DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Western Colorado Health Care System in Grand Junction

CHIP REPORT | REPORT #21-00247-210 | AUGUST 17, 2021

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Figure 1. *VA Western Colorado Health Care System in Grand Junction.*

Source: https://vaww.va.gov/directory/guide/ (*accessed January 6, 2021*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
FY	fiscal year
OIG	Office of Inspector General
QSV	quality, safety, and value
RN	registered nurse
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Western Colorado Health Care System, which includes four outpatient clinics in Colorado and Utah and a mobile clinic. 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. Registered nurse credentialing
4. Medication management (targeting remdesivir use)[2]
5. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
6. Care coordination (spotlighting inter-facility transfers)
7. High-risk processes (examining the management of disruptive and violent behavior)

The OIG conducted an unannounced virtual review of the VA Western Colorado Health Care System during the week of November 30, 2020. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm,

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

[2] The OIG's review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the VA Western Colorado Health Care System because system staff did not administer remdesivir during the review period.

the findings in this report may help this healthcare system and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

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

Leadership and Organizational Risks

At the time of the OIG's virtual review, the healthcare system's leadership team consisted of the Executive Director, Chief of Staff, acting Associate Director for Patient Care Services, and Associate Director. The healthcare system managed organizational communications and accountability through a committee reporting structure, with the Executive Quality Council overseeing several working groups, including the Quality Safety Value and Clinical Executive Boards. Leaders monitored patient safety and care through the Quality Safety Value Board, which tracked and trended quality of care and patient outcomes.

When the team conducted this inspection, the executive team had worked together for three months. The Chief of Staff and Associate Director, assigned in April 2019, were the most tenured leaders. The Executive Director and acting Associate Director for Patient Care Services assumed their roles in May and September 2020, respectively.

The OIG reviewed employee satisfaction survey results and concluded that the Chief of Staff had opportunities to adopt servant leadership traits and motivate staff, while the Associate Director for Patient Care Services had opportunities to promote a safe culture. However, selected patient experience survey scores generally reflected similar or higher care ratings than the VHA average. Patients appeared satisfied with the care provided. The Chief of Staff reported that the system developed public-private partnerships to improve veteran access and quality of care.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events.[3] The OIG did not identify any substantial organizational risk factors.

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

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

way to understand the similarities and differences between the top and bottom performers within VHA.[4]

The executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and Community Living Center SAIL models.[5] In individual interviews, the executive leaders were also able to speak in depth 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 OIG reported the results of the COVID-19 pandemic readiness and response for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[6]

Quality, Safety, and Value

The healthcare system complied with requirements for systems redesign and improvement, protected peer reviews, and a surgical work group.[7] However, the OIG identified weaknesses in the committee responsible for quality, safety, and value oversight functions.

Registered Nurse Credentialing

The OIG found that registered nurses hired by the healthcare system between January 1 and October 26, 2020, were free from potentially disqualifying licensure actions. However, the OIG found a deficiency with the completion of primary source verification prior to appointment.

High-Risk Processes

The healthcare system met many of the requirements for the management of disruptive and violent behavior. However, the OIG found deficiencies with Disruptive Behavior Committee meeting attendance and Employee Threat Assessment Team training.

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

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

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

[7] 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.

Conclusion

The OIG conducted a detailed inspection across seven key areas (two administrative and five clinical) and subsequently issued four recommendations for improvement to the Executive Director, Chief of Staff, and Associate Director for Patient Care Services. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for system leaders to use these recommendations to help guide improvements in operations and clinical care. The recommendations address issues that may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 51–52, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendations 1 and 2 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

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

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

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

As such, to examine risks to patients and the organization, the OIG focused on core processes in the following eight 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. Registered nurse credentialing

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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 2021 (October 1, 2020, through September 30, 2021); 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 remdesivir use)[6]
6. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
7. Care coordination (spotlighting inter-facility transfers)
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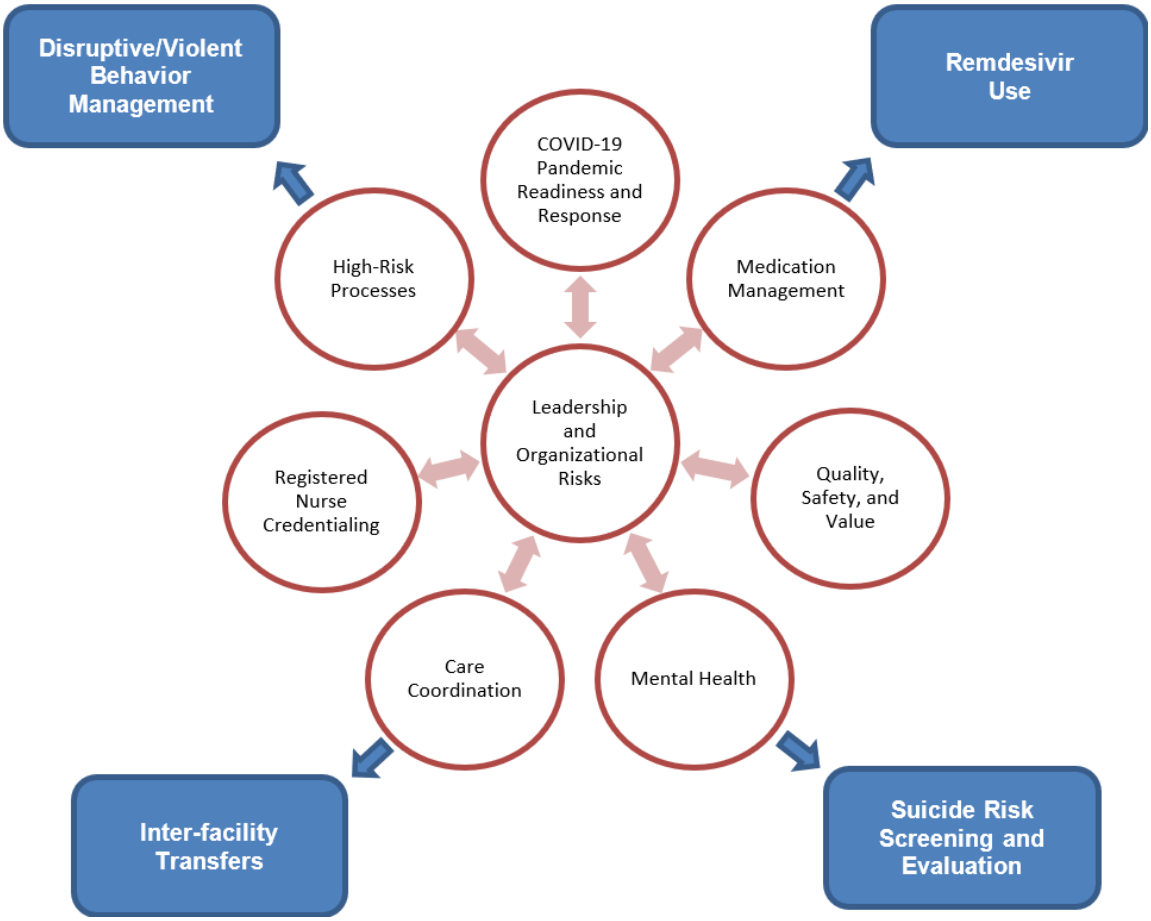


Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

[6] The OIG's review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the VA Western Colorado Health Care System because system staff did not administer remdesivir during the review period.

Methodology

The VA Western Colorado Health Care System includes the medical center, four outpatient clinics in Colorado and Utah, and a mobile clinic. Additional details about the types of care provided by the healthcare system can be found in appendixes B and C.

