US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

CHIP Report | 23-00110-168 | May 15, 2024

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Figure 1. *Roseburg VA Medical Center of the Roseburg VA Health Care System in Oregon.*

Source: https://www.va.gov/roseburg-health-care/locations/roseburg-va-medical-center/ (accessed June 23, 2023).

Abbreviations

ADPCS	Associate Director Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
SPC	Suicide Prevention Coordinator
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

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

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

The OIG initiated an unannounced inspection of the Roseburg VA Health Care System during the week of June 26, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued 11 recommendations to the Executive Director and Chief of Staff in the following areas of review: Leadership and Organizational Risks, Medical Staff Privileging, Environment of Care, and Mental Health. In addition, the OIG issued one recommendation to the Veterans Integrated Service Network Chief Medical Officer in the Medical Staff Privileging review area. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address

systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 32.

VA Comments

The Veterans Integrated Service Network Director and Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 35–36, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

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

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

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:[4]

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

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

[2] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal* 4, no. 9 (September 5, 2014): 13, https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae F. 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.

[4] CHIP site visits addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The Roseburg VA Health Care System includes the Roseburg VA Medical Center and multiple outpatient clinics in Oregon. General information about the healthcare system can be found in appendix B.

The inspection team conducted an on-site review the week of June 26, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[6] 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 healthcare system leaders complete corrective actions. The Directors' responses to the report recommendations appear within each topic area. The OIG accepted the action plans that 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.

[5] The OIG's last comprehensive healthcare inspection of the Roseburg VA Health Care System occurred in September 2020. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in November and December 2021.

[6] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[7] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their organization's vision and strategy, and "practice systems thinking and collaboration across boundaries."[8] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[9]

To assess this healthcare system's leadership and risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and healthcare system leaders' responses
6. Concerns related to Oracle Cerner[10]

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Executive Director (Director); Chief of Staff; Associate Director Patient Care Services (ADPCS); Associate Director; and Chief, Quality Management. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

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[7] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[8] Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[9] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement White Paper, 2017.

[10] "VA's Electronic Health Record Modernization (EHRM) program is an effort to replace the department's current EHR, the Veterans Health Information Systems and Technology Architecture (VistA), with a new commercial EHR solution. VA selected Cerner Corp. as its EHR vendor." "Frequently Asked Questions: What is the Electronic Health Record Modernization Program?," VA EHR Modernization, accessed July 11, 2023, https://digital.va.gov/ehr-modernization/resources/frequently-asked-question/.

The Director was appointed in April 2023, and the Associate Director, who started in October 2021, reported having served as the Acting Director since approximately eight months previously, while the position was vacant. The Chief of Staff was assigned in May 2022, and the ADPCS in December 2016.

To help assess executive leaders' engagement, the OIG interviewed the Director; Chief of Staff; acting ADPCS; Associate Director; and Chief, Quality Management regarding their knowledge, involvement, and support of actions to improve or sustain performance.[11]

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of $369,629,210 had decreased by about 2 percent compared to the previous year's budget of $375,262,898.[12] The Associate Director reported the budget decrease was largely because the COVID-19 pandemic had reduced provider workload. The Associate Director stated VISN 20 facilities had reopened more slowly than other medical centers across the nation, and the healthcare system was still not back to pre-COVID provider workload.

The Director stated the executive leadership team met every two weeks to address the system's operational issues. The Director described holding open discussions with staff to better understand their concerns and healthcare system issues, then using the feedback during a strategic planning retreat. The Associate Director reported the executive leaders began working with the National Center for Organization Development to help with team building in fall 2022.[13] The Director said they continued to work with the center to maintain the focus on team development.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[14] 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 medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation

[11] The ADPCS was on leave during the week of the OIG review, and the Associate Chief Nurse Executive was serving as acting ADPCS.

[12] Veterans Health Administration (VHA) Support Service Center.

[13] "NCOD [National Center for Organization Development] is an internal consulting service to VA leaders and staff in support of workforce engagement and satisfaction to enhance Veteran outcomes." "A Conversation with VHA National Center for Organization Development's Linda Belton," VA Health Services Research & Development Forum, accessed January 16, 2024, https://www.hsrd.research.va.gov/publications/forum/oct13/oct13-6.cfm.

[14] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

without fear of reprisal.[15] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

The healthcare system's scores were slightly lower than VHA's for all three FYs. The Associate Director told the OIG that psychological safety had become a staff priority in previous years. The leader stated the previous Director had worked to improve the culture of safety by instituting safety huddles, using VHA's Just Culture Decision Support Tool, and sharing patient safety outcomes during town hall meetings, and these practices continued under the current Director.[16] The Associate Director described implementing a power application for All Employee Survey action planning in FY 2023, which the National Center for Organization Development informed them was a best practice.[17] In addition, the leader reported an 11 percent increase in the FY 2023 survey participation from the prior year.

Table 1. All Employee Survey Question: Ability to Disclose a Suspected Violation (FYs 2020 through 2022)

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
Roseburg VA Health Care System	3.6	3.8	3.8

Source: VA All Employee Survey (accessed December 7, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[18] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from

[15] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

[16] The Just Culture Decision Support Tool provides guidance for leaders to evaluate factors that contributed to errors or at-risk behaviors and for response actions. "Just Culture Decision Support Tool," VHA National Center for Patient Safety, accessed January 8, 2024, https://www.patientsafety.va.gov/docs/Just-Culture-Decision-Support-Tool-2022.pdf.

