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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Boise VA Medical Center in Idaho

CHIP REPORT | REPORT #20-01256-179 | JULY 12, 2021

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Figure 1. *Boise VA Medical Center in Idaho.*

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

Abbreviations

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

Report Overview

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

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

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

1. COVID-19 pandemic readiness and response[1]
2. Quality, safety, and value
3. Medical staff privileging
4. Medication management (targeting long-term opioid therapy for pain)
5. Mental health (focusing on the suicide prevention program)
6. Care coordination (spotlighting life-sustaining treatment decisions)
7. Women's health (examining comprehensive care)
8. High-risk processes (emphasizing reusable medical equipment)

The unannounced virtual review was conducted during the week of September 14, 2020, at the Boise VA Medical Center. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this medical center's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this medical center and other Veterans Health Administration (VHA) facilities

[1] "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It." World Health Organization, was 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)."

identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued 10 recommendations that are directed to the Medical Center Director, Chief of Staff, and Nurse Executive. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual review, the medical center's leadership team consisted of the acting Medical Center Director, Chief of Staff, Nurse Executive, and acting Associate Medical Center Director. Organizational communications and accountability were managed through a committee reporting structure, with the Executive Leadership Council overseeing several working groups. The leaders monitor patient safety and care through the Quality Executive Board, which is responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the medical center's leaders had worked together as a team for over three months. The acting Medical Center Director and acting Associate Medical Center Director assumed their roles on June 1, 2020, when the Medical Center Director was assigned as the acting Network Director of VISN 20. The Chief of Staff and Nurse Executive began their positions in October 2016 and April 2020, respectively.

The OIG reviewed selected employee satisfaction survey results and found the medical center average for the selected survey leadership questions was similar to or higher than the VHA average. Patient experience survey results for the medical center generally reflected higher outpatient ratings than VHA averages, and patients appeared satisfied with the care provided.

The inspection team also reviewed accreditation agency findings, sentinel events, and large-scale disclosures of adverse patient events and did not identify any substantial organizational risk factors.[2] However, during the review of institutional disclosures, the OIG identified surgical complications that were experienced by two patients who received care in 2017 and appeared to meet the criteria for peer review. Although reviews were not conducted in 2017, the Risk Manager reported initiating the peer review process for both cases during the week of the OIG's virtual review.

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."

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

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 executive leaders were generally knowledgeable, within their tenure and scope of responsibilities, about VHA data and/or medical center-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning measures. In individual interviews, the executive leadership team members were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

COVID-19 Pandemic Readiness and Response

The results of the OIG's evaluation of the medical center's COVID-19 pandemic readiness and response were compiled and reported with other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[4]

Quality, Safety, and Value

The medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions, peer review, and the patient safety elements reviewed. However, the OIG identified a weakness in utilization management processes.[5]

Medical Staff Privileging

The medical center complied with requirements for focused and ongoing professional practice evaluations.[6] However, the OIG identified a deficiency in the healthcare provider exit review process.

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

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

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

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

Medication Management

The OIG team observed compliance with some elements of expected performance, including pain screening, documented justification for concurrent therapy with benzodiazepines, and informed consent. However, the OIG identified deficiencies with aberrant behavior risk assessments, urine drug testing, patient follow-up, and quality measure oversight.

Mental Health

The medical center complied with many of the performance elements reviewed, including a designated suicide prevention coordinator, high-risk veteran tracking and follow-up, and suicide prevention training for nonclinical employees at new employee orientation. However, the OIG noted concerns with monthly outreach activities and annual suicide prevention refresher training.

Care Coordination

Generally, the medical center met expectations for the life-sustaining treatment decisions committee and supervision of designees. However, the OIG identified a deficiency with practitioners documenting life-sustaining treatment decisions notes.

Women's Health

The medical center complied with some of the performance indicators reviewed, including a designated Women's Health Patient Aligned Care Team and available Primary Care Mental Health Integration services. However, the OIG identified deficiencies in gynecologic care coverage, designated community-based outpatient clinic women's health primary care providers, Women Veterans Health Committee meeting attendance, and women veterans program manager duties.

High-Risk Processes

The medical center met many of the requirements for the proper operations and management of reusable medical equipment. However, the OIG identified deficiencies with staff competency assessments.

Conclusion

The OIG conducted a detailed inspection across nine key areas (two administrative and seven clinical) and subsequently issued 10 recommendations for improvement to the Medical Center Director, Chief of Staff, and Nurse Executive. The number of recommendations should not be used, however, as a gauge for the overall quality of care provided at this medical center. The intent is for medical center leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-

critical findings that, if not addressed, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 71–72, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendation 9 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities providing healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Boise VA Medical Center 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 medical center leaders so that informed decisions can be made to improve care.[1]

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

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

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

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[5]
3. Quality, safety, and value (QSV)
4. Medical staff privileging

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

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

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

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

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

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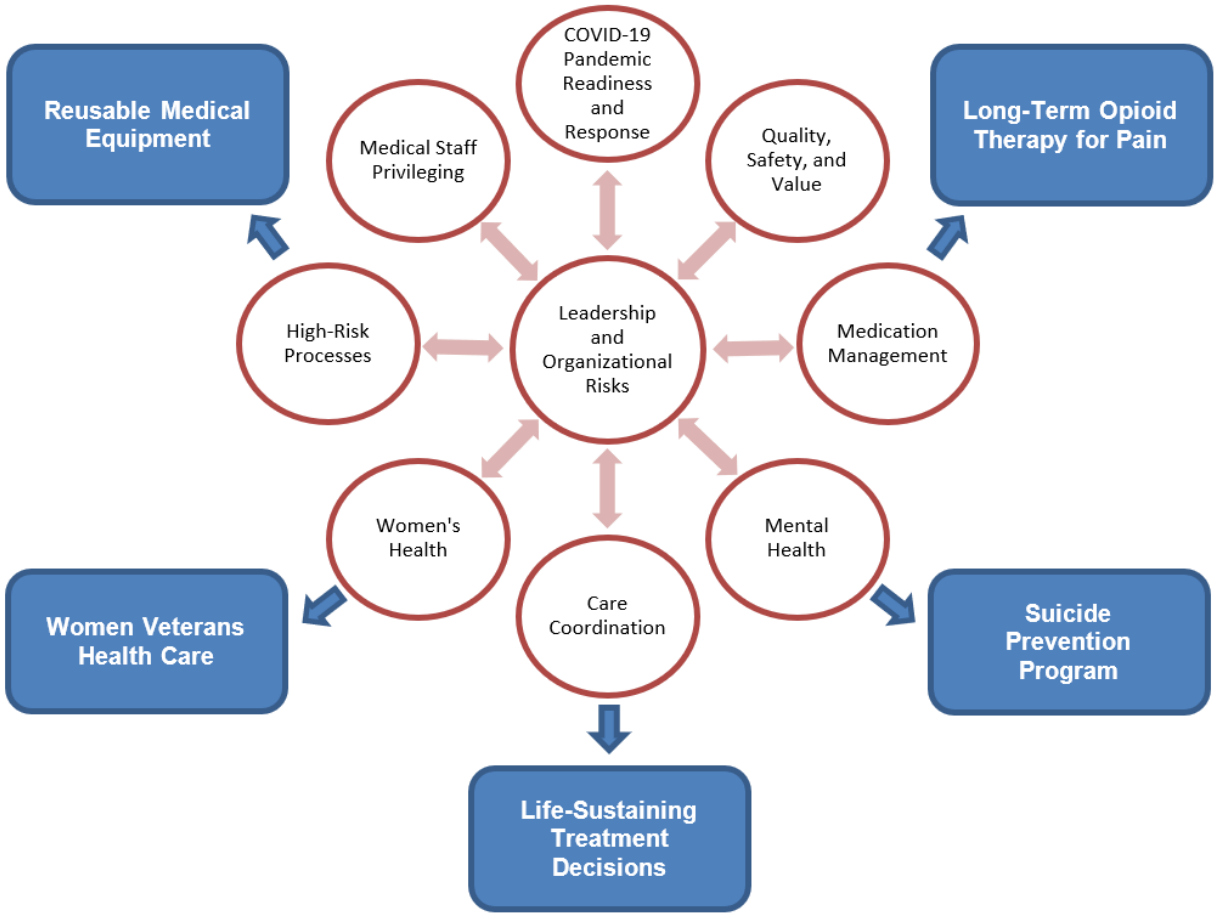

Figure 2. *Fiscal year (FY) 2020 comprehensive healthcare inspection of operations and services. Source: VA OIG.*

Methodology

The Boise VA Medical Center includes five outpatient clinics in Idaho and Oregon. Additional details about the types of care provided by the medical center can be found in appendixes B and C.

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

The inspection examined operations from October 29, 2016, through September 18, 2020, the last day of the unannounced multiday evaluation.[7] During the virtual site visit, the OIG did not receive any complaints beyond the scope of the inspection.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[9] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the medical center completes corrective actions. The Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that system leaders developed based on the reasons for noncompliance.

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

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

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

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

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

Results and Recommendations

Leadership and Organizational Risks

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

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation surveys and oversight inspections
5. Identified factors related to possible lapses in care and medical center response
6. VHA performance data (medical center)
7. VHA performance data (community living centers CLC))[11]

Executive Leadership Position Stability and Engagement

Because each VA medical center organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this medical center's reported organizational structure. At the time of the OIG virtual review, the medical center had a leadership team consisting of the acting Medical Center Director, Chief of Staff, Nurse Executive, and acting Associate Medical Center Director. The Chief of Staff and Nurse Executive oversee patient care, which requires managing service directors and chiefs of programs and practices.