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality and clinical functions, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports.[7] The team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection examined operations from July 22, 2017, through December 4, 2020, the last day of the unannounced multiday evaluation.[8] During the virtual site visit, the OIG did not receive any complaints beyond the scope of the inspection.

The OIG reported the results of the COVID-19 pandemic readiness and response for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[9]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[10] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

[8] The range represents the time period from the prior CHIP site visit to the completion of the unannounced, multiday virtual CHIP visit in December 2020.

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can affect a healthcare system's ability to provide care in the clinical focus areas.[11] To assess this healthcare system's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the healthcare system response
8. VHA performance data (healthcare system)
9. VHA performance data (community living center (CLC))[12]

Executive Leadership Position Stability and Engagement

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

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

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

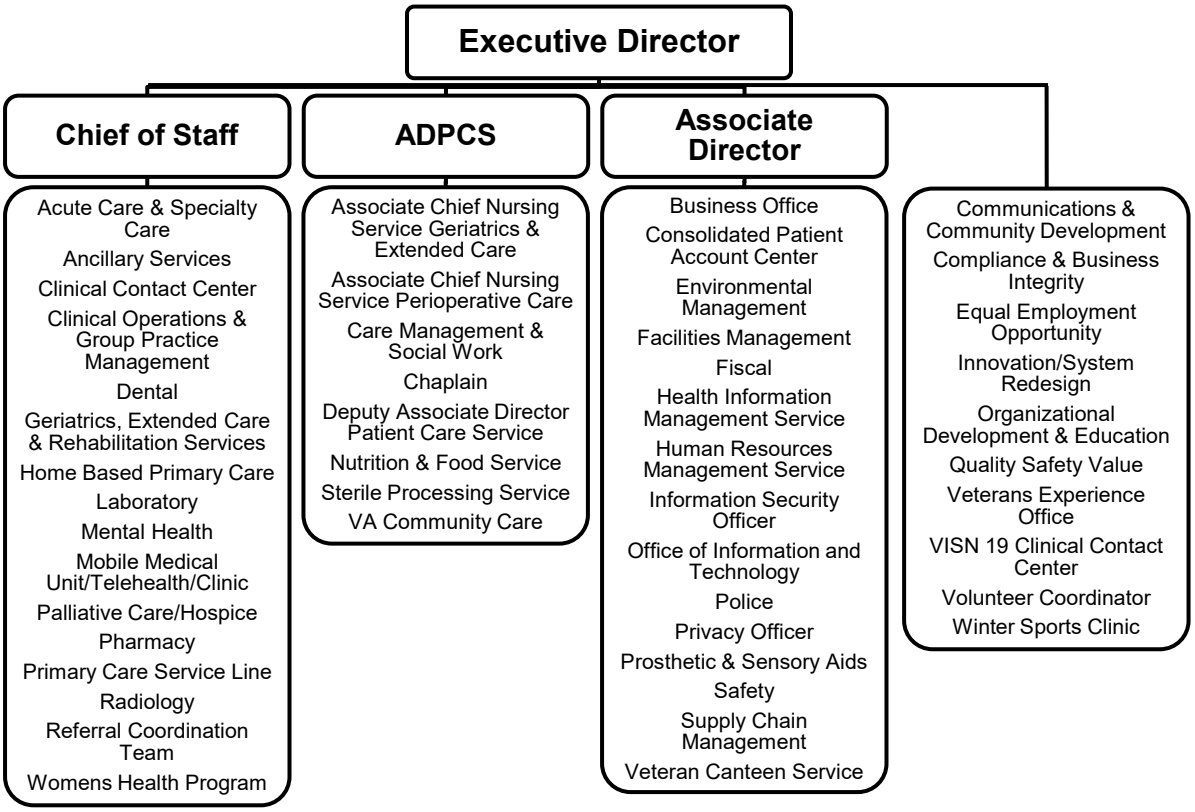


Figure 3. *Healthcare system organizational chart.*
Source: VA Western Colorado Health Care System (received November 30, 2020).

At the time of the OIG virtual review, the executive team had worked together for three months. The Chief of Staff and Associate Director, assigned in April 2019, were the most tenured leaders. The Associate Director served as the acting Executive Director from September 15, 2019, through May 11, 2020, prior to the Executive Director's permanent assignment in May 2020. Although a permanent ADPCS was assigned in July 2016, at the time of the OIG review, an acting ADPCS had been covering the role since September 2020 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Executive Director	May 24, 2020
Chief of Staff	April 28, 2019
Associate Director for Patient Care Services	September 4, 2020 (acting) July 10, 2016 (permanent)
Associate Director	April 14, 2019

Source: VA Western Colorado Health Care System acting Human Resources Officer (received November 30, 2020) and VISN 19 Chief Human Resources Officer (received December 1 and 2, 2020).

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

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and system-level factors contributing to poor performance on specific Strategic Analytics for Improvement and Learning (SAIL) measures. Additionally, leaders generally had a full understanding of CLC SAIL measures. In individual interviews, they were able to speak knowledgeably about actions taken to maintain or improve organizational performance, employee satisfaction, or patient experiences during the previous 12 months. These actions are discussed in greater detail below.

The Executive Director served as the chairperson of the Executive Quality Council, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Quality Council oversaw various working groups such as the Clinical Executive, Nursing Executive, and Organizational Development and Education Boards. These leaders monitored patient safety and care through the Quality Safety Value Board, which tracked and trended quality of care and patient outcomes and reported to the Executive Quality Council (see figure 4).