[17] Power Apps (applications) are Microsoft tools that let users quickly create programs and connect to data to manage and track business processes. "What is Power Apps?," Microsoft, accessed July 11, 2023, https://learn.microsoft.com/en-us/power-apps/powerapps-overview.

[18] "Patient Experiences Survey Results," VHA Support Service Center.

FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

The healthcare system's survey results indicated patient satisfaction with inpatient and outpatient care had declined since FY 2020. The Chief, Quality Management provided documentation of the FY 2022 conversion of the medical inpatient unit into a community living center for hospice care to better address needs of the aging veteran population.[19] The Chief, Quality Management also reported leaders had hired a Veterans Experience Officer in FY 2021 and several performance improvement projects were currently underway. The leader added that they worked with VHA's National Improvement Office in spring 2023 to help increase patient experience scores.

The Chief of Staff attributed the declining patient satisfaction with primary and specialty care partly to a lack of providers, reporting the system was 48 percent staffed at the time of the OIG's review. The Chief of Staff stated staff often referred patients to the community because the healthcare system's rural location made it difficult to recruit and retain both primary and specialty care providers.[20]

To mitigate provider shortages, the Chief of Staff described having other staff cover the vacant positions' duties, as well as using contract personnel and telehealth services. To increase recruitment, the leader told the OIG they used VA's education loan payment reimbursement program and maximized applicable incentives enacted in the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022.[21] The Chief of Staff also discussed expanding their partnerships with Idaho State and Oregon Health Sciences universities to bring aboard clinical students and residents, including physician assistants.

To offset provider shortages in mental health, the Associate Director reported using tele-mental health services. The leader stated they also considered hiring clinical pharmacists and changing the social worker positions to include licensed professional counselors and marriage and family therapists but had not yet decided on a plan of action.

[19] Community living center neighborhoods have a home-like environment with a living space that engages residents and staff to take pride in their residence and workplace. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.) Leaders closed the medical inpatient unit to add hospice beds in May 2021. "Roseburg VA to Close Medical Floor, Add Hospice Beds," *The News-Review*, May 23, 2021, https://www.nrtoday.com/news/veterans/roseburg-va-to-close-medical-floor-add-hospice-beds/article.

[20] "VHA authorizes use of community providers for what is called an episode of care, or a course of treatment for a specific medical problem during a set time period." Congressional Budget Office, *The Veterans Community Care Program: Background and Early Effects*, October 2021.

[21] Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022, Pub. L. No. 117-168, 136 Stat. 1759 (2022) § 103.

Table 2. Survey of Healthcare Experiences of Patients (FYs 2020 through 2022)

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	79.5	69.7	66.4	68.9	–‡
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?*†	82.5	82.4	81.9	79.9	81.7	76.9
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	84.8	85.9	83.3	78.1	83.1	77.9

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8 and 14, 2022).

**The response average is the percent of "Definitely yes" responses.*

†*The response average is the percent of "Very satisfied" and "Satisfied" responses.*

‡*The Chief of Staff said the medical inpatient unit was closed in FY 2022. Therefore, there were no reported inpatient survey results for FY 2022.*

Identified Factors Related to Possible Lapses in Care and Healthcare System Leaders' Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[22] According to The Joint Commission's standards for leadership, a culture of safety and continual process

[22] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 20, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

improvements lead to safe, quality care for patients.[23] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[24]

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[25] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[26] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[27] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[28]

The OIG requested a list of sentinel events and institutional disclosures that occurred during FY 2022 and reviewed the information staff provided. The Director stated patient safety managers and service chiefs inform the executive leadership team of adverse events in daily safety huddles and morning meetings. According to the Director, on Mondays, leaders review a report of all patient safety events that occur over the weekend. Further, leaders said the executive leadership team learn of deaths through safety huddles, after-hours notification, and quarterly Quality, Safety and Value Council reports that include mortality data. The Chief of Staff said risk managers first review adverse events with front-line managers and then with the Chief of

[23] The Joint Commission, *Standards Manual*, E-dition, January 1, 2022. A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

[24] Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

[25] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission's definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

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

[27] VHA Directive 1004.08.

[28] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. The new directive contains similar language regarding patient safety as the rescinded handbook.)

Staff and Director (if available) to determine whether they require an institutional disclosure; subsequently, the Chief of Staff provide disclosure to the patient, family, or patient's personal representative.

To prevent adverse events from reoccurring, the Director discussed reviewing root cause analysis results, adding that patient safety managers report overdue or near due action items to executive leaders every two weeks.[29] A Patient Safety Manager told the OIG that during new employee orientation, managers review the healthcare system's Patient Safety Program, which includes high-reliability organization principles and instructions for entering adverse events in the Joint Patient Safety Reporting system.[30] The Patient Safety Manager also reported hosting monthly staff safety forums with a high-reliability organization theme in which participants share safety stories and recognize good catches.[31]

The OIG identified a deficiency with the healthcare system's handling of a sentinel event related to a home oxygen fire. This finding is discussed in further detail in the Leadership and Organizational Risks Findings and Recommendations section of the report below.

Oracle Cerner

At the time of the OIG review, the healthcare system was one of five medical centers that had implemented the Oracle Cerner electronic health record system. On April 21, 2023, VA announced a pause in rollout at further sites so resources could be redirected to these five sites as part of a program reset to prioritize improvements at sites using the new system.[32] The OIG published several reports related to Oracle Cerner with findings about implementation issues.[33]

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[29] A root cause analysis "is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook*, December 2022.

