DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 20: VA Northwest Health Network in Vancouver, Washington

CHIP REPORT | REPORT #20-01254-185 | AUGUST 4, 2021

MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

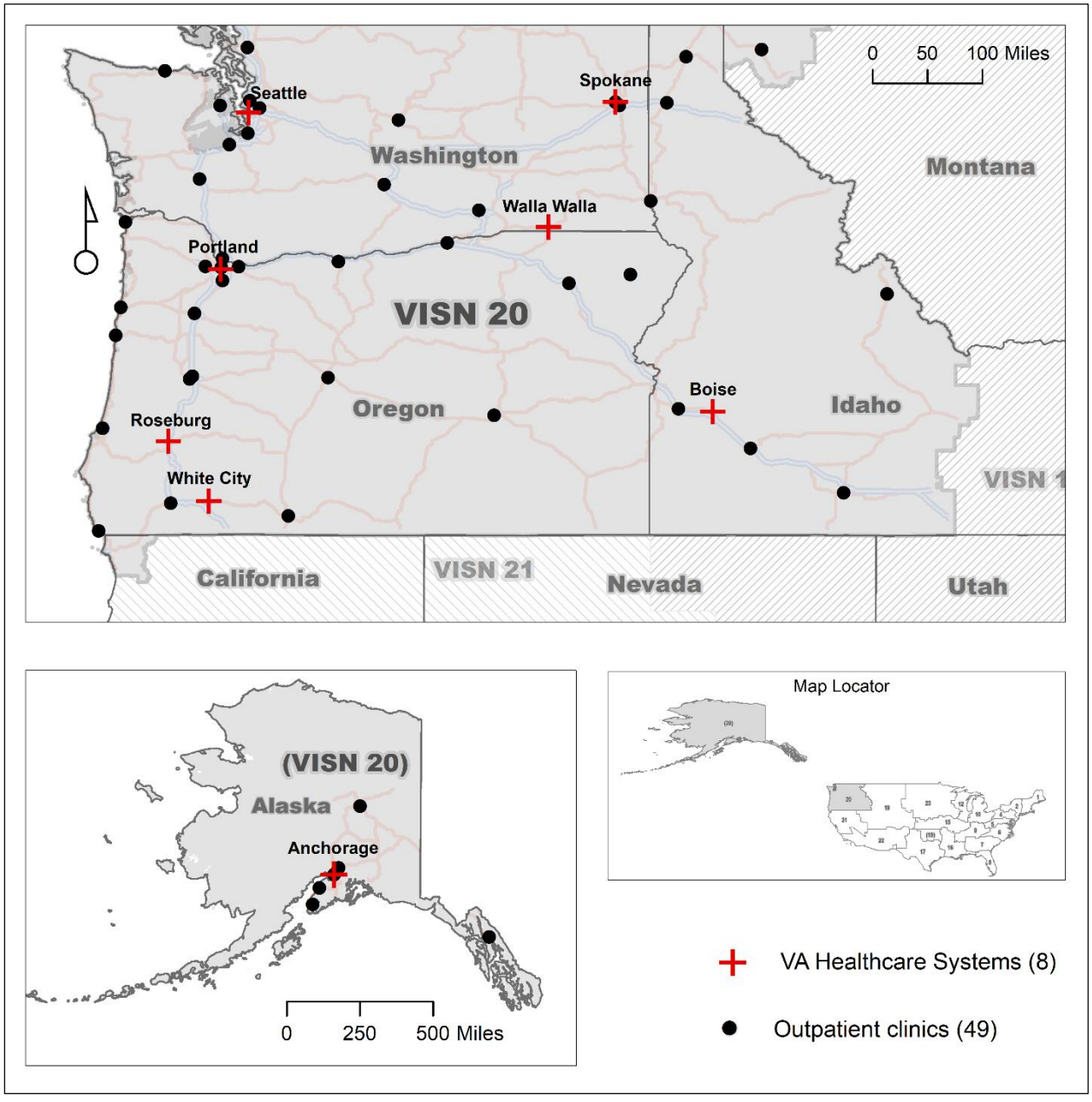


Figure 1. *Veterans Integrated Service Network 20: VA Northwest Health Network.*
Source: Veterans Affairs Site Tracking database (accessed September 17, 2020).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	chief medical officer
CRH	clinical resource hub
FTE	full-time equivalent
FY	fiscal year
HCS	health care system
HRO	human resource officer
OIG	Office of Inspector General
QMO	quality management officer
RME	reusable medical equipment
SAIL	Strategic Analytics for Improvement and Learning
SPS	Sterile Processing Services
VAMC	VA medical center
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 leadership performance and oversight by the Veterans Integrated Service Network (VISN) 20: VA Northwest Health Network. The inspection covers key clinical and administrative processes associated with promoting quality care.

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

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

1. COVID-19 pandemic readiness and response[1]
2. Quality, safety, and value
3. Medical staff credentialing
4. Environment of care
5. Medication management (targeting long-term opioid therapy for pain)
6. Women's health (examining comprehensive care)
7. High-risk processes (emphasizing reusable medical equipment)

The OIG conducted this unannounced virtual review during the week of September 21, 2020. Inspections of the following VISN 20 facilities were also initiated during the weeks of September 14 and 21, 2020:

- Boise VA Medical Center (VAMC) (Idaho)
- Mann-Grandstaff VAMC (Spokane, Washington)
- Roseburg VA Health Care System (HCS) (Oregon)
- VA Portland HCS (Oregon)
- VA Puget Sound HCS (Seattle, Washington)[2]

[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 VA Puget Sound HCS is a two-campus medical center, comprised of the Seattle and American Lake (Tacoma, Washington) divisions.

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient care outcomes. The findings presented in this report are a snapshot of VISN 20 and facility performance within the identified focus areas at the time of the OIG review and may help VISN leaders identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued four recommendations to the Network Director and Chief Medical Officer (CMO). These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

The VISN leadership team consisted of the Network Director, Deputy Network Director, CMO, Quality Management Officer, and Human Resource Officer. Organizational communication and accountability were managed through a committee reporting structure, with the VISN's Governance Board overseeing the Health Care Delivery, Health Care Operations, Quality Safety Value, and Organizational Health Councils.