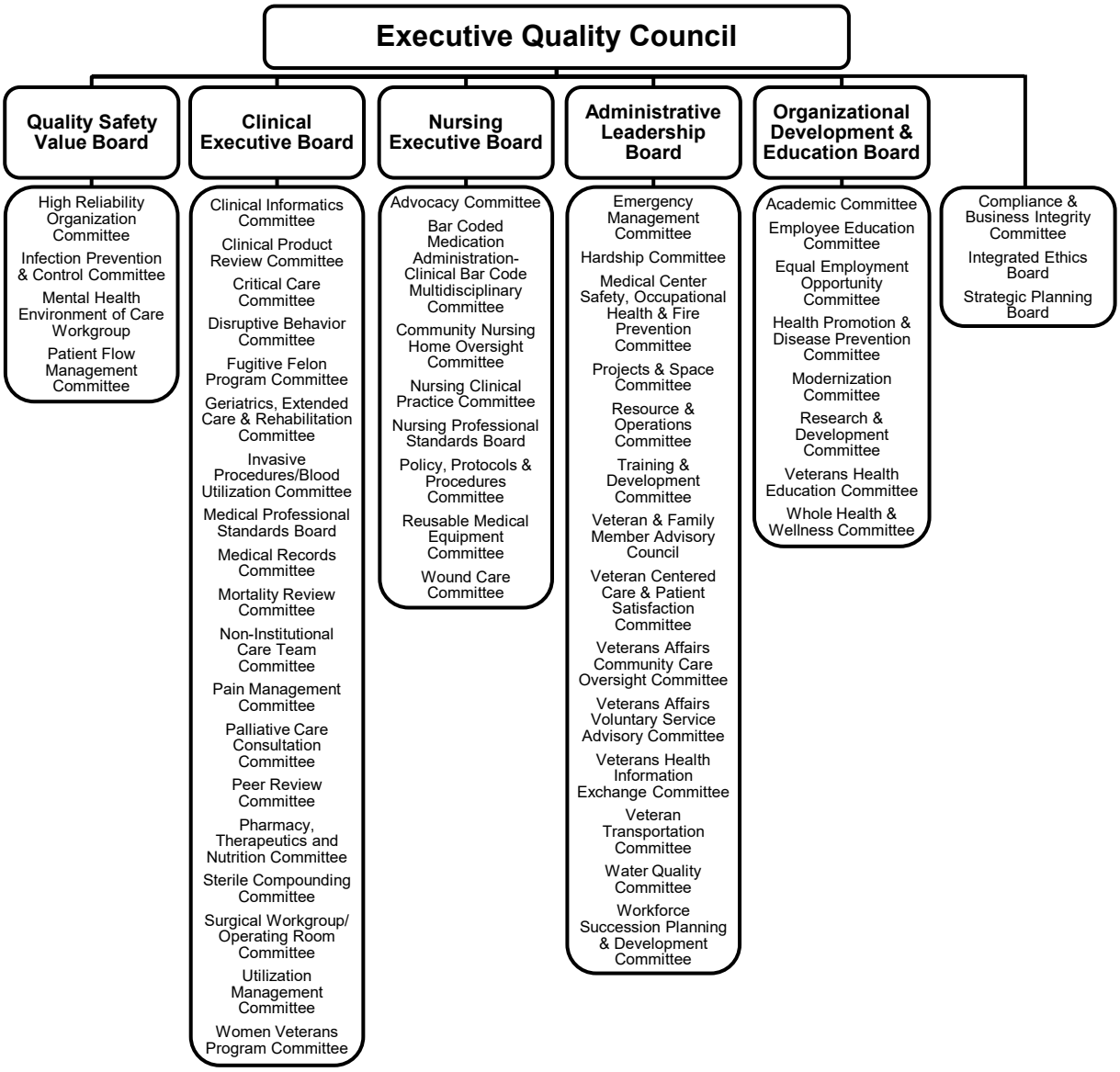


Figure 4. *Healthcare system committee reporting structure.*

Source: VA Western Colorado Health Care System (received November 30, 2020).

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of $209,327,258 increased compared to the previous year's budget of $170,885,962.[13] When asked about the effect of this change on the healthcare system's operations, the Executive Director indicated that pharmaceutical expenses had increased and the budget was being managed prudently to balance policy and operations. In addition, the Executive Director reported that in FY 2021, the service

[13] VHA Support Service Center.

chiefs were tasked with managing their service line budgets after receiving training from members of the finance team.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[14] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[15] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[16]

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[17] Leaders reported challenges in hiring psychiatrists and other specialists due to the system's rural location. The Chief of Staff reported that the system developed a public-private partnership with the intention of increasing access to services from hard-to-recruit clinicians. The Executive Director also indicated that retaining licensed practical nurses and certified nursing assistants was challenging because they frequently left to pursue higher education.

Table 2. Top Facility-Reported Clinical and Nonclinical Staffing Shortages

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Psychiatry	1. Human Resources Management
2. Neurology	2. Police
3. Pain Management/Physical Medicine and Rehabilitation	3. Custodial Worker
4. Pulmonary Diseases	4. Food Service Worker
5. Cardiology Non-Invasive	5. Miscellaneous Administration and Program

Source: VA OIG.

[14] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

[15] VA Choice and Quality Employment Act of 2017, Pub. L. No. 115-46 (2017). VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*, Report No. 20-01249-259, September 23, 2020.

[16] VA OIG, *Critical Deficiencies at the Washington DC VA Medical Center*, Report No. 17-02644-130, March 7, 2018.

[17] VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[18] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2018, through September 30, 2019.[19] Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the healthcare system average for the selected survey leadership questions was generally similar to the VHA average.[20] Scores for the Executive Director, ADPCS, and Associate Director were consistently higher than those for VHA and the healthcare system. However, the generally lower scores for the Chief of Staff indicated improvement opportunities to adopt servant leadership traits and motivate staff.[21]

Table 3. Survey Results on Employee Attitudes toward Healthcare System Leaders (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Executive Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	72.6	71.7	81.7	70.6	74.2	83.6

[18] "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.)

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

[20] 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.

[21] The All Employee Survey results are not fully reflective of employee satisfaction with the Executive Director, Chief of Staff, acting ADPCS, or Associate Director, who were either not in their roles when the survey was administered or not in their roles for the full survey review period.

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Executive Director Average	Chief of Staff Average	ADPCS Average	Assoc. 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	3.3	4.1	3.2	3.5	3.8
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.6	4.1	3.6	3.7	3.7
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.5	4.3	3.5	3.8	3.8

Source: VA All Employee Survey (accessed October 28, 2020).

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[22] The healthcare system average for the selected survey questions was similar to the VHA average. Scores for the Executive Director and Associate Director were generally better than those for VHA and the healthcare system. However, opportunities appeared to exist for the ADPCS to promote a safe workplace culture.

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

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

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Executive Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.4	3.8	3.7	4.6
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.7	4.3	3.8	3.5	4.1
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	1.5	1.6	1.4	1.8	1.3

Source: VA All Employee Survey (accessed October 28, 2020).

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The healthcare system and executive leadership team averages for the selected survey questions were similar to or better than the VHA average. Leaders appeared to maintain an environment where staff felt respected and safe and discrimination was not tolerated.

The Executive Director shared that life-size posters to end discrimination were displayed in patient waiting areas and served as a reminder of the behavior everyone was expected to exhibit. Further, the Executive Director noted that contact information for the Equal Employment Opportunity Coordinator was posted across the system in the event staff felt discriminated against and wanted to speak with someone.

Table 5. Survey Results on Employee Attitudes toward Workgroup Relationships (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Executive Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.9	4.2	4.0	3.7	4.2
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree) –5 (Strongly Agree)	4.0	4.1	4.8	4.1	4.1	4.6
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	4.4	3.8	3.7	4.2

Source: VA All Employee Survey (accessed October 28, 2020).

Patient Experience

To assess patient experiences with the healthcare system, which directly reflect on its leaders, the OIG team reviewed survey results from October 1, 2019, through July 31, 2020. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and support benchmarking its performance against the private sector.

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the VA Western Colorado Health Care

System.[23] For this system, the overall patient satisfaction survey results reflected higher care ratings than the VHA average. Patients appeared satisfied with the care provided. The Chief of Staff reported that the system developed a public-private partnership to better provide specialty care services so that veterans had increased continuity of care, especially over the winter months when it was difficult to travel over mountain passes.

Table 6. Survey Results on Patient Experience (October 1, 2019, through July 31, 2020)

Questions	Scoring	VHA Average	Health-care System Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.6	78.1
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.8	85.4
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.9	91.6

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 29, 2020).

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[24] 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 questions that reflect patients' experiences by gender (see tables 7–9), including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The results for male respondents were generally

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

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

more favorable than the corresponding VHA averages. Female respondents' patient-centered medical home and specialty care scores were, for the most part, more favorable than the corresponding VHA averages. An example of actions taken to make women veterans feel like part of the healthcare system included partnering with local veterans' service organizations to provide up to $1,200 in gifts to pregnant veterans during the system's October 2020 drive-up baby shower.

Table 7. Inpatient Survey Results on Experiences by Gender (October 1, 2019, through July 31, 2020)

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average‡
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.9	77.3	–
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	85.5	89.4	–
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).	85.1	82.9	93.8	–

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed October 29, 2020).

**The VHA averages are based on 40,127–40,617 male and 1,938–1,962 female respondents, depending on the question.*

The healthcare system averages are based on 193–199 male respondents, depending on the question.