[30] "An HRO [high-reliability organization] is an organization that experiences fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments where even small errors can lead to tragic results." "VHA's Vision for a High Reliability Organization," Department of Veterans Affairs, accessed March 16, 2022, https://www.hsrd.research.va.gov/publications/forum/summer20/default.cfm. "The Joint Patient Safety Reporting (JPSR) System is the Veterans Health Administration (VHA) patient safety event reporting system and database." VHA National Center for Patient Safety, *JPSR Guidebook*.

[31] A Good Catch Award "recognizes employees who report close calls or other patient safety concerns." "VA Boston Displays Transparency in Patient Safety," VHA National Center for Patient Safety, accessed January 8, 2024, https://www.patientsafety.va.gov/VABostonDisplaysTransparencyInPatientSafety.asp.

[32] VHA Under Secretary for Health, "EHRM Program Reset," email to VHA, April 21, 2023.

[33] VA OIG, *Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00781-108, March 17, 2022; VA OIG, *Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00781-109, March 17, 2022; VA OIG, *Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-03020-168, June 1, 2022; VA OIG, *Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 22-04135-06, November 1, 2023.

During the OIG review at the healthcare system the week of June 26, 2023, staff shared some issues they had during the Oracle Cerner implementation.[34]

The Director explained that since implementation in June 2022, leaders hired an informatics specialist and planned to add more to offset the continued loss of productivity and inefficiency caused by Oracle Cerner. The acting ADPCS stated the new system was labor intensive and staff had to find workarounds to accomplish tasks and operational processes. Additionally, the Associate Director reported coding also took longer, and as a result they had added five more coders.[35]

The acting ADPCS reported the Oracle Cerner documentation process required more time and had disrupted workflows. The leader provided an example at the community living center, where nurses were unable to view nursing assistant notes in Oracle Cerner to help with patient assessments prior to dispensing medication, which resulted in nurses having to find the nursing assistants to obtain health information to determine if it was clinically appropriate to dispense the medications. Additionally, the Risk Manager said since Oracle Cerner did not have standardized note titles, staff helped create a standardized note for patient falls to help search for fall-related information.

The Chief of Staff detailed the challenges managers had with finding external providers who could complete professional practice evaluations. The Chief of Staff explained that due to the lack of some providers' access to the new electronic health record system, staff had to copy healthcare information from the record and send it to the reviewing provider.

A Suicide Prevention Coordinator (SPC) provided an example regarding communication challenges. The SPC said that, prior to implementing Oracle Cerner, suicide-related data was available as a national-level report and indicated being unaware of a similar report with Oracle Cerner. However, during the week of the OIG inspection, the SPC acknowledged learning that a suicide-related report had been available but only after reaching out to an SPC at another medical center where Oracle Cerner was implemented. The Chief of Social Work Services and the SPC also stated Oracle Cerner staff did not always resolve urgent requests in a timely manner. For example, the SPC reported providers were unable to add SPCs to notes when patients had positive suicide screens. In August 2022, the SPC entered a request about the deficiency into the ticketing system, and at the time of the OIG inspection, that request had remained open.

[34] VA OIG, *Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*; VA OIG, *Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann-Grandstaff VA Medical Center in Spokane, Washington*.

[35] VA medical facilities use a coding system for billing third party payors for selected inpatient and outpatient services. VHA Directive 1401, *Billing for Services Provided by Supervising Practitioners and Physician Residents,* January 5, 2021.

A Patient Safety Manager informed the OIG that the VHA National Center for Patient Safety had advised patient safety managers to include patient safety events that occurred since Oracle Cerner implementation in an aggregate root cause analysis, and one of the patient safety managers was assigned this responsibility.

Leadership and Organizational Risks Findings and Recommendations

The OIG recognizes that implementation of the Oracle Cerner electronic health record system created widespread challenges for staffing, budget, workflow, patient safety, professional practice evaluations, and suicide prevention. Leaders were collectively informed and active in addressing these concerns, while staff created workarounds to complete work, pending resolution of service tickets.

The OIG found a deficiency related to a sentinel event. The VHA National Center for Patient Safety recognizes home oxygen fires as sentinel events.[36] When sentinel events occur, VHA requires staff to complete a root cause analysis to help prevent the event from reoccurring by reviewing systems and processes that contributed to the incident.[37] The OIG identified a serious FY 2022 adverse event that involved a patient injury from a home oxygen fire for which staff did not complete a root cause analysis.

The Chief, Quality Management explained the prior Patient Safety Manager reviewed the event and sent the initial investigation to the Associate Chief of Primary Care Services. The Chief of Primary Care Services said that according to respiratory therapy staff, patients received home oxygen supplies through a company accredited by The Joint Commission, and this company was responsible for following up on the incident. The Chief, Quality Management added that the prior Patient Safety Manager believed respiratory therapy staff knew about the incident and closed the initial investigation in the Joint Patient Safety Reporting system.

The OIG spoke with the Chief of Prosthetics, the liaison between the healthcare system and the home oxygen company, who stated VISN staff informed the home oxygen company of the adverse event. However, the VISN contract did not require staff at the home oxygen company to complete a root cause analysis for sentinel events; therefore, the OIG determined healthcare system staff should have completed a root cause analysis for this event.

[36] VHA National Center for Patient Safety, "Guidance Relating to Patient Safety Analyses of Home Oxygen Fires," email to VHA Patient Safety Officers, May 28, 2021.

[37] VHA National Center for Patient Safety, *Guide to Performing a Root Cause Analysis*, February 5, 2021.

