VA MISSION Act of 2018, Pub. L. No. 115-182, Stat. 1393; VA Office of Public Affairs Media Relations, *Fact Sheet: Veteran Community Care – Eligibility, VA MISSION Act of 2018*, April 2019.

[24] Reported primary care wait times are for appointments designated as clinic stop 323, Primary Care Medicine, and records visits for comprehensive primary care services. Reported mental health wait times are for appointments designated as clinic stop 502, Mental Health Clinic Individual, and records visits for the evaluation, consultation, and/or treatment by staff trained in mental diseases and disorders.

**Table 6. Primary Care Appointment Wait Times
(July 1 through September 30, 2020)**

Facility	New Patient Appointments	Average New Patient Wait from Create Date
VISN 19	3,182	18.5
Cheyenne VAMC (WY)	215	12.0
Eastern Oklahoma VA HCS (Muskogee)	553	14.4
Montana VA HCS (Fort Harrison)	602	24.4
Oklahoma City VA HCS (OK)	628	24.3
Sheridan VAMC (WY)	128	20.4
VA Eastern Colorado HCS (Aurora)	456	16.5
VA Salt Lake City HCS (UT)	471	9.8
VA Western Colorado HCS (Grand Junction)	129	14.0

Source: VHA Support Service Center (accessed November 5, 2020).

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

**Table 7. Mental Health Appointment Wait Times
(July 1 through September 30, 2020)**

Facility	New Patient Appointments	Average New Patient Wait from Create Date
VISN 19	1,161	10.9
Cheyenne VAMC (WY)	80	6.5
Eastern Oklahoma VA HCS (Muskogee)	204	14.2
Montana VA HCS (Fort Harrison)	91	12.0
Oklahoma City VA HCS (OK)	222	12.2
Sheridan VAMC (WY)	20	3.8
VA Eastern Colorado HCS (Aurora)	208	9.9
VA Salt Lake City HCS (UT)	295	11.4
VA Western Colorado HCS (Grand Junction)	41	7.6

Source: VHA Support Service Center (accessed November 5, 2020).

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

Based on wait times alone, the MISSION Act may improve access to primary care for patients in the Montana and Oklahoma City VA HCSs and Sheridan VAMC, where the average wait time

for new primary care appointments was 24.4, 24.3, and 20.4 days, respectively. The wait times also highlight opportunities for the facilities to improve the timeliness of primary care provided "in house" and decrease the potential for fragmented care among patients referred to community providers.

Wait times for new mental health patients in the VISN was at 10.9 days, and the longest wait time was 14.2 days (Eastern Oklahoma VA HCS). According to VISN leaders, the implementation of the MISSION Act has had a greater effect on wait times in rural areas. However, wait times have also been affected by the COVID-19 pandemic. The OIG recognizes that the COVID-19 pandemic has caused significant and widespread changes in the delivery of healthcare services. As a result, productivity data and supporting reports may be skewed and require further analysis by the VISN.[25]

The VISN leaders reported that almost 70 percent of the over 115,000 veterans in Eastern Oklahoma live closer to Tulsa than to the Eastern Oklahoma VA HCS in Muskogee, which is approximately 60 miles from Tulsa and beyond the 30-minute drive time outlined in the MISSION Act. The VISN supported the Oklahoma Congressional delegation's efforts to obtain funding under the Communities Helping Invest through Property and Improvements Needed for Veterans Act of 2016 (CHIP-IN Act) to build a VHA hospital in Tulsa with the donation of existing buildings on the Oklahoma State University Medical Center Campus and with other philanthropic support.[26]

Clinical Vacancies

Within the healthcare field, there is general acceptance that staff turnover—or instability—and high clinical vacancy rates negatively affect access to care, quality, patient safety, and patient and staff satisfaction. Turnover can directly affect staffing levels and further reduce employee and organizational performance through the loss of experienced staff.[27]

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[25] "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)." "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, accessed December 8, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

[26] Communities Helping Invest Through Property and Improvements Needed for Veterans Act of 2016, Pub. L. No. 114-294. The law authorizes the VA to carry out a program under which it may accept donations by non-federal entities of real property "that includes a constructed facility; or is to be used as the site of a facility constructed by the entity…[and] a facility to be constructed by the entity on real property of the Department of Veterans Affairs." The appropriation was signed into law by the president on December 27, 2020.

[27] J. Buchanan, "Reviewing the Benefits of Health Workforce Stability," *Human Resources for Health* 8, no. 29 (December 2010).

To assess the extent of clinical vacancies across VISN 19 facilities, the OIG held discussions with the Chief of Human Resources and reviewed the total number of vacancies by facility, position, service or section, and full-time equivalent (FTE) employees. Table 8 provides the vacancy rates across the VISN as of December 7, 2020.

**Table 8. Reported Vacancy Rates for VISN 19 Facilities
(as of December 7, 2020)**

Facility	Clinical Vacancies	Clinical Vacancy Rate (%)	Total Vacancy Rate (%)
VISN 19	2,214.7	16.2	18.4
Cheyenne VAMC (WY)	100.1	12.2	13.2
Eastern Oklahoma VA HCS (Muskogee)	298.4	19.3	20.9
Montana VA HCS (Fort Harrison)	149.8	12.4	15.3
Oklahoma City VA HCS (OK)	492.6	19.9	22.0
Sheridan VAMC (WY)	73.2	14.1	15.4
VA Eastern Colorado HCS (Aurora)	460.5	14.7	17.6
VA Salt Lake City HCS (UT)	538.7	21.4	23.4
VA Western Colorado HCS (Grand Junction)	101.4	15.4	19.1

Source: VISN 19 Chief of Human Resources (received December 7, 2020).