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

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

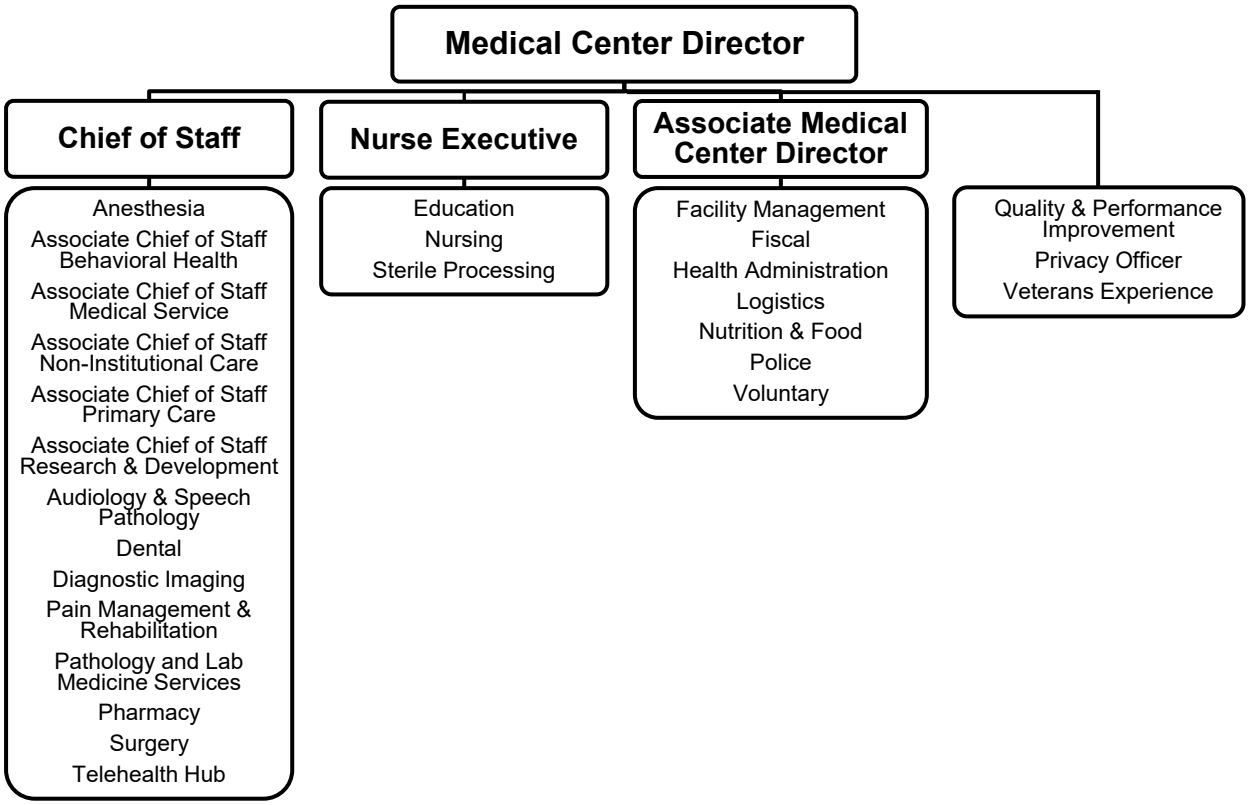

Figure 3. *Medical Center organizational chart.*

Source: Boise VA Medical Center (received September 14 and 18, 2020).

At the time of the OIG virtual site visit, the medical center leadership team had worked together for over three months. The Medical Center Director was detailed to serve as the Network 20 Director on June 1, 2020. As a result, on that same day, the Associate Medical Center Director was assigned as the acting Medical Center Director, and the Chief, Health Administration Service, was assigned as the acting Associate Medical Center Director. The Chief of Staff and Nurse Executive were permanently assigned in October 2016 and April 2020, respectively (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	April 22, 2012 (Permanent) June 1, 2020 (Acting)
Chief of Staff	October 30, 2016
Nurse Executive	April 12, 2020
Associate Medical Center Director	June 25, 2017 (Permanent) June 1, 2020 (Acting)

Source: VISN 20 Human Resources Officer and VISN 20 Human Resources Specialist (received September 14 and 16, 2020).

To help assess the medical center's executive leaders' engagement, the OIG interviewed the acting Medical Center Director, Chief of Staff, Nurse Executive, and acting Associate Medical Center Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

The executive leaders were generally knowledgeable based on their tenure and scope of responsibilities about VHA data and/or medical center-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. In individual interviews, reflective of their tenure and duties, the executive leadership team members were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

The Medical Center Director serves as the chairperson of the Executive Leadership Council, which has the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Council oversees various working groups such as the Clinical Executive, Nurse Executive, and Veteran Experience Boards.

These leaders monitor patient safety and care through the Quality Executive Board. The Quality Executive Board is responsible for tracking and trending quality of care and patient outcomes and reports to the Executive Leadership Council (see figure 4). According to medical center policy, the Medical Center Director is responsible for chairing the Quality Executive Board. However, the acting Medical Center Director was not aware of this requirement and had not chaired any Quality Executive Board meetings since assignment in June 2020.

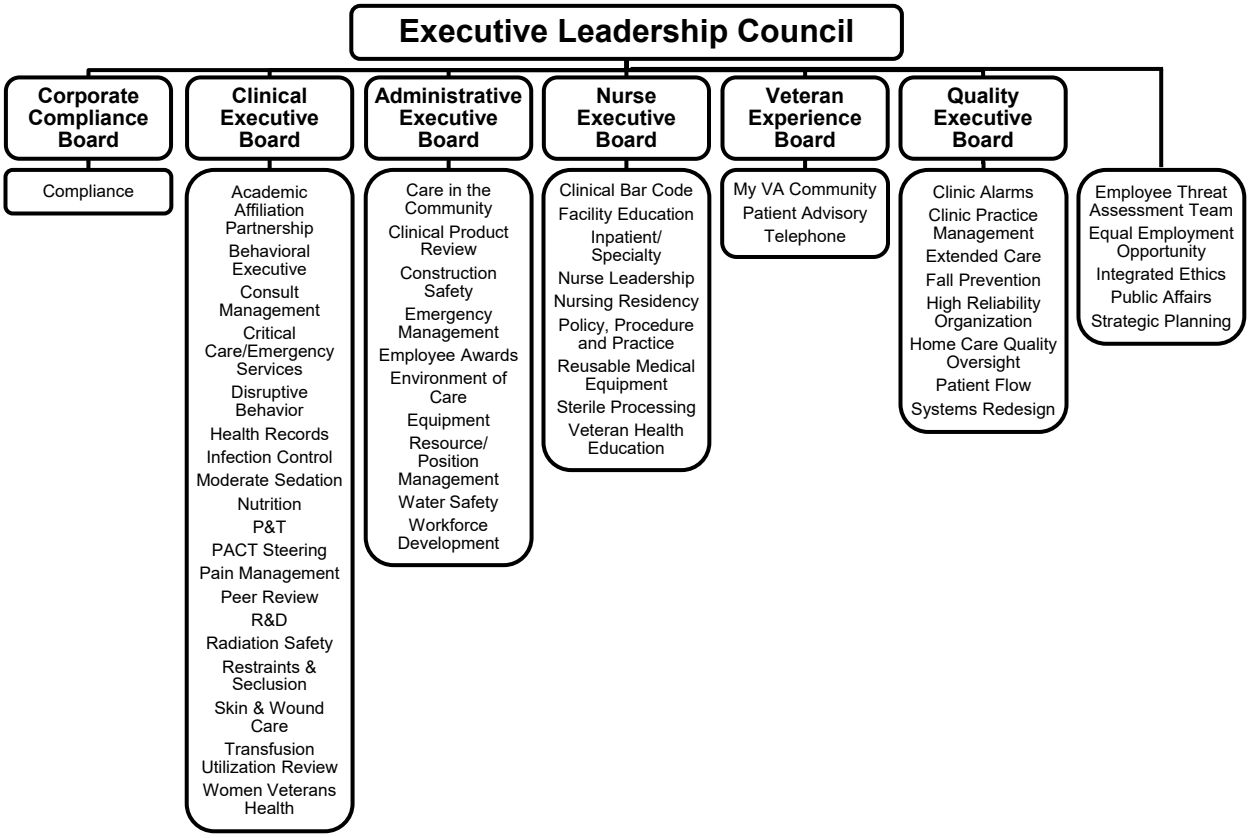

Figure 4. *Medical Center committee reporting structure.*

Source: Boise VA Medical Center (received September 14, 2020).

P&T = Pharmacy & Therapeutics
PACT = Patient Aligned Care Team
R&D = Research & Development

Employee Satisfaction

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

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

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

September 30, 2019.[13] Table 2 provides relevant survey results for VHA, the medical center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center average for the selected survey leadership questions was higher than the VHA average.[14] The Medical Center Director, Chief of Staff, and Associate Medical Center Director scores were consistently higher than those for VHA and the medical center, while the Nurse Executive's scores were consistently lower. However, the OIG notes that the 2019 All Employee Survey results are not reflective of employee satisfaction with the acting Medical Center Director, current Nurse Executive, or acting Associate Medical Center Director, who began their roles after the survey was administered.

The Chief of Staff reported that medical center leaders placed an emphasis on psychological safety, honesty, and responsiveness to staff needs. Leaders described having an open-door policy, consistently meeting with direct reports, and increasing their visibility throughout the medical center. The Nurse Executive informed the OIG that during the "Month of the Nurse", she visited all nursing units during all tours of duty to distribute food and recognition items.[15]

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Medical Center Director Average	Chief of Staff Average	Nurse Executive Average	Assoc. Medical Center Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	72.6	76.1	90.7	77.9	64.4	91.3

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

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

[15] "National Nurses Week Will Be Celebrated Throughout May," Frontier Nursing University, accessed May 4, 2021, https://frontier.edu/news/national-nurses-week-will-be-celebrated-throughout-may/. In 2020, the American Nurses Association expanded "National Nurses Week, traditionally celebrated from May 6 to May 12 each year, to a month-long celebration in May to expand opportunities to elevate and celebrate nursing."

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Medical Center Director Average	Chief of Staff Average	Nurse Executive Average	Assoc. Medical Center Director Average
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.4	3.6	3.7	3.6	2.9	4.7
All Employee Survey: My organization's senior leaders maintain high standards of honesty and integrity.	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.8	4.0	3.9	2.9	4.9
All Employee Survey: *I have a high-level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.8	4.1	3.9	2.9	4.8

Source: VA All Employee Survey (accessed June 23, 2020).

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

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[16] The medical center average for the selected survey questions was similar to the VHA average. Scores related to the Medical Center Director and Associate Medical Center Director were consistently better than those for VHA and the medical center. However, opportunities appear to exist for the Nurse Executive to improve employee feelings of moral

[16] Ratings are based on responses by employees who report to or are aligned under the Medical Center Director, Chief of Staff, Nurse Executive, and Associate Medical Center Director.

distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing).[17]

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Medical Center Director Average	Chief of Staff Average	Nurse Executive Average	Assoc. Medical Center Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.9	4.7	4.4	3.6	4.8
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at-risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.8	4.6	3.7	3.9	4.6
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day)	1.4	1.3	0.9	1.6	2.1	0.4

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

[17] The 2019 All Employee Survey results are not reflective of employee satisfaction with the acting Medical Center Director, current Nurse Executive, or acting Associate Medical Center Director, who began their roles after the survey was administered.

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients survey data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 4 provides relevant survey results for VHA and the medical center.[18] For this medical center, the patient survey results reflected higher care ratings than the VHA average. Patients appeared satisfied with their care experience.

The Chief of Staff shared that many medical center employees had worked their entire careers at the Boise VA Medical Center, so they were very invested in relationships with colleagues and veterans. Furthermore, the Chief of Staff reported focusing on meeting clinical needs to increase patient satisfaction, such as the expansion of cardiac catherization services. The acting Medical Center Director reported establishing the Veterans Experience Office, which is uniquely staffed with a registered nurse who can help address clinical issues.

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.3	76.3
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	89.7

[18] Ratings are based on responses by patients who received care at this medical center.

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	77.3	84.2
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	78.0	84.1

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

In 2015, women represented 9.4 percent of the total veteran population in the United States, and it is projected that women will represent 16.3 percent of living veterans by 2043. Further, from 2005 to 2015, the number of women veterans using VA health care increased by 46.4 percent, from almost 240,000 to 455,875.[19] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients' experiences by gender (see tables 5–7), including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG noted that overall results for male respondents were more favorable than corresponding VHA averages, while those for female inpatient respondents were consistently less favorable than VHA averages. However, female outpatient scores for Patient-Centered Medical Home and Specialty Care surveys were consistently better than VHA averages. Medical center leaders were not aware of the gender-based survey data and reported they had some work to do to bridge the disparity gap. Leaders reported having a standalone outpatient women's center, should women veterans wish for more privacy when receiving VA care.