Recommendation 1

1. The Executive Director ensures staff complete root cause analyses for sentinel events.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: Sentinel events are entered into the Joint Patient Safety Report system. Patient Safety reviews every event and when a sentinel event is identified a Root Cause Analysis is initiated, unless otherwise excluded by the National Center for Patient Safety VHA Guide to Performing Root Cause Analysis. All sentinel events are recorded on a joint patient safety/risk management tracker. The Patient Safety and Risk Management teams review the spreadsheet weekly to ensure all events are documented. The spreadsheet tracks date of event, investigation information and includes a column to track root cause analysis completion. The process for tracking root cause analyses for sentinel events has been updated to include those events that occur outside the facility, including those involving Home Oxygen Companies and Contract Nursing Homes. For events that occur outside the facility, the Patient Safety Manager will work with appropriate departments and vendors to ensure required Root Cause Analysis is completed.

Continued compliance will be measured with the numerator defined as the number of sentinel event root cause analyses completed and the denominator defined as the number of sentinel events.

The Patient Safety Manager will report compliance data to the Quality and Safety Council monthly.

The Roseburg VA Health Care System will continue to monitor until 90% compliance is maintained for six consecutive months.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[38] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[39] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[40]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[41] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[42]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[43] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[44] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[45]

The OIG team interviewed key managers and staff and reviewed relevant documents.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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

[39] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

[40] VHA Directive 1100.16.

[41] VHA Handbook 1050.01; VHA Directive 1050.01(1).

[42] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

[43] A peer review is a "critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

[44] VHA Directive 1190.

[45] VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[46] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges."[47]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[48] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[49]

VHA states the Focused Professional Practice Evaluation (FPPE) is a defined period during which service chiefs assess LIPs' professional performance. The FPPE process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation (OPPE) to ensure the continuous delivery of quality care.[50]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[51] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires facilities to have credentialing and

[46] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[47] VHA Handbook 1100.19.

[48] VHA Handbook 1100.19.

[49] VHA Handbook 1100.19.

[50] VHA Handbook 1100.19.

[51] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[52]

The OIG interviewed key managers and selected and reviewed the privileging folders of 25 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires service chiefs to initiate FPPEs for LIPs newly appointed to the medical staff and to regularly complete OPPEs.[53] The OIG found service chiefs did not consistently initiate FPPEs or regularly complete OPPEs. This resulted in LIPs practicing without timely and thorough evaluations of their practices, which could lead to patient safety concerns. The Chief of Staff reported one LIP did not have an FPPE initiated due to multiple vacancies, including the service chief and administrative officer positions. The acting Credentialing and Privileging Manager added that Medical Staff Office personnel used a spreadsheet to track FPPE completion and overlooked adding that FPPE to it. The Chief of Staff described multiple reasons for delayed OPPEs that included service chiefs covering other departments due to service chief position vacancies; competing priorities, with clinical care prioritized over administrative functions; and staff at non-Oracle Cerner sites having no access to electronic health records, which created challenges locating external evaluators with access to the records.

Recommendation 2

2. The Chief of Staff ensures service chiefs initiate Focused Professional Practice Evaluations for newly appointed licensed independent practitioners.

[52] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

[53] VHA Handbook 1100.19; VHA Directive 1100.21(1).

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Roseburg VA Health Care System has initiated use of a Professional Practice Evaluation tracking system identified as a VISN 20 best practice. Training was provided by the facility who developed the system with a deadline for implementation of April 12, 2024. This tracker is reviewed daily at the Chief of Staff huddle to ensure compliance with Professional Practice Evaluation processes. Since October 1, 2023, the Roseburg VA Health Care System has hired seven licensed independent practitioners and all seven required FPPE were initiated on time.

Continued compliance will be measured with the numerator defined as the number of FPPE initiated per month and the denominator as the number of providers requiring initiation of FPPE per month.

The Credentialing and Privileging Lead will report monthly compliance data to the Medical Staff Executive Committee which reports to the Executive Director, acting as the governing body.

The Roseburg VA Health Care System will continue to monitor until 90% compliance is maintained for six consecutive months.

Recommendation 3

3. The Chief of Staff ensures service chiefs regularly complete Ongoing Professional Practice Evaluations for licensed independent practitioners.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Roseburg VA Health Care System has initiated use of a Professional Practice Evaluation tracking system identified as a VISN 20 best practice. Training was provided by the facility who developed the system with a deadline for implementation of April 12, 2024. This tracker is reviewed at the Chief of Staff huddle to ensure compliance with Professional Practice Evaluation processes.

The tracker highlights which OPPE are coming due. Each Service Chief is required to update the tracker on the status of OPPE until completion. Using this tracker has improved oversight visibility for the Chief of Staff and the Service Chiefs. The Roseburg VA Health Care System follows a six-month cycle, ending on January 31 and July 31. Reviewing OPPE from the January 31, 2024, cycle, 2 departments of 13 have been completed, with the other 11 on schedule to be completed on time.

Continued compliance will be measured with the numerator defined as the number of OPPE completed for each six-month cycle and the denominator defined as the number of OPPE required for each six-month cycle.

The Credentialing and Privileging Lead will report compliance data to the Medical Staff Executive Committee which reports to the Executive Director, acting as the governing body, every six months.

The Roseburg VA Health Care System will monitor until 90% compliance is maintained for six consecutive months.