The OIG found the following primary care clinical vacancies across VISN 19:

- Physicians: ~37 FTE

- Physician assistants: ~7 FTE

- Nurse practitioners: ~25 FTE

- Nurses: ~21 FTE

Clinical staffing may be a contributing factor in primary care wait time challenges at the Montana and Oklahoma City VA HCSs. The Montana VA HCS had almost 3 physician and 4 nurse practitioner FTE vacancies. The Oklahoma City HCS had approximately 10 physician, 1 physician assistant, and 5 nurse practitioner FTE vacancies.

For mental health, the OIG found the following clinical vacancies across VISN 19:

- Psychiatrists: ~21 FTE

- Psychologists: ~61 FTE

- Nurses: ~46 FTE

- Social workers: ~92 FTE

Although various mental health positions were vacant at the time of the OIG's review, the VISN's average wait time for new mental health patients was 10.9 days, and the longest wait times were at the Eastern Oklahoma VA HCS (14.2 days).

The Chief of Human Resources reported holding regular meetings with the executive leadership team to review progress on hiring new staff for existing vacancies, discuss the "time to hire" report, and track timeliness of human resource actions. The Chief of Human Resources also reported recruiting challenges, including rurality and salary competition with private sector and university affiliates in metropolitan areas. The VISN provided incentives like the VA's Education Debt Reduction Program and recruitment and relocation bonuses.[28] In FY 2020, the VISN spent over $467,498 on recruitment bonuses, $175,642 on relocation bonuses, and $1,726,043 on retention allowances. Also, the VISN employed VA's rapid hiring processes to increase facility staffing levels. The VISN onboarded 577 staff between March 1, 2020, and the time of this OIG virtual review.

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders respond to identified problems. VISN and facility leaders closed all but six recommendations for improvement listed in appendix D.[29]

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."[30] 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.[31]

Figure 4 illustrates the VISN's quality of care and efficiency metric rankings and performance as of June 30, 2020. The figure uses blue and green data points to indicate high performance (for example, in the areas of emergency department (ED) throughput, hospital wide readmissions (RSRR-HWR), and adjusted length of stay (LOS)). Metrics that need improvement are in orange

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[28] "Hiring Programs and Initiatives," Department of Veterans Affairs, accessed September 6, 2020, https://www.vacareers.va.gov/Benefits/HiringProgramsInitiatives/. Education Debt Reduction Program (EDRP) "authorizes VA to provide student loan reduction payments to employees with qualifying loans who are in positions providing direct patient care and that are considered hard to recruit or retain."

[29] A "closed" status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations.

[30] "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.)

[31] "Strategic Analytics for Improvement and Learning (SAIL) Value Model."

and red (for example, stress discussed, mental health (MH) population coverage, and specialty care (SC) care coordination).[32]

Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.
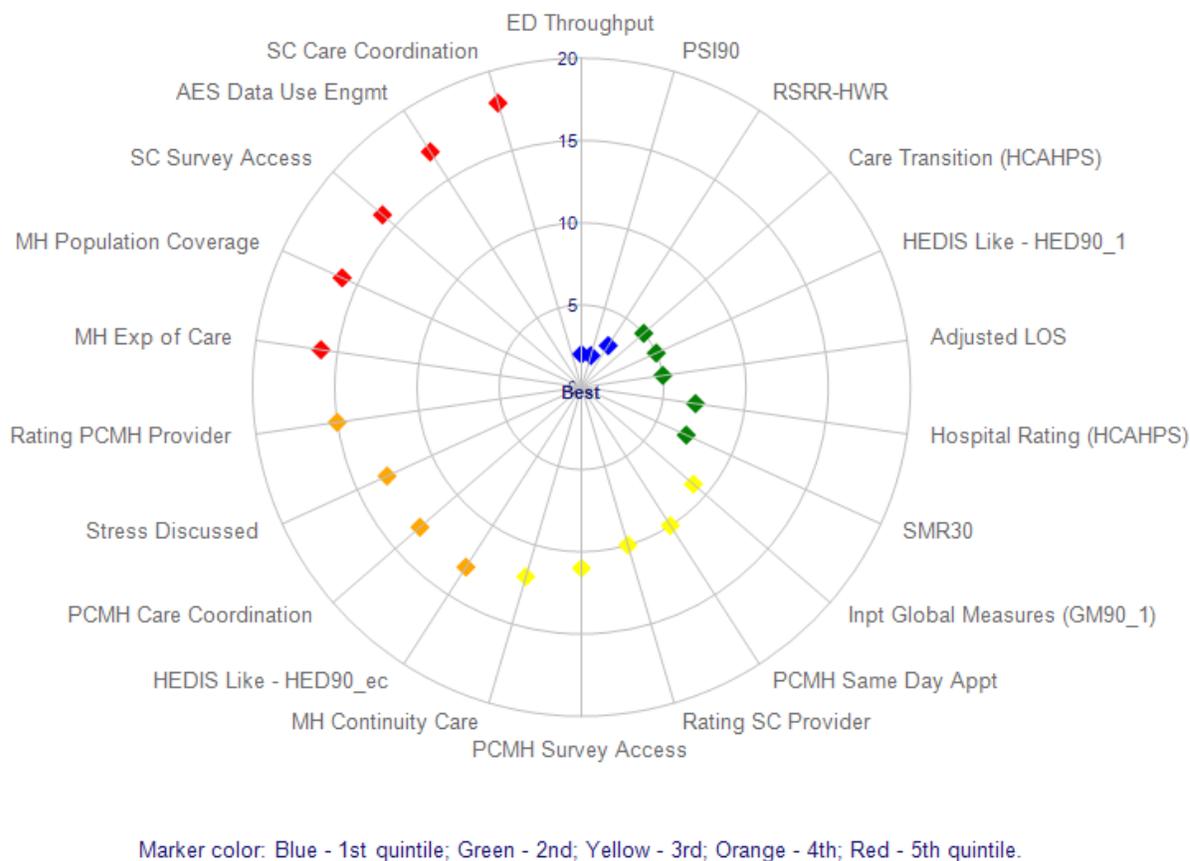
Figure 4. *VISN 19 quality of care and efficiency metric rankings for FY 2020 quarter 3 (as of June 30, 2020).*

Source: VHA Support Service Center.