‡*Survey data are not available due to a low number of female respondents.*

Table 8. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2019, through July 31, 2020)

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.6	44.7	59.1	38.8
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	60.0	53.2	64.9	83.3
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.1	69.6	73.9	80.9

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed October 29, 2020).

**The VHA averages are based on 62,558–187,954 male and 5,096–11,416 female respondents, depending on the question.*

The healthcare system averages are based on 215–627 male and 18–41 female respondents, depending on the question.

Table 9. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2019, through July 30, 2020)

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.8	46.2	52.2	87.5
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).	57.7	54.0	61.6	63.7
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).	75.1	72.1	84.4	74.8

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed October 29, 2020).

**The VHA averages are based on 52,852–156,236 male and 3,104–8,711 female respondents, depending on the question.*

The healthcare system averages are based on 242–704 male and 14–44 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 responded to identified problems.[25] Table 10 summarizes the relevant system inspections most recently performed by the OIG and The Joint

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

Commission (TJC).[26] At the time of the OIG review, the system had closed all recommendations for improvement issued since the previous CHIP site visit conducted in July 2017. In addition, two recommendations from a prior OIG report regarding a patient death and alleged conflicts of interest that published February 4, 2020, were also closed.[27]

The OIG team also noted the system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists, and results from the Long Term Care Institute's inspection of the system's CLC.[28]

Table 10. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the Grand Junction Veterans Health Care System, Grand Junction, Colorado,* Report No. 17-01744-69, January 18, 2018)	July 2017	9	0
OIG (*Concern Regarding a Patient Death and Alleged Conflicts of Interest at the VA Western Colorado Health Care System, Grand Junction,* Report No. 19-06435-84, February 4, 2020)	March 2019	2	0

[26] 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."

[27] VA OIG, *Concern Regarding a Patient Death and Alleged Conflicts of Interest at the VA Western Colorado Health Care System, Grand Junction*, Report No. 19-06435-84, February 4, 2020.

[28] 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 joint collaboration with CARF [Commission on Accreditation of Rehabilitation Facilities] to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs." "About the College of American Pathologists," College of American Pathologists, accessed February 20, 2019, 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. "About Us," Long Term Care Institute, accessed December 8, 2020, http://www.ltciorg.org/about-us/. The Long Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings."

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
TJC Hospital Accreditation	March 2019	38	0
TJC Behavioral Health Care Accreditation		6	0
TJC Home Care Accreditation		3	0

Source: OIG and TJC (inspection/survey results verified with the Chief, Quality Management on December 1, 2020).

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

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

Table 11 lists the reported sentinel events and disclosures from July 22, 2017 (the prior OIG CHIP site visit), through November 30, 2020 (the first day of the virtual review).[29]

[29] 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 VA Western Colorado Health Care System 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 leaders together with clinicians and others, as appropriate, inform the patient or 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 large-scale disclosures of adverse events (sometimes referred to as "notifications") 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 11. Summary of Selected Organizational Risk Factors (July 22, 2017, through November 30, 2020)

Factor	Number of Occurrences
Sentinel Events	6
Institutional Disclosures	11
Large-Scale Disclosures	0

Source: VA Western Colorado Health Care System Patient Safety Manager and Risk Manager (received December 1, 2020).

The Executive Director reported taking sentinel events seriously and that the Risk Manager and Patient Safety Manager had immediate discussions when a sentinel event occurred. The Executive Director spoke knowledgeably about institutional disclosures and the need to be transparent. Further, the executive leadership team discussed institutional disclosures and appropriate courses of actions, which included conducting required root cause analyses and peer reviews, when needed. The OIG did not identify any significant organizational risk factors.

Veterans Health Administration Performance Data for the Health Care System

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[30]

Figure 5 illustrates the system's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2020. Figure 5 shows the VA Western Colorado Health Care System's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of mental health (MH) continuity (of) care, rating (of) specialty care (SC) provider, and care transition). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, mental health (MH) experience (exp) of care and stress discussed).[31]

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

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

System leaders reported awareness of the "mental health experience of care" and "stress discussed" metrics' performance. For example, leaders reported that the result for the "stress discussed" metric fell in the fifth quintile because the system initially lacked a standardized template to document the discussion. To address this issue, leaders reported that the system developed a template to document discussions about stress, educated Patient Aligned Care Teams on using the template, and conducted an audit to assess the Patient Aligned Care Teams' use of the template.

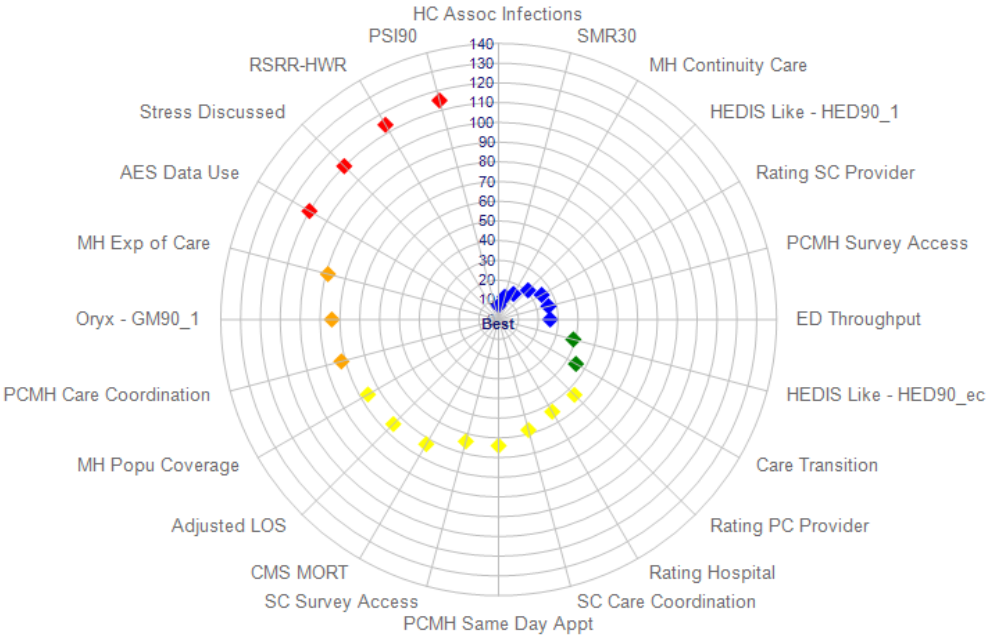


Figure 5. *VA Western Colorado Health Care System quality of care and efficiency metric rankings for FY 2020 quarter 3 (as of June 30, 2020).*

Source: VHA Support Service Center.