VHA requires service chiefs to consider relevant specialty-specific data during the OPPE process.[54] Such data must be easily retrievable and may include direct observation, clinical discussions, or periodic chart reviews.[55] The OIG found service chiefs were not able to provide the OIG with evidence they consistently considered specialty-specific data for the OPPEs. This resulted in LIPs continuing to deliver care without thorough reviews of their practices, which could negatively affect safe patient care. The acting Credentialing and Privileging Manager reported being unable to find the evaluation documentation.

[54] VHA Handbook 1100.19; VHA Directive 1100.21(1). For example, an LIP who works in neurology should also be evaluated based on criteria relevant to the care provided in that specialty.

[55] VHA Handbook 1100.19; VHA Directive 1100.21(1).

Recommendation 4

4. The Chief of Staff ensures service chiefs consider specialty-specific data during licensed independent practitioners' Ongoing Professional Practice Evaluations.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Roseburg VA Health Care System has initiated use of a Professional Practice Evaluation tracking system identified as a VISN 20 best practice. Training was provided by the facility who developed the system with a deadline for implementation of April 12, 2024. This tracker is reviewed at the Chief of Staff huddle daily to ensure compliance with Professional Practice Evaluation processes.

The Roseburg VA Health Care System has initiated use of the nationally approved OPPE forms containing specialty-specific data. The deadline for implementing these new forms is June 30, 2024. The nationally approved Hospitalist form contains criteria which would not capture the work provided locally. As such, appropriate, specific criteria will be developed by the Service Chief and approved by the Medical Staff Executive Committee by June 30, 2024.

Continued compliance will be measured with the numerator defined as the number of OPPE completed using the appropriate criteria for each six-month cycle and the denominator defined as the number of OPPE completed for each six-month cycle.

The Credentialing and Privileging Lead will report compliance data to the Medical Staff Executive Committee which reports to the Executive Director, acting as the governing body, at the end of each six-month cycle.

The Roseburg VA Health Care System will monitor until 90% compliance is maintained for six consecutive months.

Additionally, VHA requires practitioners with equivalent specialized training and similar privileges to complete professional practice evaluations.[56] The OIG did not find documentation that LIPs with equivalent specialized training and similar privileges as the LIPs under review completed some OPPEs. Practitioners without equivalent specialized training and similar privileges completing the evaluations could result in LIPs practicing without comprehensive evaluations that could highlight specific practice deficiencies that compromise patient safety. The acting Credentialing and Privileging Manager reported staff misfiled the evaluation

[56] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's Revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators," May 18, 2021; VHA Directive 1100.21(1).

documentation and could not find it. This is a similar finding from the prior comprehensive healthcare inspection.[57]

Recommendation 5

5. The Chief of Staff ensures practitioners with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: Service Chiefs are required to ensure that a provider with equivalent specialized training and similar privileges completes OPPE.

The Credentialing and Privileging analyst will audit 100% of OPPE for compliance at the end of each six-month cycle.

Continued compliance will be measured with the numerator defined as the number of reviews completed by a reviewer with equivalent, specialized training and similar privileges for each six-month cycle and the denominator defined as the number of licensed independent practitioners reviewed each six-month cycle.

The Credentialing and Privileging Lead will report compliance data to the Medical Staff Executive Committee which reports to the Executive Director, acting as the governing body, at the end of each six-month cycle.

The Roseburg VA Health Care System will track and monitor this data until 90% compliance is maintained for six consecutive months.

VHA requires an executive committee of the medical staff to review results of professional practice evaluations.[58] The OIG found the Healthcare Delivery Council did not review professional practice evaluation results. The Healthcare Delivery Council's failure to review evaluation results may result in insufficient evidence to support the Director's approval of clinical privileges. The Chief of Staff explained executive leaders implemented a new council structure in July 2022, which identified the Healthcare Delivery Council as the executive committee of the medical staff but added nonmedical staff as council members. The Chief of Staff reported the Medical Staff Credentialing and Privileging Committee reviewed professional practice evaluation results and sent privileging recommendations to the Director, but the Healthcare Delivery Council did not due to concerns it was inappropriate for the nonmedical

[57] VA OIG, *Comprehensive Healthcare Inspection of the Roseburg VA Health Care System in Oregon*, Report No. 20-01259-196, August 2, 2021.

[58] VHA Handbook 1100.19; VHA Directive 1100.21(1).

staff to make decisions outside their professional scope. This is a similar finding from the prior comprehensive healthcare inspection.[59]

Recommendation 6

6. The Chief of Staff ensures the Healthcare Delivery Council or an appropriately identified executive committee of the medical staff reviews professional practice evaluation results.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Roseburg VA Health Care System established the Medical Staff Executive Committee in February 2024. The Medical Staff Executive Committee reviews all credentialing and privileging matters monthly, including professional practice evaluation results, and is chaired by the Chief of Staff.

Continued compliance will be measured with the numerator defined as number of professional practice evaluation results reviewed by the Medical Staff Executive Committee every month and the denominator defined as the number of professional practice evaluations completed every month.

The Credentialing and Privileging Lead will report compliance data to the Medical Staff Executive Committee monthly which reports to the Executive Director, acting as the governing body.

The Roseburg VA Health Care System will track and monitor this data until 90% compliance is maintained for six consecutive months.

[59] VA OIG, *Comprehensive Healthcare Inspection of the Roseburg VA Health Care System in Oregon*.

VHA requires the VISN chief medical officer to oversee the privileging processes at medical facilities within the VISN.[60] The OIG noted that VISN leaders may have missed multiple opportunities to identify and mitigate gaps in the healthcare system's privileging processes, as evidenced by the two similar findings from the prior comprehensive healthcare inspection, which could have resulted in patient safety concerns. The VISN Credentialing and Privileging Officer reported working on sustainable action plans based on facilities' self-assessments of their credentialing and privileging processes.