At the time of the OIG's inspection, the VISN's leadership team had worked together for one month. The newest members, the CMO and Network Director, were assigned in April and August 2020, respectively. The longest-tenured member, the Human Resource Officer, had served since 2012. The Deputy Network Director and Quality Management Officer were assigned in 2014 and 2018.

The OIG reviewed selected employee satisfaction survey results and concluded that the Deputy Network Director and CMO have opportunities to improve employee perceptions of leadership and the workplace. The selected patient experience survey scores for the VISN were similar to or higher than the Veterans Health Administration (VHA) averages, indicating a generally satisfied patient population.

The OIG's evaluation of VISN access metrics and clinical vacancies identified potential organizational risks at select facilities, with wait times approaching 20 days or more and clinical vacancies in certain specialties. Interviewed leaders were knowledgeable about facility actions taken to reduce veteran suicide in VISN 20 and shared information that highlighted efforts to develop and implement strategies for high-risk veterans.

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

way to understand the similarities and differences between the top and bottom performers within VHA.[3]

Leaders were knowledgeable within their scope of responsibilities about selected SAIL and community living center metrics; however, due to their short tenure, the Network Director and CMO only had general knowledge of the current status of problematic metrics but were able to identify subject matter experts who could address specific questions about actions taken to prior to their appointments. The leaders should continue to take actions to sustain and improve performance measures contributing to quality ratings and care provided throughout the VISN.

Additionally, the OIG identified that the Network Director, CMO, and Quality Management Officer have opportunities to improve their oversight of facility-level quality, safety, and value; medical staff privileging; medication management; mental health; care coordination; women's health; and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

COVID-19 Pandemic Readiness and Response

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

Medical Staff Credentialing

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

High-Risk Processes

The VISN complied with requirements for the establishment of a sterile processing services management board. However, the VISN has opportunities to improve its facility reusable medical equipment inspection processes.