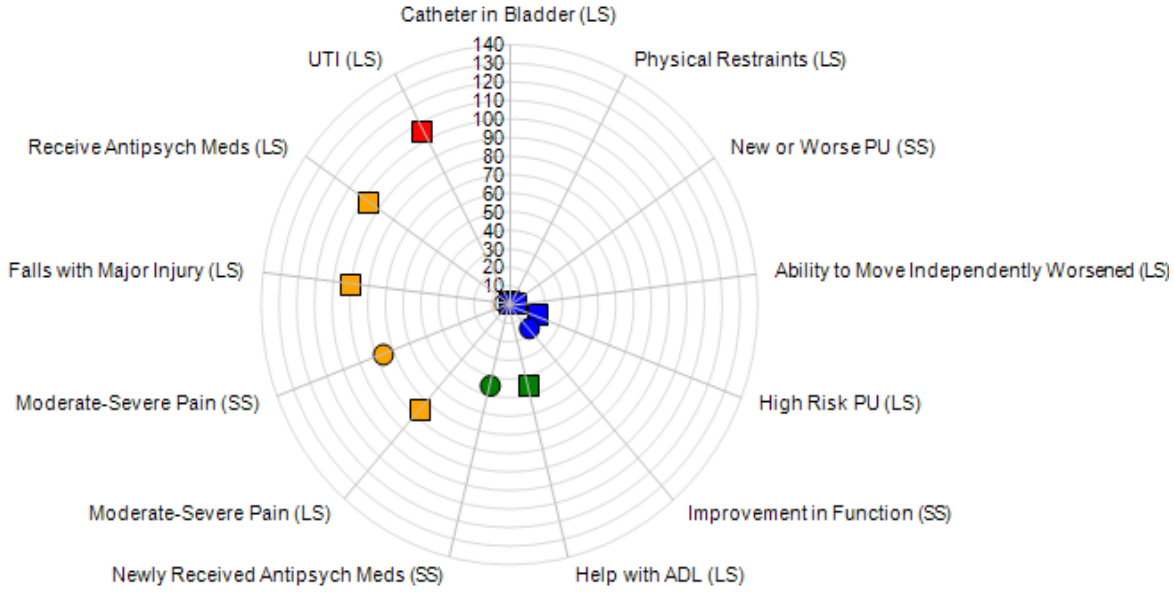
Note: The OIG did not assess VA's data for accuracy or completeness.

Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare 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."[32]

Figures 6 illustrates the system's CLC quality rankings and performance compared with other VA CLCs as of July 30, 2020. Figure 6 displays the VA Western Colorado Health Care System's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of new or worse pressure ulcer (PU)–short-stay (SS) and high risk pressure ulcer (PU)–long-stay (LS)). Metrics that need improvement are denoted in orange and red (for example, falls with major injury (LS) and urinary tract infection (UTI) (LS)).[33] System leaders reported that poor catheter hygiene and insufficient communication during nursing hand-offs contributed to the urinary tract infection (LS) metric's performance. To address these issues, leaders reported that the system started routine refresher urinary catheter training and reviewed expectations for hand-off communication with nurses.



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Figure 6. *Grand Junction CLC quality measure rankings for FY 2020 quarter 3 (as of June 30, 2020).*

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

Source: VHA Support Service Center.

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

[32] 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."

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

Leadership and Organizational Risks Findings and Recommendations

When the OIG conducted this inspection, the executive leadership team had worked together for three months. Although a permanent ADPCS had been assigned in July 2016, an acting ADPCS was covering the role and had done so since September 2020. The healthcare system managed organizational communications and accountability through a committee reporting structure with the Executive Quality Council overseeing several working groups, including the Quality Safety Value Board. Leaders monitored patient safety and care through the Quality Safety Value Board, which tracked and trended quality of care and patient outcomes.

Leaders reported challenges in hiring clinical specialists due to the system's rural location and the development of a public-private partnership to address subsequent access to care issues.

Selected employee satisfaction survey responses demonstrated positive results for the leaders, and they appeared to maintain an environment where staff felt respected and discrimination was not tolerated. However, survey responses also identified opportunities for the ADPCS to promote a safe culture in the workplace. Selected patient experience survey scores generally reflected higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

The OIG's review of the system's accreditation agency findings, sentinel events, and disclosures of adverse patient events did not identify any substantial organizational risk factors. The executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models. In individual interviews, the executive leadership team members were also able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

The OIG made no recommendations.

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.[34] 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.[35]

During this time, VA continued providing care to veterans and engaged its fourth mission, the "provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have VA eligibility for such care and services."[36] "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."[37]

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

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

The OIG also surveyed healthcare system staff to solicit their feedback and potentially identify any problematic trends and/or issues that may require follow-up. The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[38]

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

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

[36] 38 U.S.C. § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the provision of hospital care and medical services during certain disasters and emergencies: "During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

[37] 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.

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[39] 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.[40] 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."[41]

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

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

The OIG reviewers also assessed the healthcare system's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization." Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[42] The OIG team examined various requirements related to systems redesign and improvement:

- Designation of a systems redesign and improvement coordinator
- Tracking of facility-level performance improvement capability and projects
- Participation on the facility quality management committee and VISN Systems Redesign Review Advisory Group
- Staff education on performance improvement principles and techniques

[39] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[40] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.
[41] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence.*
[42] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

Next, the OIG assessed the healthcare system's processes for conducting protected peer reviews of clinical care.[43] 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."[44] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[45] The OIG team examined the completion of the following elements:

- 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[46]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[47]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the healthcare system's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care." The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) operational oversight of surgical services and quality improvement activities;

[43] 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."

[44] VHA Directive 1190.

[45] VHA Directive 1190.

[46] VHA Directive 1190.

[47] VHA Directive 1190. A peer review is assigned a Level 3 when "most experienced and competent clinicians would have managed the case differently."

(2) policy development; (3) data stewardship; and (4) fiduciary responsibility for select specialty programs."[48] The healthcare system's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (registered nurse)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events[49]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[50]

Quality, Safety, and Value Findings and Recommendations

The healthcare system complied with requirements for systems redesign and improvement, protected peer reviews, and a surgical work group. However, the OIG identified weaknesses in the committee responsible for quality, safety, and value oversight functions.

VHA requires that facilities achieve and maintain TJC accreditation. According to TJC standards, facilities are to establish a governing body responsible for QSV oversight functions and practices. The governing body reviews relevant data and information and ensures that when actions are recommended by the governing body, they are fully implemented, and changes are monitored.[51]

The OIG reviewed Quality Safety Value Board (this healthcare system's governing body) meeting minutes between December 1, 2019, and November 30, 2020, and found that patient safety, utilization management, and infection prevention data were not routinely aggregated and reviewed. In addition, the OIG found no evidence that the board followed up on recommended improvement actions to ensure implementation and sustained improvement. This may have resulted in missed opportunities to improve the healthcare system's quality care and patient safety processes. The Chief, QSV stated that performance data were sometimes discussed at

[48] "NSO Reporting, Resources, & Tools," VA Surgical Quality Improvement Program, accessed November 21, 2020, https://vaww.nso.med.va.gov/apps/VASQIP/Pages/Default.aspx. (This is an internal VA website not publicly accessible.)

[49] VHA Directive 1102.01(1), *National Surgery Office,* April 24, 2019, amended May 22, 2019.

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

[51] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs,* May 9, 2017; TJC. Leadership standards LD.01.01.01, LD.01.03.01, and LD.03.02.01.

Quality Safety Value Board meetings but were not included in the minutes because of an extended administrative position vacancy and a lack of oversight. The Chief also stated that the Quality Safety Value Board's issue tracking log was insufficient and there was a lack of service-level oversight.

Recommendation 1

1. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures that the Quality Safety Value Board reviews aggregated quality, safety, and value data.[52]

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Executive Director evaluated and determined that there were no additional reasons for noncompliance and implemented the following action to improve the facility's process in identifying opportunities for improvement and implementing and monitoring corrective actions. The Chief, Quality Safety and Value (QSV), will ensure QSV Board minutes provide evidence of aggregated data in the meeting minutes, to include patient safety, utilization management and infection prevention data. Outcomes of aggregated QSV-related data and discussion will be documented in the meeting minutes. Continuous monitoring will be conducted by the QSV Board to ensure 90% compliance is sustained for two consecutive quarters (six months). Numerator is the number of QSV Board meeting minutes which contain aggregated QSV-related data, denominator is the total number of QSV Board meeting minutes for the same review period. Compliance data shall be subsequently reported by the Chief, QSV, to the Executive Quality Council (EQC), which is chaired by the facility's Executive Director on a quarterly basis.