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

VISN leaders were aware of fifth quintile measures. They reported reorganizing VISN structure to integrate clinical communities and holding monthly SAIL improvement meetings to address issues and develop action plans with facilities.

The CMO reported that specialty care coordination and specialty care access performance measures presented challenges during the COVID-19 pandemic and that geography had also contributed to the lower performing metrics. The CMO explained that, in Montana, accessing specialty care with a pulmonologist is difficult due to the limited number of pulmonologists practicing in the state. To help facilitate veteran specialty care coordination and access, the

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

Network Director reported that the VISN completed a public-private partnership with a hospital in Billings, Montana, which embedded VA staff at the hospital and improved veteran care coordination.

The SAIL Value Model also includes SAIL CLC, which is a tool to "summarize and compare performance of CLCs in the VA."[33] The SAIL model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' *Nursing Home Compare*. The SAIL CLC provides a single resource "to review quality measures and health inspection results." [34]

SAIL CLC includes a radar diagram showing CLC performance relative to other CLCs for all 16 quality measures. Figure 5 illustrates the VISN's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. The figure uses blue and green data points to indicate high performance (for example, in the areas of catheter in bladder–long-stay (LS), outpatient emergency department (ED) visit–short-stay (SS), and high risk pressure ulcer (PU) (LS)). Measures that need improvement are in orange and red (for example, help with activities of daily living (ADL) (LS), urinary tract infections (UTI) (LS), and falls with major injury (LS)).[35]

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[33] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC): A tool to examine Quality Using Internal VA Benchmarks,* July 16, 2021. "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality, making meaningful distinctions between high and low performing nursing homes."

[34] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC): A tool to examine Quality Using Internal VA Benchmarks.*

[35] For data definitions of acronyms in the SAIL CLC measures, please see appendix F.
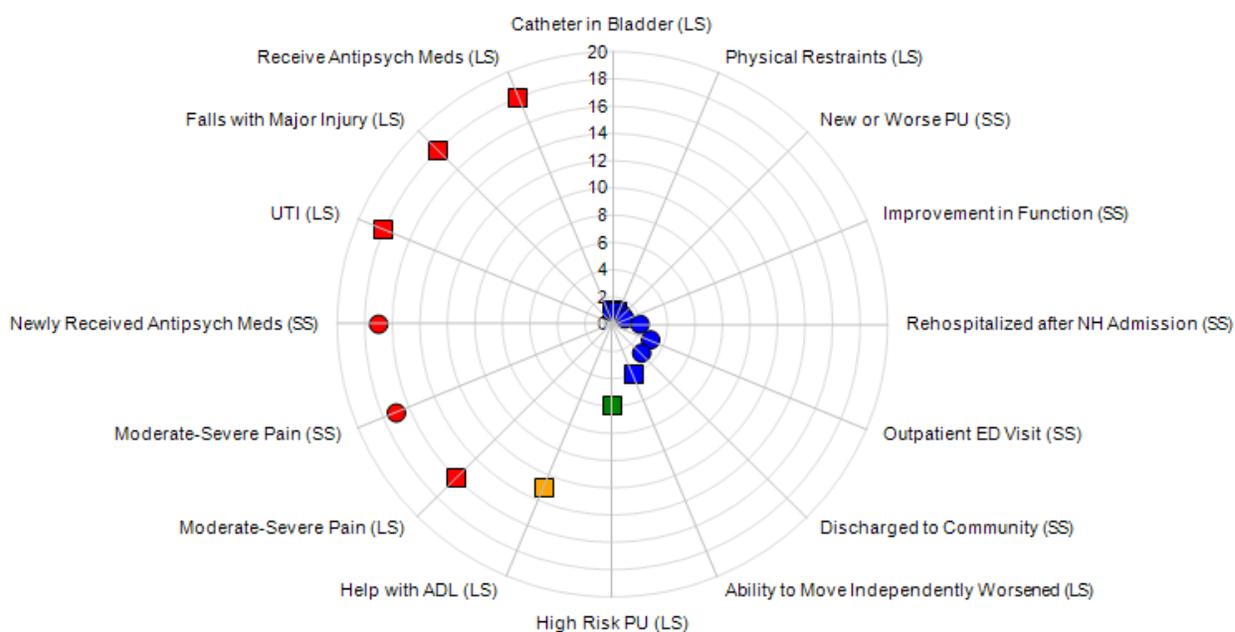
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Figure 5. *CLC quality measure rankings for FY 2020 quarter 3 (as of June 30, 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.

The VISN leaders were aware of the fourth and fifth quintile quality measures and deficiencies in the Long Term Care Institute's unannounced survey scores.[36] The leaders reported assisting facilities in developing action plans and monitoring improvement.