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

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	82.8	87.5	72.4
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.8	83.1	88.3	71.7
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	68.7	61.8	77.2	57.4

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

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

†The medical center averages are based on 407–418 male and 18–19 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.2	43.3	60.8	65.2
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.9	49.7	69.2	57.6

Questions	Scoring	VHA*		Medical Center †	
		Male Average	Female Average	Male Average	Female Average
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.6	65.7	76.9	82.5

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

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

†The medical center averages are based on 508–1,339 male and 38–83 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Medical Center †	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.5	44.7	57.5	51.1
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	55.0	60.6	88.2
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	70.4	70.1	83.9	87.6

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

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

†The medical center averages are based on 396–1,174 male and 25–87 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[20] Table 8 summarizes the relevant medical center inspections most recently performed by the OIG and The Joint Commission (TJC).[21] Of note, at the time of the OIG virtual review, the medical center had closed all recommendations for improvement issued since the previous Clinical Assessment Program inspection conducted in October 2016.

At the time of the virtual review, the OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[22] Additional results included the Long-Term Care Institute's inspection of the medical center's CLC.[23]

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

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

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

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

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Clinical Assessment Program Review of the Boise VA Medical Center, Boise, Idaho*, Report No. 16-00557-134, March 8, 2017)	October 2016	5	0
TJC Hospital Accreditation	December 2018	23	0
TJC Behavioral Health Care Accreditation		2	0
TJC Home Care Accreditation		5	0

Source: OIG and TJC (inspection/survey results verified with an accreditation manager on September 15, 2020).

Identified Factors Related to Possible Lapses in Care and Medical Center Response

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a medical center, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms.

Table 9 lists the reported sentinel events and disclosures from October 24, 2016 (the prior OIG comprehensive healthcare inspection), through September 11, 2020.[24]

[24] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The OIG noted that the Boise VA Medical Center is a medium complexity (2) affiliated system as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." Lastly, in VHA Directive 1004.08, VHA defines a large-scale disclosure of adverse events (sometimes referred to as a "notification") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."

Table 9. Summary of Selected Organizational Risk Factors (October 24, 2016, through September 11, 2020)

Factor	Number of Occurrences
Sentinel Events	4
Institutional Disclosures	8
Large-Scale Disclosures	0

Source: Boise VA Medical Center Risk Manager, Patient Safety Manager, and Chief of Staff (received September 15, 2020).

VHA requires peer review for "[d]eath during or within 30 days after a surgical or invasive procedure including same day surgery/diagnostic procedure unless the death is clearly not related to the surgery, or (if after 30 days) death is suspected to be related to the original procedure."[25] During the review of institutional disclosures, the OIG identified two patients who experienced surgical complications in 2017. Although these events appeared to meet the criteria for peer review, the OIG determined that the reviews were not conducted. The Chief of Staff acknowledged that a peer review should have been completed on the patient who experienced an intraoperative hemorrhage with subsequent anoxic injury.[26] The Chief of Staff and Risk Manager reported that, due to human error, the peer review was not conducted. For the second patient, the Chief of Staff reported believing that a peer review may not have been required. However, during the OIG review, the Risk Manager reported initiating the peer review process for both cases.

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of

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

[26]. Merriam-Webster, "Definition of intraoperative," accessed March 1, 2021, https://www.merriam-webster.com/medical/intraoperative. Intraoperative is defined as something "occurring, carried out, or encountered in the course of surgery." Taber's Online, "Definition of hemorrhage," accessed March 1, 2021, https://www.tabers.com/tabersonline/view/Tabers-Dictionary/765242/all/hemorrhage. Hemorrhage is defined as "Loss of blood. The term is usually used for episodes of bleeding that last more than a few minutes, compromise organ or tissue perfusion, or threaten life." Merriam-Webster, "Definition of anoxia," accessed March 8, 2021, https://www.merriam-webster.com/dictionary/anoxia. Anoxia is "hypoxia [oxygen deficiency] especially of such severity as to result in permanent damage."

clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[27]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of March 31, 2020. Of note, figure 5 uses blue and green data points to indicate high performance for the Boise VA Medical Center (for example, in the areas of care transition, rating (of) specialty care (SC) provider, and patient-centered medical home (PCMH) care coordination). Metrics that need improvement are denoted in orange and red (for example, stress discussed, health care (HC) associated (assoc) infections, and mental health (MH) population (popu) coverage).[28]

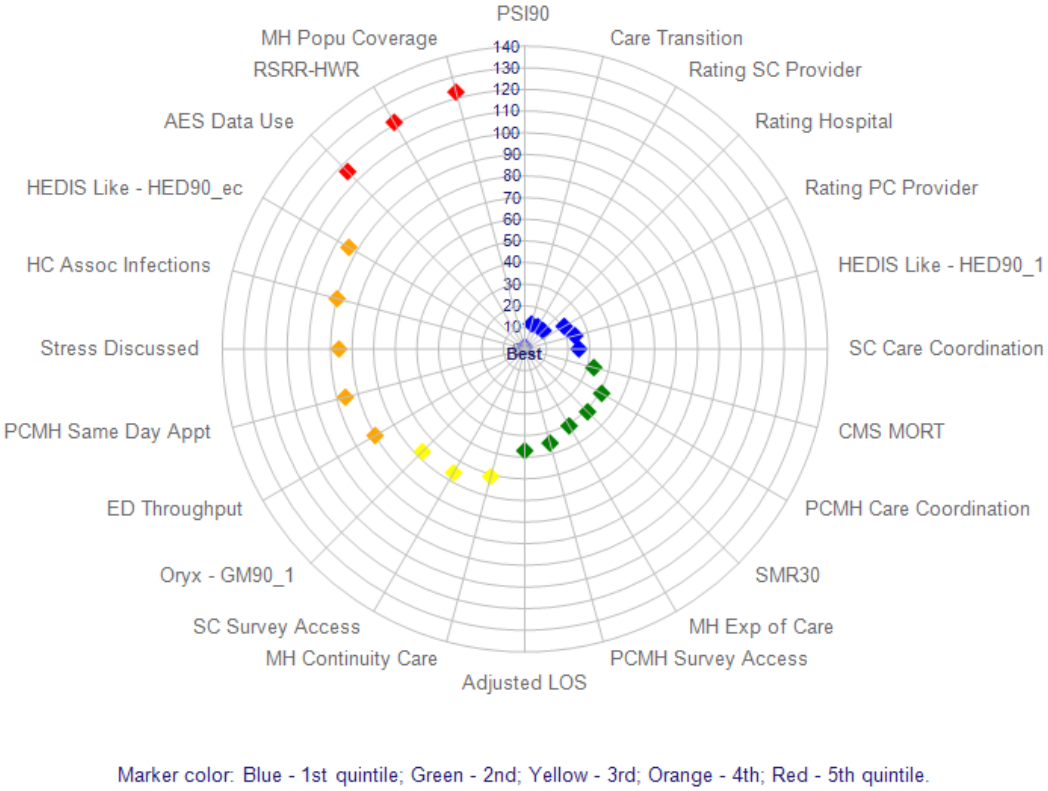

Figure 5. *Medical center quality of care and efficiency metric rankings, FY 2020 quarter 2 (as of March 31, 2020).*

Source: VHA Support Service Center.

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

[27] "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.)

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

Veterans Health Administration Performance Data for Community Living Centers

The CLC SAIL Value Model is a tool to "summarize and compare the performance of CLCs in the VA." The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[29]

Figure 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of March 31, 2020. Figure 6 uses blue and green data points to indicate high performance for the Boise CLC (for example, in the areas of urinary tract infections (UTI)–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), and improvement in function (SS)). Metrics that need improvement are denoted in orange and red (for example, moderate-severe pain (SS), high risk pressure ulcer (PU) (LS), and rehospitalized after nursing home (NH) admission (SS)).[30]

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

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

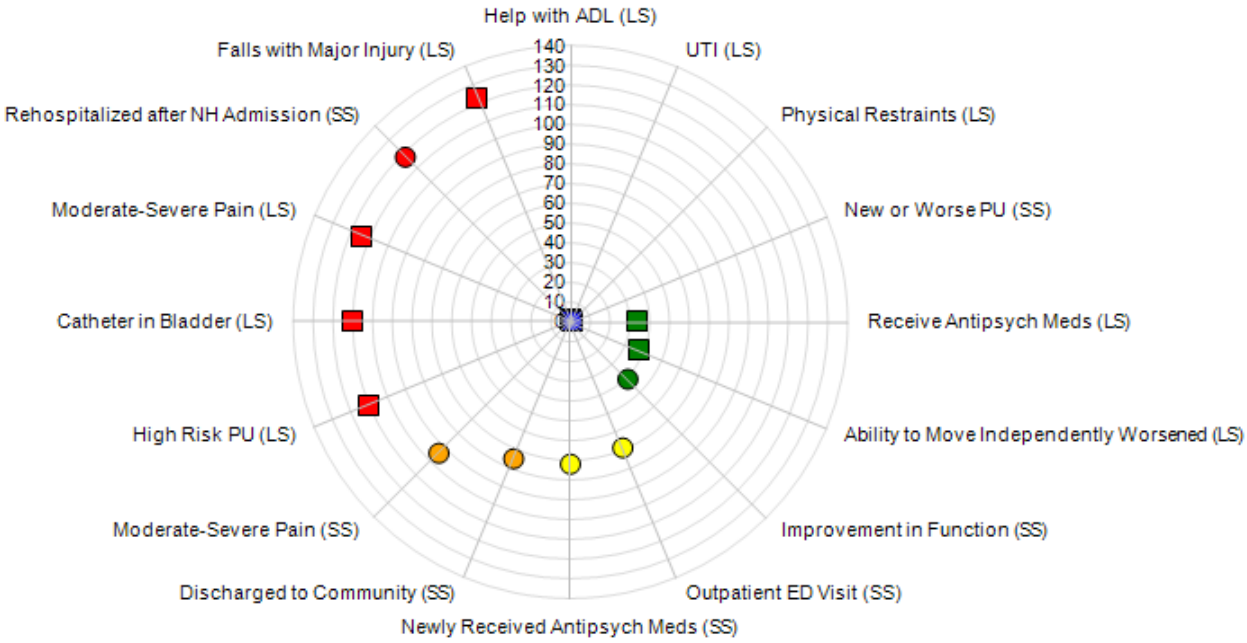

Figure 6. *CLC quality measure rankings, FY 2020 quarter 2 (as of March 31, 2020).*

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

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Conclusion

At the time of the OIG virtual review, the medical center leadership team consisted of the acting Medical Center Director, Chief of Staff, Nurse Executive, and acting Associate Medical Center Director. The leaders had worked together for over three months. The OIG found the medical center average for the selected survey leadership questions was similar to or better than the VHA average. Patient experience survey results for the medical center generally reflected higher care ratings than the VHA averages, and patients appeared satisfied with the care provided. However, gender-specific survey data revealed opportunities to improve the female inpatient care experience. The OIG's review of the medical center's accreditation findings, sentinel events, and large-scale disclosures did not identify any substantial organizational risk factors. During the review of institutional disclosures, the OIG identified surgical complications that were experienced by two patients who received care in 2017 and appeared to meet the criteria for peer review. Although reviews were not conducted at that time, the Risk Manager reported initiating the peer review process for both cases during the week of the OIG's virtual review. The executive leaders were generally knowledgeable, based on their tenure and scope of responsibilities, about VHA data and/or medical center-level factors contributing to specific

poorly performing SAIL measures and should continue their efforts to maintain and improve performance.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[31] 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.[32]

During this time, VA continued providing for veterans' healthcare needs and engaged its fourth mission, "the provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have eligibility to receive such care and services."[33] "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."[34]

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

- Emergency preparedness
- Supplies, equipment, and infrastructure
- Staffing
- Access to care
- CLC patient care and operations

The OIG also surveyed medical center staff to solicit their feedback and potentially identify any problematic trends and/or issues that may require follow-up. The results of the OIG's evaluation of the medical center's COVID-19 pandemic readiness and response were compiled and reported with other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[35]

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[31] "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.