Recommendation 2

2. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures that the Quality Safety Value Board's recommended improvement actions are fully implemented and monitored.[53]

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

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

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Executive Director evaluated and determined that there were no additional reasons for noncompliance and implemented the following actions to improve the facility's process in identifying opportunities for improvement and implementing and monitoring corrective actions. The Chief, QSV, developed an action tracker to ensure full implementation of corrective actions and ongoing sustainability of corrective actions. The tracker is embedded in QSV Board minutes. Continuous monitoring is conducted by the QSV Board. The Chief, QSV, is responsible to ensure, conduct and report compliance to the Executive Director and the EQC [Executive Quality Council] on a quarterly basis. Goal of 90% compliance sustained for two consecutive quarters (six months). Numerator is the QSV Board meeting minutes [that] will contain the action tracker to provide evidence of successful implementation and sustainment of corrective actions; denominator is the total number of QSV Board meeting minutes for the same review period.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[54] Licensure is defined by VHA as "the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration."[55]

VA requires all RNs to hold at least one active, unencumbered license.[56] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[57] When an action has been "taken against [an] applicant's sole license or against any of the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA's licensure requirements," and documented as required.[58] Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA's electronic credentialing system, prior to appointment to a VA medical facility.[59]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 25 RNs hired from January 1 through October 26, 2020. The OIG determined whether

- the RNs were free from potentially disqualifying licensure actions, or
- the Chief, Human Resources Management Service or Regional Counsel determined that the RNs met VA licensure requirements.

The OIG also reviewed the RNs' credentialing files to determine whether healthcare system staff completed primary source verification prior to the appointment.

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

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

[56] VHA Directive 2012-030. "Definition of *Unencumbered license,"* Law Insider, accessed December 3, 2020, https://www.lawinsider.com/dictionary/unencumbered-license. An unencumbered license is "a license that is not revoked, suspended, or made probationary or conditional by the licensing or registering authority in the respective jurisdiction as a result of disciplinary action."

[57] 38 U.S.C. § 7402.

[58] VHA Directive 2012-030.

[59] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

The OIG found that RNs hired by the healthcare system between January 1 and October 26, 2020, were free from potentially disqualifying licensure actions. However, the OIG found a deficiency with the completion of primary source verification prior to appointment.

VHA requires that the System Director ensures credentialing information is verified from primary sources prior to initial appointment or transfer from another medical facility.[60] The OIG found 3 of 25 RN (12 percent) credentialing files lacked evidence of primary source verification for all licenses held by each RN. This could lead to inappropriate hiring of nurses that could subsequently affect the provision of quality care. The Credentialing Specialist and Credentialing and Privileging Coordinator reported believing that completing primary source verification through the state board of nursing for each license and state of employment listed by an applicant would encompass every nursing license held.

Recommendation 3

3. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures that credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.

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

Healthcare system concurred.

Target date for completion: September 30, 2021

Healthcare system response: The Executive Director evaluated and addressed additional reasons for noncompliance and implemented the following action to improve the facility's process in identifying opportunities for improvement and implementing and monitoring corrective actions. The Credentialing and Privileging Manager and the Credentialing and Privileging Specialist (Credentialing Team) conducted a comprehensive review of RN licensure verification following the OIG CHIP visit. The use of Nursys ensures all RN licenses are primary source verified, whether disclosed on [the] VHA Nursing application or not. The Credentialing Team revised their quality process, developed an internal VetPro Checklist along with a Primary Source Verification Tracker to ensure primary source verification for each of an RN's licenses has been completed and documented on all new registered nurse's licenses prior to initial appointment.

The compliance shall be documented in a report to the Chief of Staff and the QSV Continuous Survey Readiness Coordinator (CSR), due by the 15th of the month following the end of each calendar year quarter. The CSR shall report compliance to QSV Board, with the Chief, QSV, subsequently reporting to EQC [Executive Quality Council], which is chaired by the Executive Director, on a quarterly basis until 90% compliance is sustained for two consecutive quarters (six months).

Numerator is the number of records with primary source verification on every license and reported new licensures for existing employees. Denominator is the total number of RNs hired in the previous quarter.

Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation

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.[61] 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.[62] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[63]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[64] The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.[65] The healthcare system was assessed for its adherence to the following requirements for suicide safety plans:

- Completion of suicide safety plans by required staff
- Completion of mandatory training by staff who develop suicide safety plans

To determine whether VHA facilities complied with selected requirements for suicide risk screening and evaluation within emergency departments and urgent care centers, the OIG inspection team interviewed key employees and reviewed

- relevant documents;

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

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

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

[64] Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Suicide Risk Screening and Assessment Requirements*, May 23, 2018.

[65] DUSHOM Memorandum, *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives*, October 17, 2019.

- the electronic health records of 49 randomly selected patients who were seen in the emergency department/urgent care center from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

The healthcare system generally met the requirements listed above. The OIG made no recommendations.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[66]

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients." Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.[67]

The healthcare system was assessed for its adherence to various requirements:

- Existence of a facility policy for inter-facility transfers
- Monitoring and evaluation of inter-facility transfers
- Completion of all required elements of the *Inter-Facility Transfer Form* or facility-defined equivalent by the appropriate provider(s) prior to patient transfer
- Transmission of patient's active medication list and advance directive to the receiving facility
- Communication between nurses at sending and receiving facilities

To determine whether the healthcare system complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 48 patients who were transferred from the healthcare system due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The healthcare system generally met the requirements listed above. The OIG made no recommendations.

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

[67] VHA Directive 1094. A completed *VA Inter-Facility Transfer Form* or an equivalent note communicates critical information to facilitate and ensure safe, appropriate, and timely transfer. Critical elements include documentation of patients' informed consent, medical and/or behavioral stability, mode of transportation and appropriate level of care required, identification of transferring and receiving physicians, and proposed level of care after transfer.

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[68] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff pose a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[69] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team[70]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[71]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[72]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[73]

[68] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

[69] VHA Directive 2012-026.

[70] VHA Directive 2012-026. An employee threat assessment team is "a facility-level, interdisciplinary team whose primary charge is using evidence-based and data-driven practices for addressing the risk of violence posed by employee-generated behavior(s), that are disruptive or that undermine a culture of safety."

[71] VHA Directive 2012-026. VHA defines a disruptive behavior committee or board as "a facility-level, interdisciplinary committee whose primary charge is using evidence-based and data-driven practices for preventing, identifying, assessing, managing, reducing, and tracking patient-generated disruptive behavior."

[72] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018. VA requires each medical facility's disruptive behavior committee "to use the Disruptive Behavior Reporting System (DBRS) to document a decision to implement an Order of Behavioral Restriction (OBR) and to document notification of a patient when an OBR is issued."

[73] DUSHOM Memorandum, *Workplace Behavioral Risk Assessment (WBRA)*, October 19, 2012. The Workplace Behavioral Risk Assessment is a "data-driven process that evaluates the unique constellation of factors that affect workplace safety. It enables facilities to make informed, supportable decisions regarding the level of PMDB [Prevention and Management of Disruptive Behavior] training needed to sustain a culture of safety in the workplace."

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[74] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[75] The OIG assessed staff compliance with the completion of required training.