The VISN Geriatric and Extended Care Lead reported that smaller CLCs with lower patient census had one patient with a fall and one patient with the need for administration of an antipsychotic medication, which kept a performance measure in the fifth quintile until the end of a reporting cycle. In monitoring and reviewing the scores, the Geriatric and Extended Care Lead reported finding that use of an antipsychotic medication for nausea (a permitted off-label use) was counted against the medication score and as a result, staff were working to better define the coding for treating nausea. The Geriatric and Extended Care Lead also explained that improper data input contributed to the urinary tract infection score and that an additional level of review was in place to ensure reliability of data.

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[36] "About Us," Long Term Care Institute, accessed December 8, 2020, http://www.ltciorg.org/about-us/. 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."

Observed Trends in Noncompliance

The OIG identified that the Network Director, CMO, and QMO had opportunities to improve their oversight of facility-level QSV, registered nurse credentialing, care coordination, mental health, and high-risk process functions.

During virtual CHIP visits of the VISN 19 facilities performed during the weeks of November 30 and December 7, 2020, the OIG noted trends in noncompliance for the following areas:

- QSV
  - Surgical work group
- Registered nurse credentialing
  - Primary source verification
- Care Coordination (inter-facility transfers)
  - Transfer notes
  - Active medication lists sent to receiving facilities
  - Inter-facility transfer monitoring and evaluation
- Mental Health
  - Suicide safety plan training
- High-risk processes (management of disruptive and violent behavior)
  - Committee meeting attendance
  - Training

In response to these trends, the Network Director stated that VISN staff would follow up with responsible facility directors, chiefs of staff, associate directors for patient care services, and associate directors.

Leadership and Organizational Risks Conclusion

The VISN's executive leadership team was stable at the time of the OIG visit, with all members permanently assigned and having worked together for nearly six months since the addition of the QMO. The leaders were members of the VISN's Executive Leadership Council, which had oversight of the Healthcare Operations, Healthcare Delivery, QSV, and Organizational Health Committees.

Selected survey scores related to employees' satisfaction with the VISN executive team leaders were generally higher than VHA averages. However, the Deputy Network Director had

opportunities to improve employee perceptions of leaders. The OIG noted that aggregate VISN patient experience survey scores were similar to VHA averages.

The executive team leaders seemed to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as coordinating with congressional staff to obtain funding to build a VHA hospital in Tulsa).

The OIG's review of access metrics and clinical vacancies did not identify any substantial organizational risk factors. Leaders were knowledgeable within their scopes of responsibility about selected SAIL and CLC metrics and should continue to take actions to sustain and improve performance. Further, the OIG identified that VISN leaders had opportunities to improve their oversight of facility-level QSV, registered nurse credentialing, care coordination, mental health, and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

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.[37] 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.[38]

During this time, VA continued providing care to veterans 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."[39] "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."[40]

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 VISN 19 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 reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 19 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[41]

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[37] "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.

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

[39] 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."

[40] 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.

[41] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19*, Report No. 21-01699-175, July 7, 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.[42] 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.[43] Designated leaders are directly accountable for program integration and communication within their level of responsibility. 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."[44]

To determine whether the VISN implemented and incorporated OIG-identified key processes for quality and safety, the inspection team interviewed VISN managers and reviewed meeting minutes and other relevant documents. Specifically, OIG inspectors examined the following requirements:

- Designation of a systems redesign and improvement program manager[45]

- Establishment of a systems redesign and improvement advisory group that has representation from each VISN medical center[46]

- Assignment of a chief surgical consultant who also serves as chairperson of the VISN surgical work group[47]

- Designation of a VISN lead surgical nurse who participates in the VISN surgical work group[48]

  o Chairperson of conference calls with VA facility surgical quality nurses

- Collection, analysis, and action, as appropriate, in response to VISN peer review data[49]

  o Monitoring of facility outlier data and communication of follow-up actions to VISN and facility directors

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

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

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

[45] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

[46] VHA Directive 1026.01

[47] VHA Directive 1102.01(1), *National Surgery Office*, April 24, 2019.

[48] VHA Directive 1102.01(1).

[49] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018.

        ○   Submission of quarterly VISN peer review data analysis reports to Quality, Safety, and Value

- Quarterly reporting of institutional disclosures to the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value[50]

Quality, Safety, and Value Findings and Recommendations

The OIG observed compliance with requirements related to systems redesign and improvement and institutional disclosure reporting. However, the OIG identified a deficiency with peer review summary data analyses.

VHA requires that "VISN peer review summary data is collected, analyzed, and acted upon, as appropriate."[51] The OIG reviewed QSV committee minutes from FY 2019 quarter 4 and FY 2020 quarters 2 and 4 and did not find evidence that peer review summary data were collected and analyzed. Failure to analyze summary data could result in missed opportunities to identify clinical practice trends and determine the need for improvement actions. The QMO reported that peer review summary data were discussed informally with the Risk Manager and facility peer review coordinators but not formally with the QSV committee. However, the QMO indicated that peer review summary data were submitted quarterly to the VHA Central Office. The QMO also stated that several transitions over the last year with the QMO and peer review/risk manager roles may have contributed to the noncompliance.

Recommendation 1

1. The Network Director evaluates and determines any additional reasons for noncompliance and makes certain that Veterans Integrated Service Network peer review summary data are collected, analyzed, and acted on, as appropriate.[52]

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[50] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[51] VHA Directive 1190.

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

VISN concurred.

Target date for completion: Completed

VISN response: The VISN 19 Risk Manager will collect and perform analysis of the peer review program data. The analysis and applicable associated action plans will be reported to the VISN 19 Quality, Safety, and Value Committee (QSVC) which is chaired by the VISN 19 Quality Management Officer (QMO).