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

[33] 38 U.S.C § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission for the provision of hospital care and medical services during certain disasters and emergencies : "During and immediately following a disaster or emergency…VA under 38 U.S.C §1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

[34] 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.

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.[36] 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.[37] 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."[38]

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

- Review of aggregated QSV data
- Recommendation and implementation of improvement actions
- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the medical center's processes for conducting protected peer reviews of clinical care.[39] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[40] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[41] The OIG team examined the completion of the following elements:

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

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

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

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

[40] VHA Directive 1190.

[41] VHA Directive 1190.

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[42]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Next, the inspection team assessed the medical center's utilization management (UM) program, a key component of VHA's framework for quality, safety, and value, which provides vital tools for managing the quality and the efficient use of resources.[43] It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[44] Inspectors reviewed several aspects of the UM program:

- Completion of at least 80 percent of all required inpatient reviews
- Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
- Interdisciplinary review of UM data
- Implementation and monitoring of improvement actions recommended by the interdisciplinary UM group

Finally, the OIG reviewers assessed the medical center's reports of patient safety incidents with related root cause analyses.[45] Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root

[42] VHA Directive 1190.

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

[44] VHA Directive 1117(2).

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

cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the medical center.[46] The medical center was assessed for its performance on several dimensions:

- Annual completion of a minimum of eight root cause analyses[47]
- Inclusion of required content in root cause analyses
- Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
- Provision of feedback about root cause analysis actions to reporting employees
- Submission of an annual patient safety report to medical center leaders

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents.[48]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for QSV oversight functions, peer review, and patient safety elements. However, the OIG identified a weakness in UM processes.

At the time of the virtual review, VHA required the Medical Center Director to ensure that an interdisciplinary group review UM data on an ongoing basis. This group was to include, but not be limited to, "representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR [Chief Business Office Revenue-Utilization Review]."[49] The OIG found that from January 1 through December 31, 2019, the Patient Flow Committee—which is responsible for reviewing UM data—did not have a chief business office revenue-utilization review representative. As a result, the committee performed reviews and analyses without the perspective of a key discipline. The Associate Chief of Staff, Non-Institutional Care, who was the Patient Flow Committee chair, reported intentionally not inviting a chief business office revenue-utilization review representative because the department's goals did not align with the goals of the Patient Flow Committee. On October 8, 2020, VHA changed the

[46] VHA Handbook 1050.01.

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

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

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

requirement. Under the new requirement, the Medical Center Director ensures that the review of UM data is completed by "a multidisciplinary committee, which may include representatives from" various services.[50] Therefore, the OIG made no recommendation.

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

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[51]

Clinical privileges need to be specific and based on the individual practitioner's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[52]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance." The FPPE process occurs when a provider is hired at the facility and granted initial privileges and before any new clinical privileges are granted. Additionally, VA facilities must continuously monitor the performance of their providers. VHA requirements state that "the on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered."[53] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[54]
  - Clear documentation of the results and time frames
  - Evaluation by another provider with similar training and privileges
- OPPEs
  - Application of criteria specific to the service or section
  - Use of minimum criteria for selected specialty LIPs[55]
  - Evaluation by another provider with similar training and privileges

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

[52] VHA Handbook 1100.19.

[53] VHA Handbook 1100.19.

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

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

The OIG determined whether service chiefs recommended continuing the LIPs' current privileges based in part on the results of OPPE activities and if the medical center's Executive Committee of the Medical Staff (known as the Clinical Executive Board) decided to recommend continuing privileges based on FPPE and OPPE results.

VA must put processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former licensed practitioner's clinical practice, VA has an obligation to notify state licensing boards (SLBs) and subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[56] Further, "VA medical facility Directors must designate an individual, and backup, to be responsible for the SLB reporting process. This individual will be the subject matter expert (SME) for the facility…and ensure oversight of the exit review process, including receipt, review, and maintenance of the Provider Exit Review Forms."[57] The OIG reviewers assessed whether the medical center's staff

- Designated an individual and backup responsible for the SLB reporting process,
- Completed forms within the required time frame and with required oversight, and
- Reported results to SLBs when indicated.

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

- Two solo/few practitioners who underwent reprivileging during calendar year 2019[58]
- Six LIPs who completed an FPPE in calendar year 2019
- Six LIPs privileged during calendar year 2019
- Eleven LIPs who left the medical center in calendar year 2019

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

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

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

Medical Staff Privileging Findings and Recommendations

The OIG found general compliance with requirements for most of the above performance indicators. However, the OIG identified a deficiency in the provider exit review process.

At the time of the OIG's review, VHA required the Medical Center Director to ensure that provider exit review forms, which document the review of a provider's clinical practice, be "completed within 7 calendar days of the departure of a licensed health care professional from a VA facility."[59] However, as of January 28, 2021, VHA requires the Medical Center Director to ensure that exit forms are completed within 7 business days.[60] For the 11 providers who departed the medical center in calendar year 2019, the OIG found that 5 exit review forms were not completed within the required time frame. Failure to complete a provider exit form within the specified time frame could have resulted in delayed SLB reporting of healthcare professionals who provided a substandard quality of care. The Lead Credentialing Support Assistant reported that credentialing staff changes caused a delay in notifying supervisors that provider exit forms required completion.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain a licensed healthcare professional's first- or second-line supervisor completes provider exit review forms within seven business days of professionals' departure from the medical center.

Medical center concurred.

Target date for completion: July 31, 2021

Medical center response: The Medical Center Director, Chief of Staff, and Lead Credentialing Support Assistant, who reports to the Chief, Quality & Performance Improvement, evaluated the deficiency and identified additional reasons for noncompliance with exit reviews not being completed within the required time frame as outlined in VHA Directive 1100.19.

Upon evaluation, it was identified that exit reviews for Licensed Independent Practitioners do not occur frequently. To ensure exit reviews are completed within seven business days, a multipronged quality improvement process was implemented that includes education, tracking, reminders, and follow-up. Staffing turnover in Medical Staff Credentialing that may have contributed to the noncompliance was also addressed through the VA's Workforce Modernization initiative.

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

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

Education on the time requirements to complete exit reviews was provided to Medical Staff Credentialing members on September 29, 2020 by the Lead Credentialing Support Assistant, who was the acting supervisor for Medical Staff Credentialing at that time. The Lead Credentialing Support Assistant provided education to the service chiefs who report to the Chief of Staff and are the members of the Professional Standards Board on October 9, 2020 and sent a follow up email to the members and their Administrative Officers on February 24, 2021. To track the timeliness of exit reviews, the Lead Credentialing Support Assistant developed and implemented a tracking sheet to monitor the process. To ensure that all first and second line supervisors who conduct the exit reviews are aware of the timeline requirements, the Lead Credentialing Support Assistant developed and implemented a standardized email reminder with the exit review form attached that is sent directly to the supervisor who is responsible for conducting the exit review. Once the completed exit review is received in Medical Staff Credentialing, it is recorded on the tracking sheet.

The Professional Standards Board is a longstanding, chartered board reporting to the Clinical Executive Board but was inadvertently left off the facility governance structure document. The Professional Standards Board membership consists of service chiefs for all services organized under the Chief of Staff per the facility organizational chart plus the service chiefs of psychiatry, social work, psychology, and the interim medical director for the Community Living Center.

Credentialing & Privileging staff turnover was identified during the OIG review as a factor in exit review noncompliance. This has been addressed through the VHA Credentialing and Privileging Workforce Modernization initiative that was instituted by December 31, 2020. The initiative aligned the Medical Staff Credentialing department under [the] Chief of Staff, rewrote position descriptions for all credentialing staff, increased General Service wage grades for staff and supervisors, created additional roles within the department, and many other improvements. Since this was fully implemented in December 2020, Medical Staff Credentialing has not had any staff turnover.

The Accreditation Manager is responsible for conducting the compliance audits for this recommendation. Audits are conducted monthly. The denominator definition for the measure is the total number of Licensed Independent Practitioners who departed during the quarter. The numerator definition is the total number of Licensed Independent Practitioner exit reviews that were completed within seven business days during the quarter. Audit results are reported, by the Accreditation Manager, quarterly to the Quality Executive Board of which the Medical Center Director is the Chair. Compliance will be measured and reported quarterly until 90 percent or greater compliance is met for two consecutive quarters.

`Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[61] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[62] Long-term opioid use is of particular concern in the veteran population where there is a high incidence of posttraumatic stress disorder, major depressive disorder, alcohol use, substance abuse, and suicide attempts.[63] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[64]

VHA requires routine assessments of pain and the completion of an opioid risk assessment before initiating patients on long-term opioid therapy and recommends against the therapy for patients with untreated substance use disorders. VHA also recommends avoiding drugs capable of inducing fatal interactions, such as opioids with benzodiazepines.[65] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[66] To achieve VHA's vision of providing patient-driven healthcare, providers are also required to obtain informed consent from patients and to provide education about the risks, benefits, and alternatives prior to initiating long-term opioid therapy.[67] VHA recommends evaluating patients receiving continued opioid therapy for improvement of pain and opioid-related adverse events at least every three months and more frequently as doses increase.[68]

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

- Completion of initial screening for pain
- Assessment of aberrant behavior risk
- Avoidance of concurrent therapy with benzodiazepines
- Completion of urine drug testing with intervention, when indicated

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

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

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

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

[65] "Benzodiazepines, Street Names: Benzos, Downers, Nerve Pills, Tranks," U.S. Drug Enforcement Administration, accessed December 1, 2019, https://www.deadiversion.usdoj.gov/drug_chem_info/benzo.pdf. Benzodiazepines "are a class of drugs that produce central nervous system (CNS) depression and that are most commonly used to treat insomnia and anxiety."

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

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

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

- Documentation of informed consent
- Timely follow-up with patients included required elements

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures include, but are not limited to, "adherence to published clinical practice guidelines, timeliness of pain treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment…patient satisfaction, physical and psychosocial functioning, and quality of life."[69] The OIG examined indicators for program oversight and evaluation:

- Performance of pain management committee activities
- Monitoring of quality measures
- Following the quality improvement process

The OIG interviewed key employees and managers and reviewed relevant documents and the electronic health records of 22 selected outpatients who had newly-dispensed (no VA dispensing in previous six months) long-term opioids for pain, daily or intermittently for 90 or more calendar days through VA from July 1, 2018, through June 30, 2019. The team considered whether providers acted in accordance with guidelines for the provision of pain management and the medical center's oversight process for evaluating pain management outcomes and quality.