Recommendation 7

7. The Veterans Integrated Service Network Chief Medical Officer oversees the healthcare system's privileging processes.

[60] VHA Handbook 1100.19; VHA Directive 1100.21(1).

Veterans Integrated Service Network concurred.

Target date for completion: December 31, 2024

Veterans Integrated Service Network response: The VISN Chief Medical Officer will enhance oversight by participating in the VISN 20 Quality Management annual site visit of the Roseburg VA Healthcare System scheduled the week of July 22-26, 2024. The VISN Chief Medical Officer will ensure that the VISN Credentialing and Privileging Officer completes a comprehensive review of privileging processes during the site visit, to include but not limited to, comprehensive evaluations of: FPPE of newly appointed licensed independent practitioners; OPPE for licensed independent practitioners; the Healthcare System's Medical Staff Bylaws; and documentation of privileging decisions and associated review of professional practice evaluation results in meeting minutes of the Healthcare Delivery Council or other appropriately identified executive committee of the medical staff. The VISN Credentialing and Privileging Officer shall provide a summary of their review to the VISN Chief Medical Officer, the Facility Chief of Staff, the VISN Quality Management Officer, and the Facility Credentialing and Privileging Lead at the conclusion of the site visit. All observations that require corrective action shall be incorporated into the final site visit report issued to the facility. Facility leadership will submit a corrective action plan to the VISN, and 3 consecutive, monthly status updates will be provided, in alignment with established processes. The VISN Credentialing and Privileging Officer will provide a summary of findings and oversight needs for remaining open corrective actions for the Roseburg VA Healthcare System Credentialing and Privileging Program to the VISN Quality and Safety Council at the completion of the 3 month follow up process. The VISN Quality and Safety Council is chaired by the VISN Quality Management Officer and co-chaired by the VISN Network Director and the VISN Chief Medical Officer is a voting member.

The VISN Credentialing and Privileging Officer will continue to report a summary of status updates on a quarterly basis to the VISN Quality and Safety Council. The quarterly report will be expanded to include an additional report specifically for the Roseburg VA Healthcare System which will at a minimum include status of ongoing compliance for: status of FPPE for newly appointed licensed independent practitioners; status of OPPE for licensed independent practitioners that are due during the reporting timeframe; status of the Health Care System's Medical Staff Bylaws; and documentation of privileging decisions and associated review of professional practice evaluation results in the appropriately designated forum within the governance structure meeting minutes. This quarterly reporting specific to Roseburg VA Healthcare System shall continue for a minimum term of 2 consecutive quarters, and then at the discretion of the VISN Quality Safety Council to ensure sustained performance.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[61] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[62]

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[63]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected the following patient care areas:

- Community living center (River House and The Lodge)
- Mental health inpatient unit (Acute Psychiatric Unit)
- Primary care clinic (Gold Clinic)
- Urgent Care Center

Environment of Care Findings and Recommendations

VHA requires staff to test over-the-door alarms per the manufacturer's recommendations for all sleeping rooms in mental health inpatient units.[64] The manufacturer's guidelines recommend staff test the alarms weekly and an outside maintenance provider tests them annually. The OIG found that neither staff nor an outside maintenance provider tested the over-the-door alarms in

[61] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021 (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

[62] VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[63] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.) VHA Handbook 1142.01; VHA Directive 1142(1).

[64] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)," April 10, 2023.

the Acute Psychiatric Unit in FY 2022. If staff do not test over-the-door alarms as recommended, they may fail to alert them when patients are in immediate danger. The Nurse Manager, Acute Psychiatric Unit acknowledged being unaware of any manufacturer's recommendations, stated charge nurses verified that the alarm system was operational daily and documented the verification on the charge nurse sheet, and reported believing this met the requirement. The OIG determined these actions did not align with the Mental Health Environment of Care Checklist requirements despite staff documenting the standards as met.

Recommendation 8

8. The Executive Director ensures staff follow the manufacturer's recommendations for testing over-the-door alarms for sleeping rooms in the Acute Psychiatric Unit.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Associate Chief Nurse Executive of Mental Health and Urgent Care worked with the Chief of Facility Management Services to develop a standard operating procedure, "Anti-Ligature Door Alarm Testing" in alignment with the manufacturer's recommendations. Weekly over-the-door alarm testing for each door alarm began August 2023. The testing is conducted weekly by one Facilities Management employee and one Acute Psychiatric Unit employee who test all applicable doors in the Acute Psychiatric Unit and document findings weekly on a spreadsheet.

Compliance data will be calculated monthly with the numerator defined as the total number of weeks that all over the door alarm tests were completed in the reviewed month and the denominator defined as the number weeks in the reviewed month.

The Assistant Chief of Facility Management Services will report this data to the Health and Safety Committee monthly.

The Roseburg VA Health Care System will monitor until 100% compliance is maintained for six consecutive months.

VHA requires staff to periodically test panic alarms in the mental health inpatient unit and document VA police response times.[65] The OIG found no evidence staff tested panic alarms or documented VA police response times in FY 2022, which may result in an unsafe environment for patients, visitors, and staff in emergency situations. The Chief of Police stated panic alarm testing began in May 2023 and provided the OIG with documentation. The OIG determined staff

[65] VHA Directive 5019.02(1), *Harassment, Sexual Assaults and Other Defined Public Safety Incidents in VHA*, September 12, 2022, amended October 13, 2022; VHA Directive 1167; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)."

did not comply with the Mental Health Environment of Care Checklist requirement despite documenting this standard as met. The Nurse Manager said different individuals are involved in environment of care inspections, which may have led to inconsistencies in staff documentation.