The VISN Risk Manager will report the data at a minimum of twice annually to the QSVC as indicated in the QSVC reporting schedule. Peer Review data was reported to the QSVC on April 21, 2021 (was deferred from the scheduled January 2021 report), and July 21, 2021. Based on the evidence provided, we request closure of recommendation.

Medical Staff Credentialing

VHA has defined procedures for the credentialing of medical staff—"the systematic process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training and experience, and current competence and health status."[53] When certain actions are taken against a provider's licenses, the Chief of Human Resources Management Service, or Regional Counsel, must determine whether the provider meets licensure requirements for VA employment.[54] Further, physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued, and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review" by Regional Counsel and concurrence and approval of the appointment by the VISN CMO. The Deputy Under Secretary for Health for Operations and Management is responsible for "ensuring that VISN Directors maintain an appropriate credentialing and privileging process consistent with VHA policy," which includes VISN CMO oversight of facilities' processes.[55]

The OIG inspection team reviewed VISN facility physicians hired after January 1, 2018.[56] When reports from the National Practitioner Data Bank or Federation of State Medical Boards appear to confirm that a physician has a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined whether there was evidence of the

- Chief of Human Resources Management Service, or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements,

- Regional Counsel or designee's documented review to determine if the physician meets appointment requirements, and

- VISN CMO concurrence and approval of the Regional Counsel or designee's review.

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

[54] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012.

[55] VHA Handbook 1100.19.

[56] GAO, *Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*, GAO-19-6, February 2019. VHA Central Office directed VHA-wide licensure reviews that were "started and completed in January 2018, focused on the approximately 39,000 physicians across VHA and used licensure-action information from the Federation of State Medical Boards." The OIG reviewed VISN facility physicians hired after January 1, 2018, to continue efforts to identify staff not meeting VHA employment requirements since "VHA officials told us [GAO] these types of reviews are not routinely conducted…[and] that the initial review was labor intensive."

Medical Staff Credentialing Finding and Recommendation

The OIG identified weaknesses in the review and approval of four physicians who had potentially disqualifying licensure actions prior to VA appointment.

VHA policy states that physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review."[57] The physician's "credentials file must be reviewed with Regional Counsel, or designee, [and]…the review and the rationale for the conclusions must be forwarded to the VISN CMO for concurrence and approval of the appointment."[58]

The OIG reviewed profile information for 513 physicians using publicly available data and VetPro.[59] The OIG found that four physicians had a potentially disqualifying licensure action that required further review. In all of the following cases, the OIG found that VetPro lacked evidence of the required documented review for concurrence and approval of the physicians' appointments, which could have resulted in inappropriate hiring decisions that jeopardized the quality of patient care.

The first physician was hired in 2020 and had a medical license placed on probation in 2019. The CMO reported being unaware of the case, acknowledged that it should have been reviewed at the VISN level, and stated that facility staff likely misinterpreted the requirements and unintentionally did not report the information to the VISN. The CMO also reported that plans were in place to revamp provider licensure processes prior to hiring.

Another physician was hired in 2019 and had a medical license placed on probation in 1999. Initially, the CMO reported believing that the nature of the report indicated that it was a restriction and not a probation. However, during subsequent communication, the CMO reported that a review was completed in January 2021, and that facility committee minutes reflected discussion and approval of this case, along with the Regional Counsel review.

The third physician was hired in 2019 and had a medical license placed on probation in 2006. Initially, the CMO stated that it did not warrant a review because it was a restriction and not a licensure issue. However, during subsequent review and correspondence, the CMO reported that Regional Counsel and CMO reviews for this physician were recently completed.

The last physician was hired in 2020 and had a medical license suspended in 2006. Initially, the CMO reported being unsure the case warranted review because of the nature of the action.

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

[58] VHA Handbook 1100.19.

[59] VHA Handbook 1100.19. "VetPro is an Internet enabled data bank for the credentialing of VHA health care practitioners that facilitates completion of a uniform, accurate, and complete credentials file."

However, during subsequent communication, the CMO reported that the case was in the process of being reviewed.

Recommendation 2

2. The Chief Medical Officer determines the reason for noncompliance and makes certain to review the credentials file and approve the VA appointment for physicians who had a potentially disqualifying licensure action.[60]

VISN concurred.

Target date for completion: Completed

VISN response: The Chief Medical Officer (CMO) completed the four (4) warranted licensure action reviews. Upon review, it was determined that all providers in fact met the hiring standards. To ensure all future licensing actions are reviewed upon initial credentialing, VACO [VA Central Office] and the VISN 19 CMO's Office has provided education to all credentialing staff at the facility level. An educational reminder has also been sent out via e-mail from the Director, Medical Staff Affairs in which she outlined the requirements when licensure issues are identified during the initial credentialing process. Additionally, SOP-40 "Conducting and Documenting a Chief Medical Officer Credentials Review" has been created and shared with all facilities C&P [Credentialing and Privileging] Staff. As the VISN 19 sites reopen, we will be ensuring that all files that meet the CMO review are being completed. Lastly, the position of a VISN 19 Credentialing and Privileging Officer has been created and filled. This position will allow the VISN to ensure that all required reviews are being completed. Based on the evidence provided, we request closure of recommendation.