Medication Management Findings and Recommendations

The medical center complied with some of the indicators of expected performance, including pain screening, documented justification for concurrent therapy with benzodiazepines, and informed consent. However, the OIG identified deficiencies with aberrant behavior risk assessments, urine drug testing, patient follow-up, and quality measure oversight.

VA/DoD clinical practice guidelines recommend completion of an aberrant behavior risk assessment that includes a history of untreated substance abuse and aberrant drug-related behaviors prior to initiating long-term opioid therapy.[70] The OIG found that providers did not complete an aberrant behavior risk assessment for 64 percent of the patients reviewed.[71] This may have resulted in providers prescribing opioids for patients at high risk for misuse. The Chief, Anesthesia Service, who chairs the Pain Management Committee, attributed

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

[70] *Pain Management, Opioid Safety, VA Educational Guide* (2014), July 2014. Examples of aberrant drug related behaviors include "lost prescriptions, multiple requests for early refills, unauthorized dose escalation, apparent intoxication, and frequent accidents." *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain* Version 3.0. February 2017.

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

noncompliance to the lack of a standardized electronic health record template to capture the required components of long-term opioid therapy documentation.

VA/DoD clinical practice guidelines state that providers "should obtain UDT [urine drug testing] prior to initiating or continuing LOT [long-term opioid therapy] and periodically thereafter."[72] The OIG found that providers did not conduct initial urine drug testing for 27 percent of patients, based on electronic health records reviewed.[73] This may have resulted in providers' inability to identify whether patients adhered to opioid therapy or determine potential drug diversion. The Chief, Anesthesia Service and the Associate Chief of Staff, Primary Care reported that medical center providers followed VISN guidance, which required yearly urine drug testing.

VA/DoD practice guidelines also recommend that providers evaluate the "benefits of continued opioid therapy and risk for opioid-related adverse events at least every three months."[74] The OIG found that 32 percent of patients' electronic health records lacked evidence of follow-up care every three months after long-term opioid therapy initiation.[75] Failure to conduct follow-up visits may have resulted in missed opportunities to assess adherence to the therapy plan and effectiveness of treatment, or discuss the risks of continued opioid therapy. The Chief, Anesthesia Service and the Associate Chief of Staff, Primary Care reported believing the requirement was met when providers evaluated patients prior to initiating long-term opioid therapy.

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

VHA requires the medical center to have a multidisciplinary pain management committee to "provide oversight, coordination, and monitoring of pain management activities and processes" and monitor the "quality of pain assessment and the effectiveness of pain management interventions."[76] The OIG reviewed the Pain Management Committee meeting minutes from July 1 through December 31, 2019, and found no evidence that the committee monitored the quality of pain assessment or effectiveness of pain management interventions. This resulted in the committee's inability to identify deficiencies or provide recommendations to medical center leaders. The Chief, Anesthesia Service acknowledged a lack of awareness of the committee's responsibility to monitor the required measures.

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

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

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

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

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

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Pain Management Committee monitors the quality of pain assessment and effectiveness of pain management interventions.

Medical center concurred.

Target date for completion: October 1, 2021

Medical center response: The Chief of Staff and the Chief, Anesthesia Service evaluated the deficiency and identified additional reasons for noncompliance with the monitoring of quality of pain assessment and effectiveness of pain management interventions. During the OIG CHIP review, the Chief Anesthesia Service, as Acting Chair of the Pain Management Committee, was educated to the committee responsibilities for monitoring quality of pain assessments and the effectiveness of pain management interventions as required by VHA Directive 2009-053.

Upon further evaluation it was identified, by the committee Acting-Chair, that the Pain Management Committee did not include committee responsibilities for quality monitoring. To resolve the deficiency, members of the Pain Management Committee updated the charter to include committee responsibilities for review of metrics and quality indicators pertinent to pain management and opioid safety. Captured metrics now include, but are not limited to, monitoring for the quality of pain assessments and effectiveness of pain management interventions. The revised charter was approved by the Clinical Executive Board on January 28, 2021. Quality of pain assessments monitor results are scheduled to be reported to the Pain Management Committee, by the committee Co-Chair, quarterly starting March 2021. Effectiveness of pain interventions monitor results are scheduled to be reported quarterly to the Pain Management Committee, by the committee Co-Chair, starting April 2021.

In March of 2021, the Accreditation Manager initiated compliance auditing for each measure. The Pain Management Committee meeting minutes are audited monthly to monitor for compliance with the committee monitoring and reporting for:

1) Quality of pain assessments at a minimum frequency of once per quarter.

2) Effectiveness of pain interventions at a minimum frequency of once per quarter.

The denominator definition for each independent measure is the total number of reports due in the quarter. The numerator definition for each independent measure is the total number of reports presented in the quarter. The Accreditation Manager will report audit results, for each measure, quarterly to the Quality Executive Board, of which the Chief of Staff is a voting member. Compliance will be measured and reported monthly until 90 percent or greater compliance is met for two consecutive quarters.

Mental Health: Suicide Prevention Program

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[77] The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018. However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[78]

VHA has identified suicide prevention as a top priority and implemented various evidence-based approaches to reduce the veteran suicide rate. In addition to expanded mental health services and community outreach, VHA has developed comprehensive screening and assessment processes to identify at-risk patients.[79]

VHA requires that each medical center and very large community-based outpatient clinic (CBOC) have a full-time suicide prevention coordinator (SPC) to track and follow up with high-risk veterans, develop a process for responding to referrals from hotlines such as the Veteran Crisis Line, and conduct community outreach activities.[80] The OIG examined various requirements related to SPCs:

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

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

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

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

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

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

in his or her electronic health record "as soon as possible but no later than 1 business day after such determination by the SPC."[81] According to VHA, "Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death…The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions."[82] The HRS PRF is reviewed at least every 90 days and depending on changes to the suicide risk status, will remain active or be removed.[83] Additionally, VHA requires designated high-risk patients to have a completed suicide safety plan and four face-to-face visits with an acceptable provider within the first 30 days of designation.[84]

The OIG noted that from July 1, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA required that "Any patient determined to be High Risk for Suicide [by the licensed independent provider] must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination."[85] However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management changed the requirement for the HRS PRF placement to be "as soon as possible but no later than 1 business day after determination by the SPC."[86] VHA further provided additional clarifying information:

- The "SPC exclusively controls the HRS PRF and must limit their use to patients who meet the criteria of being placed on the facility high-risk suicide list."
- "The time frame of placing the flag begins once the SPC makes the determination that an HRS PRF is warranted."
- The SPC's determination process "may be beyond 24 hours after a referral, due to case consultation and review."[87]

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

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

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

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

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

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

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

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

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

On March 27, 2020, VHA also updated existing policy requirements to allow the review of an HRS PRF to "occur no earlier than 10 days before and no later than 10 days after the 90-day due date."[88]

Inspectors examined the completion of several requirements:

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

All VHA employees must complete suicide risk and intervention training within 90 days of entering their position. Clinical staff (including physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and Vet Center counselors) must complete Suicide Risk Management Training for Clinicians, and nonclinical staff must complete Operation S.A.V.E. training.[89] VHA also requires that all staff receive annual refresher training.[90] In addition, SPCs are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[91]

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

- Relevant documents;

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

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

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

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

- The electronic health records of 34 outpatients whose electronic health records were flagged as high risk for suicide from July 1, 2018, to June 30, 2019; and
- Staff training records.

Mental Health Findings and Recommendations

The OIG found the medical center had complied with requirements for the designation of an SPC, tracking and follow-up of high-risk veterans, and the provision of suicide prevention training for nonclinical employees at new employee orientation. However, the OIG found deficiencies.

With VHA's original requirement that was in place when these patients received care—that "Any patient determined to be High Risk for Suicide must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"[92]—the OIG determined that 21 percent of HRS PRFs were not placed within 24 hours of referral to the SPC.[93] Based on the current updated requirement that the SPC be responsible for determining placement of the HRS PRF (without a defined time frame for doing so), the OIG further calculated that the average time from referral to HRS PRF placement for the patients reviewed was 2 days (observed range was 0–7 days).[94]

Further, the OIG noted concerns with reviewing HRS PRFs within the required time frame. VHA required that the Medical Center Director ensure that all patients with an HRS PRF be reevaluated at least every 90 days.[95] The OIG found that six percent of patients with an HRS PRF were not reevaluated at least every 90 days.[96] However, based on the updated requirement that the SPC ensure HRS PRFs are reviewed up to 10 days prior to or after the due date for reevaluation, the OIG found that clinical staff reviewed all patients within the new time frame (observed range was 80–99 days).[97]

Additionally, the OIG noted concerns with monthly outreach activities and annual suicide prevention refresher training.

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

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

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

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

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

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

VHA requires the SPC to conduct five suicide prevention community outreach activities each month.[98] The OIG found that from October 1, 2019, through December 31, 2019, the SPC did not conduct the required five outreach activities per month. Failure to provide outreach could limit veterans' awareness of VA mental health programs and services. The SPC reported that required program responsibilities such as direct patient care, provider consultation, and assistance with HRS patients took priority over suicide prevention outreach. Additionally, the SPC reported that it was difficult to find community outreach locations during holiday months.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Suicide Prevention Coordinator conducts at least five suicide prevention outreach activities per month.

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

Medical center concurred.

Target date for completion: July 31, 2021

Medical center response: The Chief of Staff, Associate Chief of Staff Behavioral Health, and the facility Suicide Prevention Program Coordinators evaluated the deficiency and identified additional reasons for noncompliance. As noted during the time of the review, concerns related to the time involvement for delivering patient care-especially for those identified to be high risk, consulting with providers and limited outreach opportunities were confirmed as reasons for non-compliance. Upon deeper evaluation by the facility, underlying causes to the previously identified reasons were identified. Those causes included lack of coordination of scheduling of outreach activities between the two Suicide Prevention Program Coordinators and identification that not all types of activities that qualify as outreach were being captured in the tracking of outreach activities. To resolve the deficiency, the facility Suicide Prevention Program Coordinators implemented a shared calendar on December 1, 2020 to improve visibility of scheduled and completed activities meeting the outreach criteria that occur each month. The Suicide Prevention Program Coordinators utilize the shared calendar to communicate and ensure coverage during situations when one coordinator may have a priority patient care need arise that conflicts with their ability to complete the outreach.

In December of 2020, the Accreditation Manager initiated monthly compliance auditing. The audit evaluates if five or more outreach activities were completed during the month. The denominator is the total number of outreach activities scheduled during the month. The numerator is the total number of outreach activities performed each month. Audit results are being reported quarterly by the Accreditation Manager, starting February 24, 2021, to the Quality Executive Board of which the Chief of Staff is a voting member. Compliance will be measured and reported until 90 percent or greater compliance is met for six consecutive months.

VHA requires that all staff complete annual suicide prevention refresher training.[99] The OIG found that 7 of 20 staff did not complete the required annual training within 365 days. Failure to complete training requirements could lead to suboptimal interventions for patients at risk for suicide. The Associate Chief of Staff for Behavioral Health and the Nurse Executive reported a lack of awareness of the annual requirement.

Recommendation 4

4. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that all staff complete annual suicide prevention refresher training.

[99] VHA Directive 1071.