Recommendation 9

9. The Executive Director ensures staff test panic alarms in the Acute Psychiatric Unit and document VA police response times.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: Roseburg VA Police began monthly panic alarm testing of each active "panic fob" in May 2023. The process for monthly testing includes the police service initiating a test panic alarm with each fob to verify they alarm. In addition, they perform a separate drill to determine response time. Both are tracked via spreadsheet and results are provided to the Acute Psychiatric Unit Nurse Manager when completed. All panic alarm testing and police response times will be reported to the Mental Health Environment of Care Committee for tracking and documenting in the biannual Mental Health Environment of Care Committee Report.

Compliance data will be calculated monthly with the numerator defined as the number of panic alarm tests completed and the denominator defined as the number of panic fobs on unit. The results of the panic fob testing will be reported at the Mental Health Environment of Care Committee monthly. Additionally, the total number of response time drills and the response time will be reported monthly to Mental Health Environment of Care Committee.

The Chief of Police will report compliance data to the Health and Safety Committee monthly.

The Roseburg VA Health Care System will monitor until 90% compliance is maintained for six consecutive months.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[66] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[67] The suicide rate for veterans was higher than for nonveteran adults during 2020.[68] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[69]

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[70] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[71]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time SPC to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[72]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 49 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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[66] VA Secretary memo, "Agency-Wide Required Suicide Prevention Training," October 15, 2020.

[67] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 20, 2022.

[68] VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

[69] Congressional Research Service, "Veteran Suicide Prevention," IF11886 version 2, July 29, 2021.

[70] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," November 23, 2022.)

[71] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)"; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

[72] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. "Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

VHA requires designated staff to complete the Comprehensive Suicide Risk Evaluation when the suicide risk screen is positive. In ambulatory care settings, the screen and evaluation should occur on the same calendar day unless it is "not logistically feasible or clinically appropriate," such as in situations where urgent or emergent care is needed.[73] The OIG estimated staff did not complete an evaluation for 57 (95% CI: 44 to 71) percent of patients who had a positive suicide risk screen, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[74] Failure to complete the Comprehensive Suicide Risk Evaluation after a positive suicide screen poses a safety risk because patients with suicidal thoughts and behaviors might go unnoticed and untreated. An SPC reported primary care providers may have perceived suicide evaluations as a behavioral health responsibility, which resulted in missed evaluations. The acting Associate Chief of Staff for Mental Health added that primary care providers had a local standard operating procedure that did not include information on how to document when patients decline on the evaluation template, which may have been a reason why they did not complete some of them.

Recommendation 10

10. The Chief of Staff ensures designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.

[73] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)"; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)."

[74] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: To ensure all positive Columbia Suicide Severity Rating Scale screens are followed by a Comprehensive Suicide Risk Evaluation on the same calendar day, the Suicide Prevention Coordinators have implemented twice daily checks of a real time report to identify any needed Comprehensive Suicide Risk Evaluation. Once a need is identified, the Suicide Prevention Coordinator emails the Mental Health Associate Chief of Staff who reports the fall out at the Chief of Staff daily meeting. Additionally, supervisory staff are tasked to directly notify the provider of the missed evaluation and instruct them to complete.

Compliance data will be calculated monthly by the Suicide Prevention Coordinators. The numerator is defined as number of Comprehensive Suicide Risk Evaluations completed the same calendar day and the denominator as the number of positive Columbia Suicide Severity Rating screens.

The Suicide Prevention Coordinator will report compliance data to the Quality and Safety Council monthly.

The Roseburg VA Health Care System will monitor until 90% compliance is maintained for six consecutive months.

VHA requires clinical staff to notify the suicide prevention team when patients report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.[75] The OIG found staff did not notify the suicide prevention team for the two patients who reported suicidal behaviors during the evaluation, which may have delayed further evaluation and mental health intervention. An SPC reported believing primary care providers generally lacked awareness of the requirement and there were plans to provide training.

Recommendation 11

11. The Chief of Staff ensures clinical staff notify the suicide prevention team when patients report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.

[75] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer Memo, "Suicide Behavior and Overdose Reporting"; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting."

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: With the transition to Oracle Health in June 2022 the process for notifying the Suicide Prevention Team was changed. The Suicide Prevention Team is now notified via a High-Risk Flag referral list through the new electronic health record, Oracle Health discern reporting. When a provider completes a high-risk consult form documenting suicidal behaviors which is embedded in both the Comprehensive Suicide Risk Evaluation and Suicide Behavior Overdose Report, the Veteran information is placed on the High-Risk Referral Flag list which is generated through discern reporting by the Suicide Prevention Coordinators daily. The process followed by the Suicide Prevention Team is to review the High-Risk Flag referral list daily and determine if a high-risk flag is required. To ensure Veterans who may have had a suicide or preparatory event, or self-direct/self-harm behavior, but the provider did not complete a High-Risk Referral Flag consult, the Suicide Prevention Coordinators also review all Comprehensive Suicide Risk Evaluation documentation and Suicide Behavior Overdose Reports to assess whether the Veteran requires further follow up. If further evaluation is needed, the Suicide Prevention Coordinator reaches out to the Veteran's provider directly to obtain additional information. When the Suicide Prevention Coordinator determines a flag is warranted, but was not requested by the screening provider, the Suicide Prevention Coordinator team, meets to discuss and determines flag placement.