To determine whether VHA facilities implemented and incorporated OIG-identified key processes for the management of disruptive and violent behavior, the inspection team examined relevant documents and training records and interviewed key managers and staff.

High-Risk Processes Findings and Recommendations

The OIG found that the healthcare system addressed many of the indicators of expected performance for the management of disruptive and violent behavior. However, the OIG found deficiencies with Disruptive Behavior Committee meeting attendance and Employee Threat Assessment Team training.

VHA requires that the Chief of Staff and Nurse Executive (ADPCS) are responsible for establishing a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; a patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and the Union Safety Committee.[76]

The OIG found that from December 2019 through November 2020, administrative support staff did not attend 42 percent of the meetings. Additionally, the OIG found that representatives from the Prevention and Management of Disruptive Behavior Program and VA police did not attend 92 and 17 percent of the meetings, respectively. This could result in a lack of knowledge and expertise when assessing patients' disruptive behavior. The Disruptive Behavior Committee co-chairs and Chief of Organizational Development and Education explained that a staff vacancy, competing patient care priorities, and not being aware of the attendance requirements led to noncompliance. Additionally, the Deputy Chief of Police cited competing work demands as a reason for the lack of meeting attendance.

[74] DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

[75] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

[76] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.

Recommendation 4

4. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure all required representatives attend Disruptive Behavior Committee meetings.

Healthcare system concurred.

Target date for completion: September 30, 2021

Healthcare system response: The Chief of Staff and Associate Director for Patient Care Services evaluated reasons for noncompliance and determined no additional reasons as indicated in the initial recommendations and implemented the following action to improve the facility's process in identifying opportunities for improvement and implementing and monitoring corrective actions.

The Chair of the Disruptive Behavior Committee (DBC), chair is responsible for DBC attendance oversight, monitoring attendance at all meetings to ensure attendance by required members or their designated representative per Directive (Senior Clinician Chair, representative of the Prevention Management of Disruptive Behavior Program, VA Police, Health Information Management Service and/or Privacy Officer (ad hoc), Patient Safety/Risk Management, Patient Advocate, Representative of the Union Safety Committee and Clerical Support). The DBC Chair or designee shall report aggregate attendance metrics of all meetings held to the QSV Continuous Survey Readiness Coordinator (CSR) on a quarterly basis with a goal of 90% or greater attendance by the required members to ensure sustainability. Numerator is the number of meetings each member attended, evidenced by [the] DBC minutes attendance roster. Denominator is the number of all meetings held during the quarter.

The CSR shall report aggregate metric compliance to the QSV Board quarterly. The Chief, QSV, shall subsequently report metrics to the EQC [Executive Quality Council], which is chaired by the Executive Director. The DBC Chair shall also report attendance metrics to the Clinical Executive Board (CEB), which is chaired by the Chief of Staff and attended by the Associate Director of Patient Care Services. Attendance metrics shall be reported to QSV Board and CEB on a quarterly basis until 90% compliance is sustained for two consecutive quarters (six months).

VHA requires the chair and members of the Employee Threat Assessment Team to complete specific workplace violence prevention program training.[77] The OIG found that 88 percent of Employee Threat Assessment Team members did not complete the required training. This could result in ineffective efforts to de-escalate disruptive behaviors in times of crisis. The Chief of Organizational Development and Education stated that not being informed of new Employee

[77] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018.

Threat Assessment Team members led to noncompliance. Additionally, the Prevention and Management of Disruptive Behavior Program Coordinator attributed noncompliance to a system-wide lack of oversight caused by an education coordinator position vacancy. The Prevention and Management of Disruptive Behavior Program Coordinator reported that Employee Threat Assessment Team members completed or were assigned the training prior to the completion of the OIG's virtual review. Therefore, the OIG made no recommendation.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines four OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Executive Director, Chief of Staff, and ADPCS. The intent is for these leaders to use the recommendations to guide improvements in operations and clinical care. The recommendations address findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Budget and operations • Staffing • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Identified factors related to possible lapses in care and healthcare system response • VHA performance data (healthcare system) • VHA performance data (CLC)	• None	• None
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback	The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• The Quality Safety Value Board reviews aggregated QSV data. • The Quality Safety Value Board's recommended improvement actions are fully implemented and monitored.	• None
RN Credentialing	• RN licensure requirements • Primary source verification	• Credentialing staff complete primary source verification of all RNs' licenses prior to initial appointment.	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• None	• None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• None	• All required representatives attend Disruptive Behavior Committee meetings.

Appendix B: Healthcare System Profile

The table below provides general background information for this medium complexity (2) affiliated healthcare system reporting to VISN 19.[1]

Table B.1. Profile for VA Western Colorado Health Care System (575) (October 1, 2017, through September 30, 2020)

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019	Healthcare System Data FY 2020‡
Total medical care budget	$153,336,109	$170,885,962	$209,327,258
Number of:			
• Unique patients	14,959	15,457	15,155
• Outpatient visits	190,321	197,640	175,612
• Unique employees§	592	656	748
Type and number of operating beds:			
• Community living center	30	31	31
• Medicine	13	14	11
• Mental health	8	8	6
• Surgery	10	3	3
Average daily census:			
• Community living center	24	27	18
• Medicine	8	9	9
• Mental health	2	2	2
• Surgery	1	1	1

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, 2017, through September 30, 2018.*

October 1, 2018, through September 30, 2019.

‡*October 1, 2019, through September 30, 2020.*

§*Unique employees involved in direct medical care (cost center 8200).*

[1] An affiliated healthcare system is associated with a medical residency program. 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 healthcare system provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table C.1. provides information relative to each of the clinics.[1]

Table C.1. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2019, through September 30, 2020)

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Montrose, CO	575GA	3,383	186	Dermatology Endocrinology Gastroenterology Nephrology Podiatry Rheumatology	–	Nutrition Social Work Weight management
Craig, CO	575GB	1,086	105	Dermatology Endocrinology Nephrology Podiatry	–	Nutrition Pharmacy Weight management

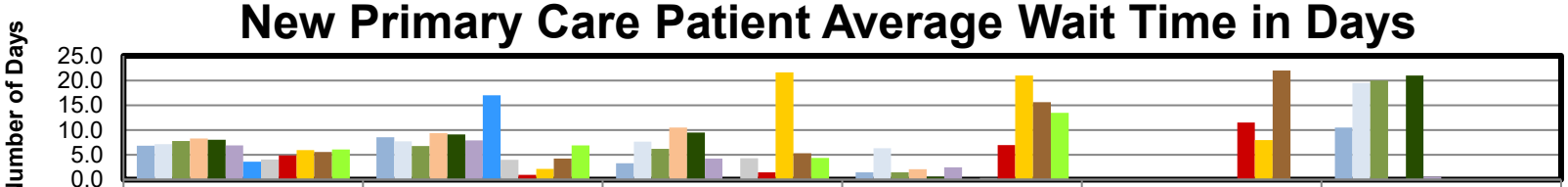
[1] The OIG omitted Grand Junction, CO (575QD) as no workload/encounters or services were reported. VHA Directive 1230(4), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended June 17, 2021. An encounter is a "professional contact between a patient and a provider vested with responsibility 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.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Glenwood Springs, CO	575QA	1,105	1,020	Endocrinology Gastroenterology Nephrology Podiatry	–	Nutrition Social Work Weight management
Moab, UT	575QB	2,073	80	Endocrinology Gastroenterology General surgery Nephrology Neurology Podiatry	–	Nutrition Prosthetics