Medical center concurred.

Target date for completion: August 31, 2021

Medical center response: The Medical Center Director, Nurse Executive, Talent Management System Domain Manager, and Suicide Prevention Program Coordinators evaluated the deficiency and did not identify any additional reasons for noncompliance. Processes have been implemented to monitor staff whose suicide prevention refresher training is nearing the 365-day expiration. Each month, starting January 2021, Suicide Prevention Program Coordinators receive a Talent Management System report identifying employees that are deficient in completing, or are nearing expiration of, required suicide prevention training modules. On March 8, 2021, Suicide Prevention Program Coordinators implemented procedures to communicate the pending expiration report to facility service chiefs and supervisors. The intent of this email communication is to ensure service chief/supervisor awareness of staff suicide prevention training status and directs supervisors to follow-up with identified staff to ensure completion of the required training modules.

In February of 2021, the Accreditation Manager initiated monthly compliance auditing. The audit monitors for compliance with timely completion of suicide prevention refresher training, to ensure no employee without an extenuating circumstance, such as a leave of absence, has failed to complete the required training within the required timeframe(s). Employees who were identified to have an extenuating circumstance will be given a 30-day grace period before being considered non-compliant upon their return. For this measure, the denominator definition is the total number of suicide prevention refresher training modules assigned. The numerator is the total number of suicide refresher training modules compliant. Audit results are reported quarterly by the Accreditation Manager, starting May 26, 2021, to Quality Executive Board of which the Medical Center Director is the chair. Compliance will be measured and reported until 90 percent or greater compliance is met for six consecutive months.

Care Coordination: Life-Sustaining Treatment Decisions

Life-sustaining treatments (LSTs) are intended to extend the life of a patient expected to die soon without medical intervention. LSTs may include artificial nutrition, hydration, and mechanical ventilation. VHA issued the life-sustaining treatment decision (LSTD) handbook to standardize practices related to discussing and documenting goals of care and LSTDs. Per VHA, the goal is to encourage personalized, proactive, patient-driven treatment plans for veterans with serious illness by "eliciting, documenting, and honoring patients' values, goals, and preferences."[100]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD handbook by July 12, 2018.[101] Implementation requirements included initiating conversations about the goals of care. A goals of care conversation is a discussion between a healthcare provider and a patient or surrogate to help define the patient's values, goals, and preferences for care and, based on the discussion, make choices about starting, limiting, or ceasing LSTs.[102] VHA requires practitioners to initiate goals of care conversations with high-risk patients—including hospice patients or their surrogates—within a time frame that meets the medical needs of the patient or at the time of a triggering event.[103]

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

- Decision-making capacity,
- Identification of a surrogate if the patient loses decision-making capacity,
- Patient or surrogate understanding of the patient's condition,
- Goals of care,
- Plan of care for the use of LST, including whether cardiopulmonary resuscitation will be attempted in the event of cardiac arrest, and
- Informed consent for the LST plan.

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

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

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

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

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

- Decision-making capacity,
- Goal(s) of care,
- Plan of care for the use of LST, and
- Informed consent for the LST plan.

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

The medical center was assessed for its adherence to requirements for goals of care conversations:

- Completion of LSTD notes
- Timely documentation of LSTD
- Inclusion of required elements in LSTD documentation
- Completion of LSTD note/orders by an authorized provider or delegation to a designee met all requirements

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[104] Inspectors examined if the medical center established an LSTD committee that was comprised of a multidisciplinary membership, which included representation from the Ethics Consultation Service, and reviewed proposed LST plans.

To determine whether the medical center complied with the OIG-selected requirements related to LSTD for hospice patients, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 46 randomly selected hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

[104] VHA Handbook 1004.03(1).

Care Coordination Findings and Recommendations

The medical center generally complied with requirements for the LSTD committee and supervision of designees. However, the OIG found a deficiency with practitioners completing LSTD progress notes.

VHA requires that practitioners "document the patient's goals of care and LST plan."[105] The OIG estimated that practitioners did not complete LSTD progress notes for 48 percent of patients, based on the electronic health records reviewed.[106] Failure to complete LSTD progress notes may prevent patients from having their "values, goals, and preferences regarding the initiation, limitation or discontinuation of LSTs" identified and met.[107] The Interim Medical Director, Geriatrics and Palliative Care and the Hospice Program Manager attributed the noncompliance to a lack of practitioner education on the documentation requirements.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures practitioners complete life-sustaining treatment decision progress notes.

[105] VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017 was in effect at the time of this review and was amended to VHA Handbook 1004.03(1) on March 19, 2020. Both versions reflect the similar requirement language.

[106] The OIG is 95 percent confident that the true compliance rate is somewhere between 37.5 and 66.3 percent, which is statistically significantly below the 90 percent benchmark.

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

Medical center concurred.

Target date for completion: January 21, 2022

Medical center response: The Chief of Staff and Interim Medical Director Geriatrics and Palliative Care, who reports to the Chief, Medicine evaluated the deficiency and did not identify any additional reasons for noncompliance. A national update to the required Life Sustaining Treatment template was implemented in April 2021. In addition, the Clinical Application Coordinator added a reminder to the Hospice/Palliative Care Consult to enter a Life Sustaining Treatment Decision note prior to submitting the request for consult. The former Interim Chief Geriatrics and Palliative Care, and current Community Living Center Medical Director, is the medical center's subject matter expert for LST. The Community Living Center Medical Director will provide educational materials to providers who request Hospice/Palliative Care consults on the requirements for entering a Life Sustaining Treatment Decision progress note, prior to submitting the request for consult, to supplement the updated template in the electronic health record. Target for educational material distribution is July 2021.

The Accreditation Manager is responsible for conducting the compliance audit for this recommendation. Compliance audits will be conducted monthly and initiated upon completion of provider educational material distribution. Target for audit implementation is August 2021. The denominator definition is the total number of patients who have had an inpatient, or outpatient, Hospice/Palliative Care consult completed during the month. The numerator definition is the total number of patients who have had an inpatient, or outpatient, Hospice/palliative Care consult completed that also have the required Life Sustaining Treatment progress note documented. Audit results will be reported, by the Accreditation Manager, monthly to the Quality Executive Board of which the Chief of Staff is a voting member. Compliance will be measured and reported quarterly until 90 percent or greater compliance is met for six consecutive months.

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[108] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans are anticipated to increase.[109] To help the VA better understand the needs of the growing women veterans population, efforts have been made by VHA to identify and address the urgent needs "by examining health care use, preferences, and the barriers Women Veterans face in access to VA care."[110] Additionally, a VA report in 2016 on suicide among veterans pointed out concerning trends in suicide among women veterans and discussed "the importance of understanding suicide risk among women veterans and developing gender-tailored suicide prevention strategies."[111]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment. Facilities must, therefore, ensure availability of appropriate resources, services, and staffing ratios.[112] VHA also requires delivery of quality care to all women veterans accessing VA emergency services. In addition, VHA requires facilities to establish a multidisciplinary women veterans health committee that "develops and implements a Women's Health Program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans."[113]

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

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

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

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

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

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

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

[113] VHA Directive 1330.01(3).

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

Women's Health Findings and Recommendations

The medical center complied with requirements for some of the performance indicators reviewed. However, the OIG identified deficiencies in gynecologic care coverage, designated CBOC women's health primary care providers, Women Veterans Health Committee meeting attendance, and women veterans program manager duties.

VHA requires the Chief of Staff to ensure that the medical center has a process "in place for 24 hours per day and 7 days per week (24/7) for ED [Emergency Department] and facility call coverage for gynecologic care."[114] The OIG determined the medical center did not provide 24/7 coverage for gynecological care in the Emergency Department, have a specific written referral process, or have a written gynecologic care call coverage schedule. This could have resulted in limited access to quality comprehensive women's healthcare. The Associate Chief of Staff, Primary Care stated that Emergency Department providers consulted local community gynecology on-call physicians when the sole medical center gynecologist was not available.

[114] VHA Directive 1330.01(2), *Health Care Services for Women Veterans,* February 15, 2017, amended July 24, 2018. (This directive was in place for the review period in this report. It was amended on June 29, 2020, and again on January 8, 2021. The directives contain the same or similar language regarding the gynecologic care coverage.)

Additionally, the Associate Chief of Staff, Primary Care reported that when emergent/urgent gynecologic care is needed, the patient is transferred to local community physicians in accordance with community care guidance and the medical center's inter-facility transfer process.

Recommendation 6

6. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that processes and procedures are in place for 24 hours a day, 7 days per week Emergency Department and medical center call coverage for gynecologic care.

Medical center concurred.

Target date for completion: August 31, 2021

Medical center response: The Chief of Staff, Women Veterans Program Manager, Emergency Department Supervisory Physician, and Associate Chief of Staff Primary Care evaluated the deficiency and did not identify any additional reasons for noncompliance. The medical center has a sole gynecologist on staff and therefore it is not feasible to establish a formal call coverage schedule for gynecological care. In the absence of a call schedule and to ensure that women Veterans have access to appropriate services, the Associate Chief of Staff Primary Care, Chief of Surgery, Women Veterans Program Manager, Emergency Department Supervisory Physician, and a staff gynecologist developed a standard operating procedure that sets forth mandatory processes and procedures for 24 hour a day and seven day a week routine and urgent-emergent gynecological care coverage. The SOP also outlines procedures for consultations with community providers in the absence of the medical center solo gynecologist. Between December 2020 and January 2021, Primary Care clinic, CBOC, and Emergency Department nurses, medical assistants, advanced practice providers, and physicians were educated to the responsibilities, processes, and procedures set forth in the SOP. Surgery service physician assistants and surgeons were also educated to the responsibilities, processes, and procedures set forth in the SOP. To maintain current standards for social distancing in a time of the world-wide COVID-19 pandemic; the medical center supervisors for the Primary Care clinics, CBOCs, Emergency Department, and Surgery service, conducted staff education utilizing one or more of the following methods: Virtual meetings, email correspondence, and face to face meetings when safe to do so.

On February 1, 2021, the facility Accreditation Manager initiated compliance auditing. Emergency Department visits are being audited monthly to monitor for compliance with female veterans, who seek urgent-emergent and/or off-tour (i.e. outside of normal business hours) obstetric or gynecological care, receive treatment either inhouse or were transferred to a community hospital that provides needed services. The denominator definition for this measure is the total number of women Veterans seeking urgent-emergent or off-tour obstetric or gynecological care. The numerator definition is the total number of women veterans who received urgent-emergent obstetric or gynecological treatment inhouse or were transferred out for treatment. Audit results are reported, by the Accreditation Manager, quarterly to the Quality Executive Board of which the Chief of Staff is a voting member. Compliance will be measured and reported monthly until 90 percent or greater compliance is met for six consecutive months.

VHA requires that each CBOC has at least two designated women's health primary care providers or arrangements for leave coverage when CBOCs have only one designated

provider.[115] The OIG found that the Salmon VA Clinic, which has only one women's health primary care provider, had no defined coverage when the provider was on leave. The Twin Falls VA Clinic and Mountain Home VA Clinic, which are multi-provider sites, did not have at least two designated women's health primary care providers. This lack of coverage could have limited the medical center's ability to provide comprehensive healthcare services to women veterans. The Associate Chief of Staff, Primary Care attributed the noncompliance to geographic distance, providers not meeting the women's health designation criteria, a staff vacancy, and the burdens of leave coverage.