The Suicide Prevention Team will audit 100% of Comprehensive Suicide Risk Evaluations and Suicide Behavior Overdose Reports to ensure that patients who demonstrated suicidal behavioral had an appropriate High Risk Flag referral entered every month.

Compliance data will be calculated monthly with the numerator defined as High-Risk Flag Referral and the denominator defined as Veterans reporting suicidal behavior during the Comprehensive Suicide Risk Evaluation.

The SPC will report compliance data to the Quality and Safety Council monthly.

The Roseburg VA Health Care System will monitor until 90% compliance is maintained for six consecutive months.

VHA requires the SPC to conduct, track, and report a minimum of five outreach activities per month.[76] The OIG found SPCs did not conduct at least five outreach activities per month from April through August 2022, which may affect VHA collaboration with the local community and lead to missed opportunities for timely community intervention for patients in crisis. An SPC attributed the deficiencies to the departure of a prior SPC with established ties to community partners, an inadequate number of staff to coordinate outreach activities while completing daily

[76] VHA Directive 1160.07.

suicide prevention responsibilities, and limited opportunities for outreach activities due to the healthcare system's rural location. The SPC also described community partners' preferences to attend training that resulted in certificates for participants, which the healthcare system did not provide.

Recommendation 12

12. The Chief of Staff ensures the suicide prevention coordinators conduct, track, and report a minimum of five suicide prevention outreach activities each month.

Healthcare system concurred.

Target date for completion: September 30, 2024

Healthcare system response: The Suicide Prevention Coordinator worked extensively with Roseburg VA Health Care partners to schedule outreach activities every month. Incorporating input from community partners, the Suicide Prevention Coordinators successfully scheduled monthly outreach activities beginning in October 2023. Outreach activity has been reported via the National Outreach Program Reporting or Suicide Prevention Applications Network Program.

Compliance data will be measured monthly with the numerator defined as the number of outreach activities completed, including "Signs, Ask, Validate, Encourage and Expedite" training and the denominator is defined as the number of events required, including "Signs, Ask, Validate, Encourage and Expedite" training.

The Suicide Prevention Coordinator will report compliance data to the Quality and Safety Council monthly.

The Roseburg VA Health Care System will continue to monitor monthly Outreach Activities until 90% compliance is maintained for six consecutive months.

Report Conclusion

To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed inspection of five clinical and administrative areas and provided 12 recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this healthcare system. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines 12 OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Executive Director, Chief of Staff, and VISN Chief Medical Officer. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• Staff complete root cause analyses for sentinel events.
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs initiate Focused Professional Practice Evaluations for newly appointed licensed independent practitioners. • Service chiefs regularly complete Ongoing Professional Practice Evaluations for licensed independent practitioners. • Service chiefs consider specialty-specific data during licensed independent practitioners' Ongoing Professional Practice Evaluations. • Practitioners with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations. • The Healthcare Delivery Council or an appropriately identified executive committee of the medical staff reviews professional practice evaluation results. • The Veterans Integrated Service Network Chief Medical Officer oversees the healthcare system's privileging processes.
Environment of Care	• Staff follow the manufacturer's recommendations for testing over-the-door alarms for sleeping rooms in the Acute Psychiatric Unit. • Staff test panic alarms in the Acute Psychiatric Unit and document VA police response times.

Review Areas	Recommendations for Improvement
Mental Health: Suicide Prevention Initiatives	• Designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen. • Clinical staff notify the suicide prevention team when patients report suicidal behaviors during the Comprehensive Suicide Risk Evaluation. • Suicide prevention coordinators conduct, track, and report a minimum of five suicide prevention outreach activities each month.

Appendix B: Healthcare System Profile

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

Table B.1. Profile for Roseburg VA Health Care System (653)
(October 1, 2019, through September 30, 2022)

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	$334,392,564	$375,262,898	$369,629,210
Number of:			
• Unique patients	28,182	27,535	27,260
• Outpatient visits	278,528	302,625	255,490
• Unique employees	1,004	992	946
Type and number of operating beds:			
• Community living center	50	55	55
• Domiciliary	22	0	0
• Medicine	12	0	0
• Mental health	10	10	10
Average daily census:			
• Community living center	31	36	44
• Domiciliary	6	–	–
• Medicine	1	1	0
• Mental health	6	5	5

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, 2019, through September 30, 2020.*
†*October 1, 2020, through September 30, 2021.*
‡*October 1, 2021, through September 30, 2022.*
§*Unique employees involved in direct medical care (cost center 8200).*

[1] VHA medical facilities are classified according to a complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 18, 2024

From: Executive Director, VA Northwest Health Network (10N20)

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

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

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

1. Thank you for the opportunity to provide a response to the findings from the draft report of the Comprehensive Healthcare Inspection of the Roseburg VA Health Care System in Oregon.
2. I concur with the findings and recommendations and will ensure that corrective actions are completed as described in the responses.

(Original signed by:)

Tiel Keltner for
Teresa D. Boyd

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: March 26, 2024

From: Executive Director, Roseburg VA Health Care System (653)

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

To: Director, VA Northwest Health Network (10N20)

1. Thank you for the opportunity to provide a response to the findings from the draft report of the Comprehensive Healthcare Inspection of the Roseburg VA Health Care System.
2. I concur with the findings and recommendations and will ensure that actions to correct these findings are completed as described in responses to the draft report.

(Original signed by:)

Patrick A. Hull, MT, MBA,
Executive Director (SES)

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