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[60] The OIG reviewed evidence sufficient to demonstrate that VISN staff had completed improvement actions, and therefore, closed the recommendation before publication of the report.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires that healthcare facilities provide a safe, clean, and functional environment of care for veterans, their families, visitors, and employees in accordance with applicable Joint Commission Environment of Care standards, federal regulatory requirements, and applicable VA and VHA requirements.[61] The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.[62] VHA provides policy, mandatory procedures, and operational requirements for implementing an effective supply chain management program at VA healthcare facilities which includes responsibility for VISN-level oversight.[63]

The OIG inspection team reviewed relevant documents and interviewed VISN managers. Specifically, inspectors examined the following requirements:

- Establishment of a policy that maintains a comprehensive environment of care program at the VISN level

- Establishment of a VISN Emergency Management Committee[64]

    o Met at least quarterly

    o Documented an annual review within the previous 12 months of the VISN's

        - Emergency Operations Plan

        - Continuity of Operations Plan

        - Hazards Vulnerability Analysis

    o Conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leaders for review and approval

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[61] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016; VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[62] VHA Directive 1608.

[63] VHA Directive 1761(2), *Supply Chain Inventory Management*, October 24, 2016, amended October 26, 2018. (The directive was rescinded and replaced by VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.)

[64] VHA Directive 0320.01.

- Assessment of inventory management programs through an annual quality control review[65]

Environment of Care Findings and Recommendations

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

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[65] VHA Directive 1761(2).

Mental Health: Suicide Prevention

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.[66] 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.[67] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[68]

VHA requires VISN leaders to appoint mental health staff to serve as a member of its primary governing body, participate on each state's suicide prevention council or workgroup, and coordinate activities with state and local mental health systems and community providers.[69]

The OIG reviewed relevant documents and interviewed managers to determine whether VISN staff complied with various suicide prevention requirements:

- Designation of a mental health professional to serve on the VISN's primary governing body and each state's suicide prevention council or workgroup

- Designation of a mental health liaison to coordinate activities with state, county, and local mental health systems and community providers

Mental Health Findings and Recommendations

Generally, the VISN achieved the requirements listed above. The OIG made no recommendations.

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

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

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

[69] Principal Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, *Patients at High-Risk for Suicide*, April 24, 2008; VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring patients when their needs can be better managed at another facility.[70]

When VA or non-VA staff transfer a patient "to a VA facility in a manner that violates [VA] policy," the VISN CMO is responsible for contacting the transferring facility and conducting a fact-finding review to determine if the transfer was appropriate.[71] Examples of patient transfers that do not comply with VA policy include

- patients who were not appropriately screened and/or did not consent prior to transfer,

- patients who were not transferred with qualified personnel or equipment,

- transfers that were not approved by a VA physician, or

- pertinent medical records that were not sent with patients at the time of transfer.[72]

The OIG reviewed relevant documents and interviewed key managers to determine whether the VISN CMO contacted the transferring facility and conducted a fact-finding review for reported cases of possible inappropriate transfers to a VA facility in calendar year 2020.

Care Coordination Findings and Recommendations

The Clinical Services Coordinator stated that no incidents of inappropriate inter-facility transfers were reported to the CMO's office during calendar year 2020. The OIG made no recommendations.

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[70] VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

[71] VHA Directive 1094.

[72] VHA Directive 1094.

Women's Health: Comprehensive Care

Women were estimated to represent approximately 10 percent of the veteran population as of September 30, 2019.[73] 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 is anticipated to increase.[74] To help the VA better understand the needs of the growing women veterans population, VHA has made efforts to examine "health care use, preferences, and the barriers Women Veterans face in access to VA care."[75]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive health care services in all VA medical facilities.[76] VHA also requires that VISNs appoint a lead women veterans program manager (WVPM) to serve as the VISN representative on women veterans' issues and identify gaps through "VISN-wide needs assessments, site visits, surveys, and/or other means, including conducting yearly site visits at each facility within the VISN."[77]

To determine whether the VISN complied with OIG-selected VHA requirements, the inspection team reviewed relevant documents and interviewed selected managers on the following VISN-level requirements:

- Appointment of a lead WVPM

- Establishment of a multidisciplinary team that executes strategic planning activities for comprehensive women's health care

- Provision of quarterly program updates to executive leaders

- Monthly calls held with facility WVPMs and women's health medical directors

- Completion of annual site visits at each VISN facility

  o Needs assessment conducted

  o Progress towards implementation of recommended interventions tracked

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[73] "Veteran Population," Table 1L: VetPop2018 Living Veterans by Age Group, Gender, 2018-2048, National Center for Veterans Analysis and Statistics, accessed November 30, 2020, https://www.va.gov/vetdata/Veteran_Population.asp.

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

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

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

[77] VHA Directive 1330.02, *Women Veterans Program Manager*, August 10, 2018.

- Assessments to identify staff education gaps

  o Development of educational program and/or resources when needs identified

- Availability of VISN-level support staff for implementing performance improvement projects

- Analysis of women veterans access and satisfaction data

  o Implementation of improvement actions when recommended

Women's Health Findings and Recommendations

The VISN complied with many of the requirements listed above. However, the OIG identified weaknesses with the provision of quarterly program updates to VISN leaders and assessments of staff education gaps.

VHA requires that the lead WVPM provide quarterly program updates to the Network Director or the CMO.[78] The OIG did not find evidence of the required quarterly program updates. Failure to provide routine updates could prevent VISN leaders from properly allocating resources to support comprehensive healthcare for women veterans. The lead WVPM stated that the information is reported to the Healthcare Delivery Committee and believed this met the intent of the requirement. However, the OIG reviewed the Healthcare Delivery Committee meeting minutes from all quarters of FY 2020 and FY 2021 quarter 1 but only found evidence of a women's health program update in the November 2019 minutes.