Recommendation 7

7. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that each community-based outpatient clinic has at least two designated women's health primary care providers or arrangements for leave coverage when there is only one designated provider.

[115] VHA Directive 1330.01(3). (This directive was in place for the review period in this report. It was amended on January 8, 2021. Both directives contain the same or similar language regarding designated women's health primary care providers.)

Medical center concurred.

Target date for completion: August 31, 2021

Medical center response: The Chief of Staff, Women Veterans Program Manager, Emergency Department Supervisory Physician, and Associate Chief of Staff Primary Care evaluated the deficiency and did not identify any additional reasons for noncompliance. The medical center has a sole gynecologist on staff and therefore it is not feasible to establish a formal call coverage schedule for gynecological care. In the absence of a call schedule and to ensure that women Veterans have access to appropriate services, the Associate Chief of Staff Primary Care, Chief of Surgery, Women Veterans Program Manager, Emergency Department Supervisory Physician, and a staff gynecologist developed a standard operating procedure that sets forth mandatory processes and procedures for 24 hour a day and seven day a week routine and urgent-emergent gynecological care coverage. The SOP also outlines procedures for consultations with community providers in the absence of the medical center solo gynecologist. Between December 2020 and January 2021, Primary Care clinic, CBOC, and Emergency Department nurses, medical assistants, advanced practice providers, and physicians were educated to the responsibilities, processes, and procedures set forth in the SOP. Surgery service physician assistants and surgeons were also educated to the responsibilities, processes, and procedures set forth in the SOP. To maintain current standards for social distancing in a time of the world-wide COVID-19 pandemic; the medical center supervisors for the Primary Care clinics, CBOCs, Emergency Department, and Surgery service, conducted staff education utilizing one or more of the following methods: Virtual meetings, email correspondence, and face to face meetings when safe to do so.

On February 1, 2021, the facility Accreditation Manager initiated compliance auditing. Emergency Department visits are being audited monthly to monitor for compliance with female veterans, who seek urgent-emergent and/or off-tour (i.e. outside of normal business hours) obstetric or gynecological care, receive treatment either inhouse or were transferred to a community hospital that provides needed services. The denominator definition for this measure is the total number of women Veterans seeking urgent-emergent or off-tour obstetric or gynecological care. The numerator definition is the total number of women veterans who received urgent-emergent obstetric or gynecological treatment inhouse or were transferred out for treatment. Audit results are reported, by the Accreditation Manager, quarterly to the Quality Executive Board of which the Chief of Staff is a voting member. Compliance will be measured and reported monthly until 90 percent or greater compliance is met for six consecutive months.

VHA requires that the Women Veterans Health Committee meets quarterly, reports to executive leaders, and has a core membership. Core membership must include a women veterans program manager, a women's health medical director, "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care

management, nursing, ED [Emergency Department], radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership."[116]

While the Women Veterans Health Committee included the required members, the OIG noted that from July 1 through December 31, 2019, representatives from the Emergency Department, radiology, laboratory, business office/non-VA Medical Care, and executive leadership team did not attend scheduled meetings. This resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for the quality and equitable care for women veterans. The Associate Chief, Nursing, Specialty Care and Associate Chief of Staff, Primary Care acknowledged awareness of the requirement and stated that a major reorganization within the Primary Care Service Line, which oversees women's health, and the subsequent lack of clarity regarding new roles contributed to the deficiency.

Recommendation 8

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

[116] VHA Directive 1330.01(3). (This directive was in place for the time frame of the minutes reviewed in this report. It was amended on January 8, 2021. The two directives contain the same or similar language regarding the Women Veterans Health Committee.)

Medical center concurred.

Target date for completion: December 31, 2021

Medical center response: The Medical Center Director, Chief of Staff, Associate Chief Nurse Primary Care, and the Women Veterans Program Manager evaluated the deficiency and reasons for noncompliance. During the OIG CHIP review, the Women Veterans Program Manager received clarification of her role as the Women Veterans Health Committee Chair to include responsibilities for monitoring committee membership attendance and reporting to the Chair of Clinical Executive Board when attendance is lacking. Upon further evaluation it was also identified that there was a need to clearly identify individuals to represent required disciplines. To ensure compliance with committee representation requirements, the Women Veterans Health Committee reviewed and updated the committee charter to ensure required membership, as outlined in VHA Directive 1330.01(3), is represented. The charter was approved by the Clinical Executive Board via email electronic vote and was signed on November 25, 2021. Individuals representing required disciplines were identified and notified, by the Women Veterans Committee Chair, regarding the expectation to attend, or send a designee, to regularly scheduled committee meetings.

In June of 2021, the facility Accreditation Manager will initiate compliance auditing. The Women Veterans Committee meeting minutes will be audited to monitor for compliance with required committee representatives, or their designees, attending a minimum of 90 percent of scheduled meetings. The denominator definition for the measure is the total number of voting members/representative disciplines as outlined in the committee charter. The numerator definition is the total number of voting members/representative disciplines in attendance at the scheduled meeting. Audit results are reported, by the Accreditation Manager, quarterly to the Quality Executive Board of which the Medical Center Director is the Chair. Compliance will be measured and reported quarterly until 90 percent or greater compliance is met for two consecutive quarters.

VHA requires the medical center to have a women veterans program manager who is full-time and free of collateral duties.[117] The Women Veterans Program Manager reported serving as a clinic manager who supervised nine staff. Collateral duties could negatively affect the ability to coordinate quality healthcare services to women veterans. The Associate Chief Nurse, Primary Care acknowledged an awareness of the requirement and reported a sustained inability (over several years) to recruit a women veterans program manager, which resulted in the two positions being merged.

[117] VHA Directive 1330.01(3*), Health Care Services for Women Veterans*, February 15, 2017, amended June 29, 2020. (This directive was in place for the review period in this report and was amended January 8, 2021. The two directives contain the same or similar language regarding a women veterans program manager.)

Recommendation 9

9. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures the Women Veterans Program Manager is full-time and free of collateral duties.[118]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Medical Center Director, Chief of Staff, and Associate Chief Nurse Primary Care evaluated the deficiency and did not identify any additional reasons for noncompliance. The Associate Chief Nurse Primary Care, Associate Chief of Staff Primary Care, and Human Resources Specialist (Employee Relations/Labor Relations) shared the role changes with the Women Veteran Program Manager. Effective January 2021, the Women Veterans Program Manager functional statement was revised to comply with full-time equivalent and duty functions in accordance with VHA Directive 1330.01(3). The Women Veterans Program Manager functional statement was reviewed and approved by the Associate Director of Patient Care Services/Chief Nurse Executive, and is now classified and functions as a full-time administrative role, without collateral duties, with a maximum allotment of 1/8 clinical time, for the purpose of maintaining licensure. The previous Women Veteran Program Manager transitioned to the Women's Wellness Center Clinic Manager. The new Women Veterans Program Manager will begin on June 6, 2021. The Medical Center Director was apprised of these changes via reporting to the Quality Executive Board of which the Medical Center Director serves as chair.

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

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have Sterile Processing Services (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment."[119] The goal of SPS is to "provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[120] To ensure this, VHA requires facilities to conduct the following activities:

- Maintain a current inventory list of all RME
- Have standard operating procedures (SOPs) that are based on current manufacturers' guidelines and reviewed at least triennially
- Use CensiTrac® Instrument Tracking System for tracking reprocessed instruments[121]
- Perform annual risk analysis and report results to the VISN SPS Management Board
- Monitor data for reprocessing and storing RME
- Conduct annual airflow/ventilation system inspections[122]

VHA requires strict controls that closely monitor climate, storage, and sterilization parameters and additionally requires that quality assurance documentation of this monitoring be maintained for a minimum of three years.[123] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[124]

In addition, RME reprocessing areas must be clean, restricted, and airflow-controlled. All areas where RME reprocessing occurs must have safety data sheets, an unobstructed eyewash station, personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[125]

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

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

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

[122] VHA Directive 1116(2).

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

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

[125] VHA Directive 1116(2).

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued annual and essential staff competency assessments, and monthly continuing education. This ensures that staff have sufficient aptitude, knowledge, and skills to effectively and safely reprocess and sterilize RME.[126]

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

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

High-Risk Processes Findings and Recommendations

The medical center met many of the requirements for the proper operations and management of RME. However, the OIG identified deficiencies with staff competency assessments.

[126] VHA Directive 1116(2).

VHA requires the Chief, SPS to ensure that SOPs align with manufacturers' guidelines and that SPS staff complete competency assessments prior to performing reprocessing duties.[127] The OIG found that none of the 20 SPS staff's colonoscope and ureteroscope competency assessments aligned with the medical center's SOP; therefore, the competencies were invalid.[128] This could have resulted in improper cleaning of the RME and subsequent compromised patient safety. The Assistant Chief, SPS reported the use of an outdated colonoscope SOP to draft the assessment, competency transcription errors, and recent process changes as the reasons for noncompliance.

Recommendation 10

10. The Nurse Executive evaluates and determines any additional reasons for noncompliance and ensures that Sterile Processing Services staff complete competency assessments that align with medical center standard operating procedures prior to reprocessing reusable medical equipment.

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

[128] Merriam Webster, "Definition of ureteroscope," accessed February 28, 2021 https://www.merriam-webster.com/medical/ureteroscope. A ureteroscope is an "endoscope for visually examining and passing instruments into the interior of the ureter."

Medical center concurred.

Target date for completion: August 31, 2021.

Medical center response: The Nurse Executive and the Chief of Sterile Processing Service evaluated the deficiency and did not identify any additional reasons for noncompliance. Prior to completion of the OIG CHIP site visit, the competency assessment documents in question, the standard operating procedures (SOPs), and instrument instructions for use, were reviewed by the Chief and Assistant Chief of Sterile Processing Service. To address the immediate deficiency for transcription errors and use of outdated SOPs to draft the competency assessment documents that had occurred during recent processes changes, the Assistant Chief of Sterile Processing Service updated the colonoscope SOP and competency form to reflect the most current information. In addition, the Assistant Chief updated the ureteroscope competency to align with the most current SOP. Current and newly hired Medical Supply Technicians, who have responsibilities for reprocessing the colonoscope and ureteroscope, were assigned and successfully demonstrated competencies. Competency evaluations were demonstrated by two or more of the following methods: Test, return demonstration, simulation, interview, observation, or in-service. Completed competencies were electronically signed, by both the validator and employee, and documented within the Censitrac Instrument Tracking System, an Assistant Under Secretary for Health for Operations (10N) approved tracking system. Approved validators include the Assistant Chief of Sterile Processing and the Reusable Medical Equipment Coordinator. The Assistant Chief of Sterile Processing conducted a review of each employee's colonoscope and ureteroscope competency to verify completion.

To reduce any potential risk of future deficiencies the Chief of Sterile Processing Service is actively working to improve processes and procedures for managing SOPs. Procedures include the auditing of SOPs, as compared to local inventory, to identify areas for improvement. Additionally, the facility has approved the purchase of Aesculap [a medical supply company] instrumentation which will allow the purchase of instruments from one manufacturer, where possible, to ensure the processing instructions are consistent.