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



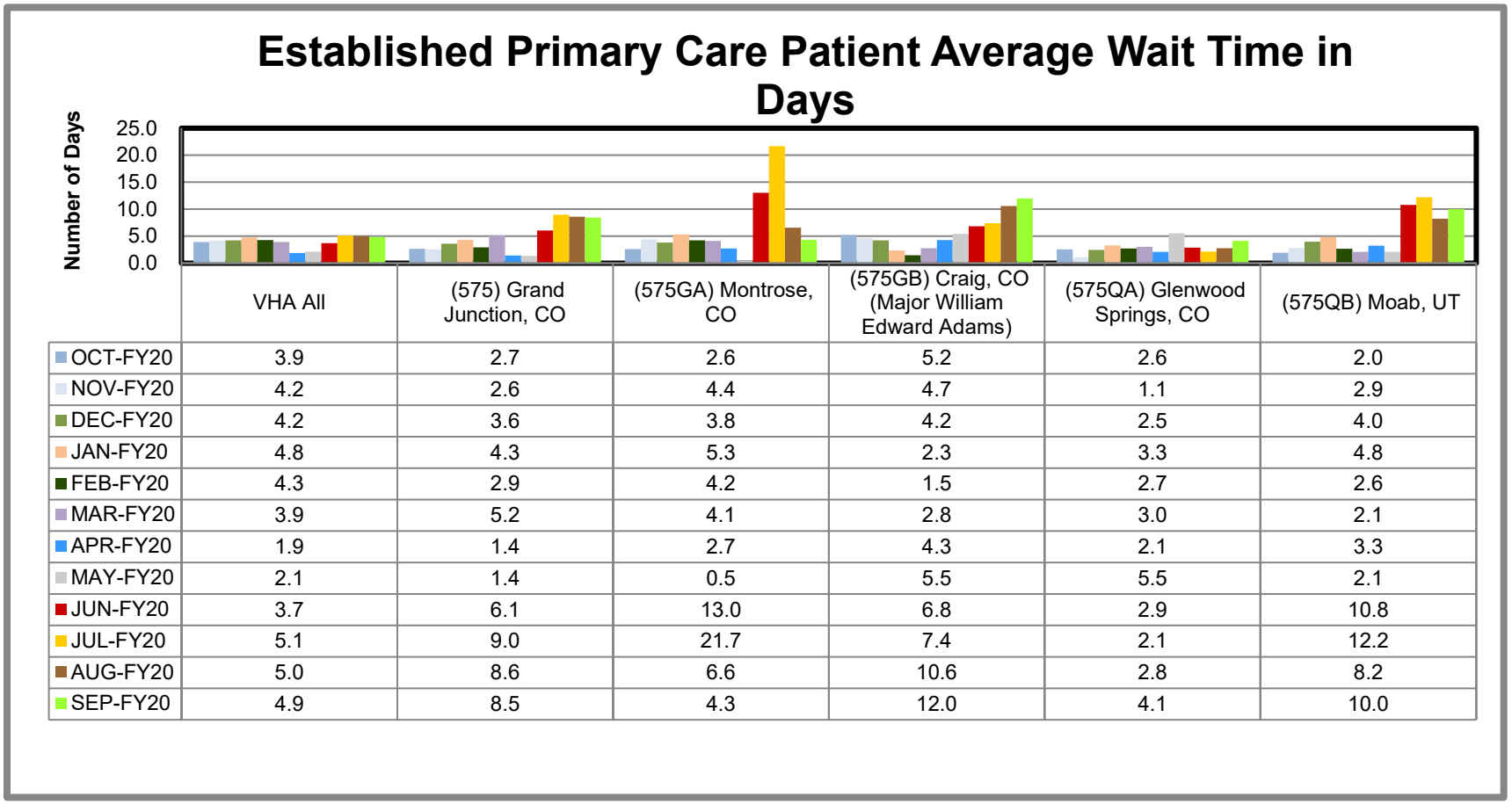
	VHA All	(575) Grand Junction, CO	(575GA) Montrose, CO	(575GB) Craig, CO (Major William Edward Adams)	(575QA) Glenwood Springs, CO	(575QB) Moab, UT
OCT-FY20	6.9	8.5	3.3	1.5	n/a	10.5
NOV-FY20	7.1	7.7	7.7	6.3	0.0	19.5
DEC-FY20	7.8	6.8	6.2	1.5	0.0	20.0
JAN-FY20	8.3	9.4	10.5	2.1	n/a	0.0
FEB-FY20	8.1	9.1	9.5	0.6	n/a	21.0
MAR-FY20	6.9	7.9	4.3	2.5	n/a	0.6
APR-FY20	3.6	17.0	0.0	0.0	0.0	n/a
MAY-FY20	4.0	4.0	4.3	0.3	n/a	n/a
JUN-FY20	4.9	0.9	1.5	7.0	11.5	n/a
JUL-FY20	5.9	2.2	21.7	21.0	8.0	0.0
AUG-FY20	5.6	4.3	5.4	15.7	22.0	0.0
SEP-FY20	6.1	6.9	4.4	13.5	0.0	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. The OIG omitted (575QD) Grand Junction 28 Road, CO as no data were reported.

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



	VHA All	(575) Grand Junction, CO	(575GA) Montrose, CO	(575GB) Craig, CO (Major William Edward Adams)	(575QA) Glenwood Springs, CO	(575QB) Moab, UT
OCT-FY20	3.9	2.7	2.6	5.2	2.6	2.0
NOV-FY20	4.2	2.6	4.4	4.7	1.1	2.9
DEC-FY20	4.2	3.6	3.8	4.2	2.5	4.0
JAN-FY20	4.8	4.3	5.3	2.3	3.3	4.8
FEB-FY20	4.3	2.9	4.2	1.5	2.7	2.6
MAR-FY20	3.9	5.2	4.1	2.8	3.0	2.1
APR-FY20	1.9	1.4	2.7	4.3	2.1	3.3
MAY-FY20	2.1	1.4	0.5	5.5	5.5	2.1
JUN-FY20	3.7	6.1	13.0	6.8	2.9	10.8
JUL-FY20	5.1	9.0	21.7	7.4	2.1	12.2
AUG-FY20	5.0	8.6	6.6	10.6	2.8	8.2
SEP-FY20	4.9	8.5	4.3	12.0	4.1	10.0

Source: VHA Support Service Center.

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (575QD) Grand Junction 28 Road, CO as no data were reported.

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

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

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

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

Source: VHA Support Service Center.

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

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
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.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
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 24, 2021

From: Director, Rocky Mountain Network (10N19)

Subj: Comprehensive Healthcare Inspection of the VA Western Colorado Health Care System in Grand Junction

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

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

1. I have reviewed the findings, recommendations, and action plan of the Western Colorado Health Care System in Grand Junction. I am in agreement with the above.

(Original signed by:)

Ralph Gigliotti

Network Director, VISN 19

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: June 17, 2021

From: Director, VA Western Colorado Health Care System (575/00)

Subj: Comprehensive Healthcare Inspection of the VA Western Colorado Health Care System in Grand Junction

To: Director, Rocky Mountain Network (10N19)

1. I have reviewed the draft report – Comprehensive Healthcare Inspection of the VA Western Colorado Health Care System in Grand Junction. We concur with all the findings and recommendations.

2. I appreciate the opportunity for this review as a continuing process to improve the care to our Veterans.

(Original signed by:)

Richard W. Salgueiro

Executive Director

OIG Contact and Staff Acknowledgments

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