Recommendation 3

3. The Network Director evaluates and determines any additional reasons for noncompliance and makes certain that the lead Women Veterans Program Manager provides quarterly program updates to Veterans Integrated Service Network leaders.[79]

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[78] VHA Directive 1330.01(3).

[79] The OIG reviewed evidence sufficient to demonstrate that VISN staff had completed improvement actions, and therefore, closed the recommendation before publication of the report.

VISN concurred.

Target date for completion: Completed

VISN response: The Women Veterans Program Manager will provide quarterly program updates to executive leadership through the Healthcare Delivery Committee (HDC). The HDC is chaired by the Chief Medical Officer (CMO). The CMO reports to Executive Leadership, which is chaired by the Network Director.

VISN Women Veterans Program Lead reported three times in FY21 to the Healthcare Delivery Committee; March 19th, May 21st, and August 20th. Women Veterans Program is a quarterly standing agenda item on the Healthcare Delivery Committee. Based on the evidence provided, we request closure of recommendation.

VHA also requires that the lead WVPM conducts "assessments to identify VA staff education gaps related to women's health" and develops "educational programs, materials, and resources where gaps are identified."[80] The OIG did not find evidence of educational gap assessments. Failure to address education gaps could limit staff's ability to provide key women veterans services. The lead WVPM acknowledged not conducting a needs assessment, but reported looking at the women's health dashboard annually and reviewing Women's Assessment Tool for Comprehensive Health surveys to identify the facilities' needs.[81] Additionally, the lead WVPM reported providing support, such as identifying candidates to attend mini-residencies, to facilities with self-identified education needs. The lead WVPM also reported believing that making sure there was an appropriately trained women's health provider at every site met the intent for a gap analysis.

Recommendation 4

4. The Network Director evaluates and determines any additional reasons for noncompliance and ensures that the lead Women Veterans Program Manager completes staff education gap assessments related to women's health and develops educational programs and resources where gaps are identified.

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[80] VHA Directive 1330.02.

[81] The Women's Assessment Tool for Comprehensive Health (WATCH) is an online survey completed by the facilities and reviewed by facility and VISN leaders.

VISN concurred.

Target date for completion: September 30, 2021

VISN response: A Women's Health (WH) Needs Assessment was developed and sent to VISN facilities on April 2, 2021. An analysis was completed, and an action plan developed with individual sites during their virtual site visits. Facility action plans submissions are being tracked and the action plans are monitored monthly for updates. The VISN Women Veteran program lead will follow to the end of FY21 to ensure completion of facility action plans.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care within this VISN, the OIG conducted a detailed review of key clinical and administrative processes associated with promoting quality care and provided four recommendations on issues that may adversely affect patients. While the OIG's recommendations are not a comprehensive assessment of the caliber of services delivered within this VISN, they illuminate areas of concern and guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines four OIG recommendations that are attributable to the Network Director and Chief Medical Officer. The intent is for VISN leaders to use these recommendations to guide improvements in operations and clinical care. The recommendations address findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Access to care • Clinical vacancies • Oversight inspections • VHA performance data • Observed trends in noncompliance	Four OIG recommendations that can lead to patient and staff safety issues or adverse events are attributable to the Network Director and Chief Medical Officer. See details below.
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations	The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 19 jurisdiction 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	• Systems Redesign and Improvement Program staff and requirements • VISN Surgical Work Group • Collection, analysis, and action in response to VISN peer review data • Quarterly reporting of institutional disclosures for each facility	• VISN peer review summary data are collected, analyzed, and acted on, as appropriate.	• None
Medical Staff Credentialing	• Chief of Human Resources Management Service or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements • Regional Counsel or designee's documented review to determine the if the physician meets appointment requirements and subsequent concurrence/approval by VISN CMO	• Physicians with potentially disqualifying licensure actions receive a thorough documented review and approval of the VA appointment.	• None
Environment of Care	• Establishment of a policy that maintains a comprehensive environment of care program at the VISN level • Establishment of a VISN Emergency Management Committee • Assessment of inventory management programs through an annual quality control review	• None	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Mental Health: Suicide Prevention	• Designation of a mental health professional to serve on the VISN's primary governing body and each state's suicide prevention council or workgroup • Designation of a mental health liaison to coordinate activities with state, county, and local mental health systems and community providers	• None	• None
Care Coordination	• CMO contact and fact-finding review for reported cases of possible inappropriate inter-facility patient transfers	• None	• None
Women's Health: Comprehensive Care	• Lead women veterans program manager appointed • Multidisciplinary team that executes strategic planning activities established • Quarterly program updates provided to executive leaders • Monthly calls held with facility women veterans program managers and women's health medical directors • Annual site visits completed at each VISN facility • Staff education gap assessments conducted • Support staff available • Women veterans access and satisfaction data analyzed	• None	• The lead Women Veterans Program Manager provides quarterly program updates to VISN leaders. • The lead Women Veterans Program Manager completes staff education gap assessments related to women's health and develops educational programs and resources where gaps are identified.

Appendix B: VISN 19 Profile

The table below provides general background information for VISN 19.

Table B. Profile for VISN 19
(October 1, 2017, through September 30, 2020)

Profile Element	VISN Data FY 2018*	VISN Data FY 2019	VISN Data FY 2020‡
Total medical care budget	$3,052,135,240	$3,297,666,467	$4,122,423,032
Number of:			
• Unique patients	322,886	329,551	332,915
• Outpatient visits	3,905,522	4,043,017	3,734,780
• Unique employees§	11,566	12,174	12,610
Type and number of operating beds:			
• Community living center	214	196	209
• Domiciliary	209	223	201
• Hospital	564	513	523
• Residential rehabilitation	16	16	16
Average daily census:			
• Community living center	176	168	147
• Domiciliary	160	158	108
• Hospital	358	363	336
• Residential rehabilitation	15	15	14

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

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

*October 1, 2017, through September 30, 2018.
 October 1, 2018, through September 30, 2019.
‡October 1, 2019, through September 30, 2020.
§Unique employees involved in direct medical care (cost center 8200).