In September of 2020, the facility Accreditation Manager initiated compliance auditing. Censitrac colonoscope and ureteroscope competency documents are being audited monthly to monitor for compliance with current, and newly hired, Sterile Processing Medical Supply Technicians, who have responsibilities for reprocessing the scopes, completing required competencies. The denominator definition for this measure is the total number of Medical Supply Technicians in the month that are required to have colonoscope and ureteroscope competencies. The numerator definition is the total number Medical Supply Technicians that have completed colonoscope and ureteroscope competencies. Audit results are reported by the Accreditation Manager quarterly to the Quality Executive Board of which the Nurse Executive is a voting member. Compliance will be measured and reported quarterly until 90 percent or greater compliance is met for six consecutive months.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• None	• None
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• None	• First- or second-line supervisors complete provider exit review forms within seven business days of licensed healthcare professionals' departure from the medical center.
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• None	• The Pain Management Committee monitors the quality of pain assessment and effectiveness of pain management interventions.
Mental Health: Suicide Prevention Program	• Designated medical center suicide prevention coordinator • Tracking and follow-up of high-risk veterans • Provision of suicide prevention care • Completion of suicide prevention training requirements	• None	• The Suicide Prevention Coordinator conducts at least five suicide prevention outreach activities per month. • All staff complete annual suicide prevention refresher training.
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • LSTD progress notes completed • LSTD note/orders completed by an authorized provider or delegated appropriately	• Practitioners complete LSTD progress notes.	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• Processes and procedures are in place for 24/7 Emergency Department and medical center call coverage for gynecologic care. • Each CBOC has at least two designated women's health primary care providers or arrangements for leave coverage when there is only one designated provider.	• Required members consistently attend Women Veterans Health Committee meetings. • The Women Veterans Program Manager is full-time and free of collateral duties.
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Quality assurance • Staff training	• SPS staff complete competency assessments that align with medical center SOPs prior to reprocessing RME.	• None

Appendix B: Medical Center Profile

The table below provides general background information for this medium complexity (2) affiliated medical center reporting to VISN 20.[1]

Table B.1. Profile for Boise VA Medical Center (531) (October 1, 2016, through September 30, 2019)

Profile Element	Medical Center Data FY 2017*	Medical Center Data FY 2018†	Medical Center Data FY 2019‡
• Total medical care budget	$247,467,636	$268,760,644	$283,011,491
Number of:			
• Unique patients	36,545	38,620	41,285
• Outpatient visits	363,422	390,214	420,576
• Unique employees	1,179	1,228	1,251
Type and number of operating beds:			
• Community living center	28	32	32
• Domiciliary	18	18	18
• Medicine	22	22	22
• Mental Health	8	8	8
• Surgery	7	7	7
Average daily census:			
• Community living center	26	28	28
• Domiciliary	13	12	12
• Medicine	18	22	23
• Mental Health	4	5	5
• Surgery	4	5	4

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

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

**October 1, 2016, through September 30, 2017.*
†October 1, 2017, through September 30, 2018.
‡October 1, 2018, through September 30, 2019.

[1] The VHA medical centers are classified according to a facility complexity model; a designation of "2" indicates a facility with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs."

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Twin Falls, ID	531GE	8,212	2,231	Dermatology Podiatry	–	Nutrition Pharmacy Weight management
Caldwell, ID	531GG	11,213	2,713	Dermatology Eye Podiatry Rehab physician	–	Pharmacy Weight management
Eastern Oregon, OR	531GH	1,172	272	Dermatology	–	Pharmacy Weight management

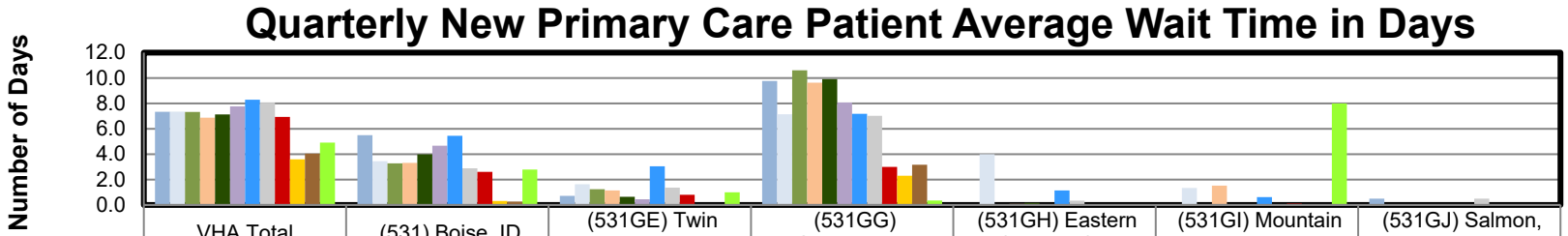
[1] Includes all outpatient clinics in the community that were in operation as of August 27, 2019. VHA Directive 1230(4), *Outpatient Scheduling Processes And Procedures*, July 15, 2016, amended June 17, 2021. An encounter is a "professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition." Specialty care services refer to non-primary care and non-mental health services provided by a physician. No diagnostic services are offered. Ancillary services include nutrition, pharmacy, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Mountain Home, ID	531GI	3,398	742	Podiatry	–	Pharmacy Weight management
Salmon, ID	531GJ	1,343	643	Podiatry	–	Pharmacy

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

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

Appendix D: Patient Aligned Care Team Compass Metrics

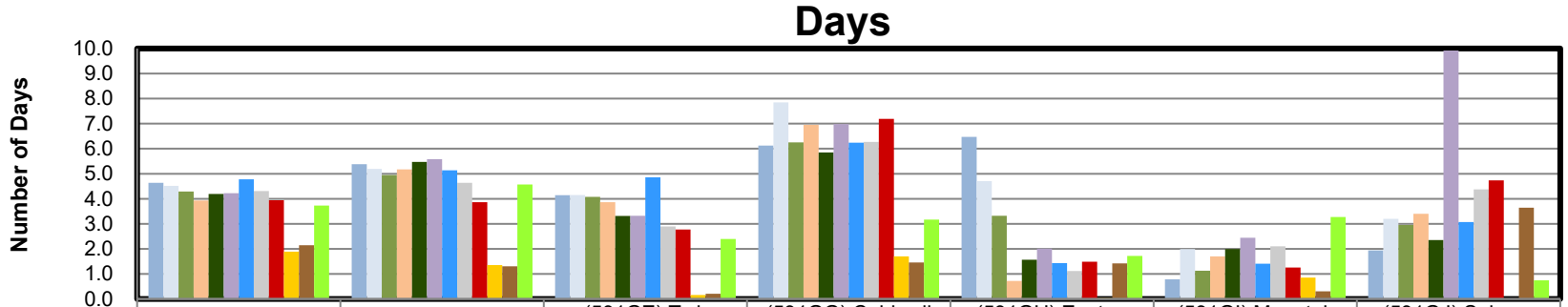


	VHA Total	(531) Boise, ID	(531GE) Twin Falls, ID	(531GG) Caldwell, ID	(531GH) Eastern Oregon, OR	(531GI) Mountain Home, ID	(531GJ) Salmon, ID
JUL-FY19	7.3	5.5	0.7	9.8	0.0	0.0	0.5
AUG-FY19	7.4	3.5	1.6	7.1	4.0	1.3	0.0
SEP-FY19	7.3	3.3	1.2	10.6	0.0	0.0	0.0
OCT-FY20	6.9	3.3	1.1	9.6	0.1	1.5	0.0
NOV-FY20	7.1	4.0	0.6	9.9	0.2	0.0	n/a
DEC-FY20	7.8	4.7	0.4	8.1	0.0	0.0	0.0
JAN-FY20	8.3	5.4	3.1	7.2	1.1	0.6	0.0
FEB-FY20	8.1	2.9	1.4	7.0	0.3	0.0	0.5
MAR-FY20	6.9	2.6	0.8	3.0	0.0	0.1	0.0
APR-FY20	3.6	0.3	n/a	2.3	0.0	n/a	n/a
MAY-FY20	4.0	0.3	0.0	3.2	0.0	n/a	n/a
JUN-FY20	4.9	2.8	1.0	0.4	0.0	8.0	n/a

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

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

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



	VHA Total	(531) Boise, ID	(531GE) Twin Falls, ID	(531GG) Caldwell, ID	(531GH) Eastern Oregon, OR	(531GI) Mountain Home, ID	(531GJ) Salmon, ID
JUL-FY19	4.6	5.4	4.1	6.1	6.5	0.8	1.9
AUG-FY19	4.5	5.2	4.2	7.9	4.7	2.0	3.2
SEP-FY19	4.3	5.0	4.1	6.3	3.3	1.1	3.0
OCT-FY20	3.9	5.2	3.9	7.0	0.7	1.7	3.4
NOV-FY20	4.2	5.5	3.3	5.9	1.6	2.0	2.4
DEC-FY20	4.2	5.6	3.3	7.0	2.0	2.4	9.9
JAN-FY20	4.8	5.1	4.9	6.2	1.4	1.4	3.1
FEB-FY20	4.3	4.6	2.9	6.3	1.1	2.1	4.4
MAR-FY20	3.9	3.9	2.8	7.2	1.5	1.3	4.7
APR-FY20	1.9	1.4	0.2	1.7	0.0	0.9	0.0
MAY-FY20	2.1	1.3	0.2	1.5	1.4	0.3	3.6
JUN-FY20	3.7	4.6	2.4	3.2	1.7	3.3	0.7

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

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

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

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

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

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

Source: VHA Support Service Center.

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

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 2, 2021

From: Director, Northwest Network (10N20)

Subj: Comprehensive Healthcare Inspection of the Boise VA Medical Center in Idaho

To: Director, Office of Healthcare Inspections (54CH06)

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

1. Thank you for the opportunity to provide a status report to the findings from the Comprehensive Healthcare Inspection of the Boise VA Medical Center in Idaho.
2. I concur with your findings and recommendations, as well as the submitted action plans.

(Original signed by:)

John A. Mendoza, Deputy Network Director, signed for Teresa D. Boyd, DO

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: June 1, 2021

From: Director, Boise VA Medical Center (531/00)

Subj: Comprehensive Healthcare Inspection of the Boise VA Medical Center in Idaho

To: Director, Northwest Network (10N20)

1. Thank you for the opportunity to provide a response to the findings from the Comprehensive Healthcare Inspection of the Boise VA Medical Center in Idaho.
2. I concur with the findings and recommendations and will ensure that actions to correct these finding are completed as described in the responses.

(Original signed by:)

David Wood

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Tamara White, RN Team Leader Priscilla Agali, DNP, FNP-C Carol Haig, CNM, WHNP-BC Carrie Jeffries, DNP, FACHE Rowena Jumamoy, MSN, RN Nicole Maxey, MSN, RN Sonia Whig, MS, RD
Other Contributors	Elizabeth Bullock Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Ashley Fahle Gonzalez, MPH, BS Jennifer Frisch, MSN, RN Justin Hanlon, BS LaFonda Henry, MSN, RN-BC Cynthia Hickel, MSN, CRNA Scott McGrath, BS Larry Ross, Jr., MS Krista Stephenson, MSN, RN Caitlin Sweany-Mendez, MPH, BS Robert Wallace, ScD, MPH

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