Appendix C: Survey Results

**Table C. Survey Results on Patient Attitudes within VISN 19
(October 1, 2019, through July 31, 2020)**

Questions	Scoring	Facility	Average Score
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.	VHA	69.6
		VISN 19	70.3
		Cheyenne, WY	65.9
		Aurora, CO	74.2
		Fort Harrison, MT	73.9
		Grand Junction, CO	78.1
		Muskogee, OK	72.3
		Oklahoma City, OK	62.4
		Salt Lake City, UT	74.0
		Sheridan, WY	78.4
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	82.8
		VISN 19	80.4
		Cheyenne, WY	82.6
		Aurora, CO	76.3
		Fort Harrison, MT	79.8
		Grand Junction, CO	85.4
		Muskogee, OK	82.0
		Oklahoma City, OK	80.9
		Salt Lake City, UT	85.7
		Sheridan, WY	79.6
		Fort Harrison, MT	85.4
		Grand Junction, CO	91.6
		Muskogee, OK	84.3
		Oklahoma City, OK	81.7
		Salt Lake City, UT	86.2
		Sheridan, WY	84.9

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (outpatient specialty care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	84.9
		VISN 19	84.2
		Cheyenne, WY	88.8
		Aurora, CO	81.9
		Fort Harrison, MT	85.4
		Grand Junction, CO	91.6
		Muskogee, OK	84.3
		Oklahoma City, OK	81.7
		Salt Lake City, UT	86.2
		Sheridan, WY	84.9

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 5, 2020).

Appendix D: Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Healthcare Inspection – Review of Montana Board of Psychologists Complaint and Assessment of VA Protocols for Traumatic Brain Injury Compensation and Pension Examinations, Report No. 15-01580-108, February 27, 2018	July 2015	0	0	–	–
Clinical Assessment Program Review of the VA Salt Lake City Health Care System, Salt Lake City, Utah, Report No. 16-00572-179, March 31, 2017	December 2016	0	20	–	0
Clinical Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado, Report No. 16-00546-388, September 29, 2017	February 2017	0	27	–	0
Clinical Assessment Program Review of the Montana VA Health Care System, Fort Harrison, Montana, Report No. 16-00573-309, July 26, 2017	March 2017	0	19	–	0
Comprehensive Healthcare Inspection Program Review of the Grand Junction Veterans Health Care System, Grand Junction, Colorado, Report No. 17-01744-69, January 18, 2018	July 2017	0	9	–	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Quality and Coordination of a Patient's Care at the VA Eastern Colorado Health Care System, Denver, Colorado, Report No. 18-01455-108, April 11, 2019	March 2018	0	8	–	0
Comprehensive Healthcare Inspection Program Review of the Oklahoma City VA Health Care System, Oklahoma, Report No. 18-01141-309, September 27, 2018	June 2018	0	2	–	0
Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center, Wyoming, Report No.18-04680-162, July 24, 2019	December 2018	0	17	–	1*
Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma, Report No. 18-06510-222, September 24, 2019	December 2018	0	11	–	2
Comprehensive Healthcare Inspection of the Sheridan VA Medical Center, Wyoming, Report No. 18-04681-228, September 26, 2019	December 2018	0	22	–	1‡
Concern Regarding a Patient Death and Alleged Conflicts of Interest at the VA Western Colorado Health Care System, Grand Junction, Report No. 19-06435-84, February 4, 2020	March 2019	0	2	–	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Inadequate Resident Supervision and Documentation of an Ophthalmology Procedure at the Oklahoma City VA Health Care System in Oklahoma, Report No. 20-03886-141, May 18, 2021	October 2020	0	3	–	2§

Source: Inspection/survey results verified with the Quality Management Health System Specialist on December 9, 2020.

*As of June 2021, 1 of 17 recommendations issued to the medical center remained open.
As of June 2021, 2 of 11 recommendations issued to the medical center remained open.
‡As of June 2021, 1 of 22 recommendations issued to the medical center remained open.
§As of June 2021, 2 of 3 recommendations issued to the medical center remained open.

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

Measure	Definition	Desired Direction
AES Data Use Engmt	Composite measure based on three individual All Employee Survey (AES) data use and sharing questions	A higher value is better than a lower value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Care transition (HCAHPS)	Care transition (inpatient)	A higher value is better than a lower value
ED Throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HEDIS like – HED90_1	HEDIS-EPRP based PRV TOB BHS	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS-eOM based DM IHD	A higher value is better than a lower value
Hospital rating (HCAHPS)	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Inpt Global Measures (GM90_1)	ORYX inpatient composite of global measures related to influenza immunization, alcohol and drug use, and tobacco use	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 population coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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 PCMH 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: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) 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: August 30, 2021

From: Director, VA Rocky Mountain Network (10N19)

Subj: Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 19: VA Rocky Mountain Network

To: Director, Office of Healthcare Inspections (54CH04)

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

1. I have reviewed the findings, recommendations, and action plan of the Veterans Integrated Service Network 19: VA Rocky Mountain Network. I am in agreeance with the above.

(Original signed by:)

Ralph Gigliotti

VISN 19 Network Director

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