Conclusion

The OIG conducted a detailed inspection across eight key areas and subsequently issued four recommendations for improvement to the Network Director and CMO. The number of recommendations should not be used, however, as a gauge for the overall quality of care provided within this VISN. The intent is for VISN leaders to use these recommendations as a

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

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

road map to help improve operations and clinical care throughout the network of assigned facilities. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director agreed with the comprehensive healthcare inspection program findings and recommendations and provided acceptable improvement plans. (See appendix G, page 50, and the responses within the body of the report for the full text of the Network Director's comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

Purpose and Scope

The purpose of this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to evaluate leadership performance and oversight by Veterans Integrated Service Network (VISN) 20: VA Northwest Health Network. This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so that informed decisions can be made to improve care.[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]

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

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[4]
3. Quality, safety, and value
4. Medical staff credentialing
5. Environment of care
6. Medication management (targeting long-term opioid therapy for pain)
7. Women's health (examining comprehensive care)
8. High-risk processes (emphasizing reusable medical equipment)

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

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected documents and administrative and performance measure data. The team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.[5]

The inspection examined operations from January 23, 2017, through September 25, 2020, the last day of the unannounced multiday evaluation.[6] During the virtual review, the OIG did not receive any complaints beyond the scope of the inspection.

Inspections of the following VISN 20 facilities were also initiated during the weeks of September 14 and 21, 2020:

- Boise VA Medical Center (VAMC) (Idaho)
- Mann-Grandstaff VAMC (Spokane, Washington)
- Roseburg VA Health Care System (HCS) (Oregon)
- VA Portland HCS (Oregon)
- VA Puget Sound HCS (Seattle, Washington)[7]

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

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

[5] The OIG did not inspect three VISN 20 facilities (Alaska VA Healthcare System in Anchorage; Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington; and VA Southern Oregon Rehabilitation Center and Clinics in White City, Oregon) due to recently-performed comprehensive healthcare inspections in fiscal year 2019.

[6] The range represents the time from the last Combined Assessment Program review of the Boise VAMC to the completion of the unannounced, multiday virtual CHIP visit on September 25, 2020 (see appendix D).

[7] The VA Puget Sound HCS is a two-division system, with facilities in Seattle (Washington) and American Lake (Tacoma, Washington).

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

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

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

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

Results and Recommendations

Leadership and Organizational Risks

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

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Access to care
5. Clinical vacancies
6. VISN efforts to reduce veteran suicide
7. Electronic health record modernization
8. Oversight inspections
9. VHA performance data

Additionally, the OIG briefed VISN managers on identified trends in noncompliance for facility virtual CHIP visits performed during the weeks of September 14 and 21, 2020.

Executive Leadership Position Stability and Engagement

A VISN consists of a geographic area that encompasses a population of veteran beneficiaries. The VISN is defined based on VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VAMCs, clinics, and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is designed to be the basic budgetary and planning unit of the veterans' healthcare system.[11]

VISN 20 is the largest network in terms of geographic size, providing care in Alaska, Washington, Oregon, Idaho, and in small portions of Montana and California. The VISN oversees 8 health care systems, which include 49 outpatient clinics. According to data from the

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

[11] Detailed explanation of VISNs provided by Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration, Department of Veterans Affairs, before the House Committee on Veterans' Affairs, May 22, 2018.

VA National Center for Veterans Analysis and Statistics, VISN 20 had a veteran population of 1,027,940 within its borders at the end of fiscal year (FY) 2020 and a projected population of 1,011,475 by the end of FY 2021.

VISN 20 had a leadership team consisting of the Network Director, Deputy Network Director, Chief Medical Officer (CMO), Quality Management Officer (QMO), and Human Resource Officer (HRO). The CMO was responsible for overseeing facility-level patient care programs. Figure 2 illustrates the VISN's reported organizational structure.[12]

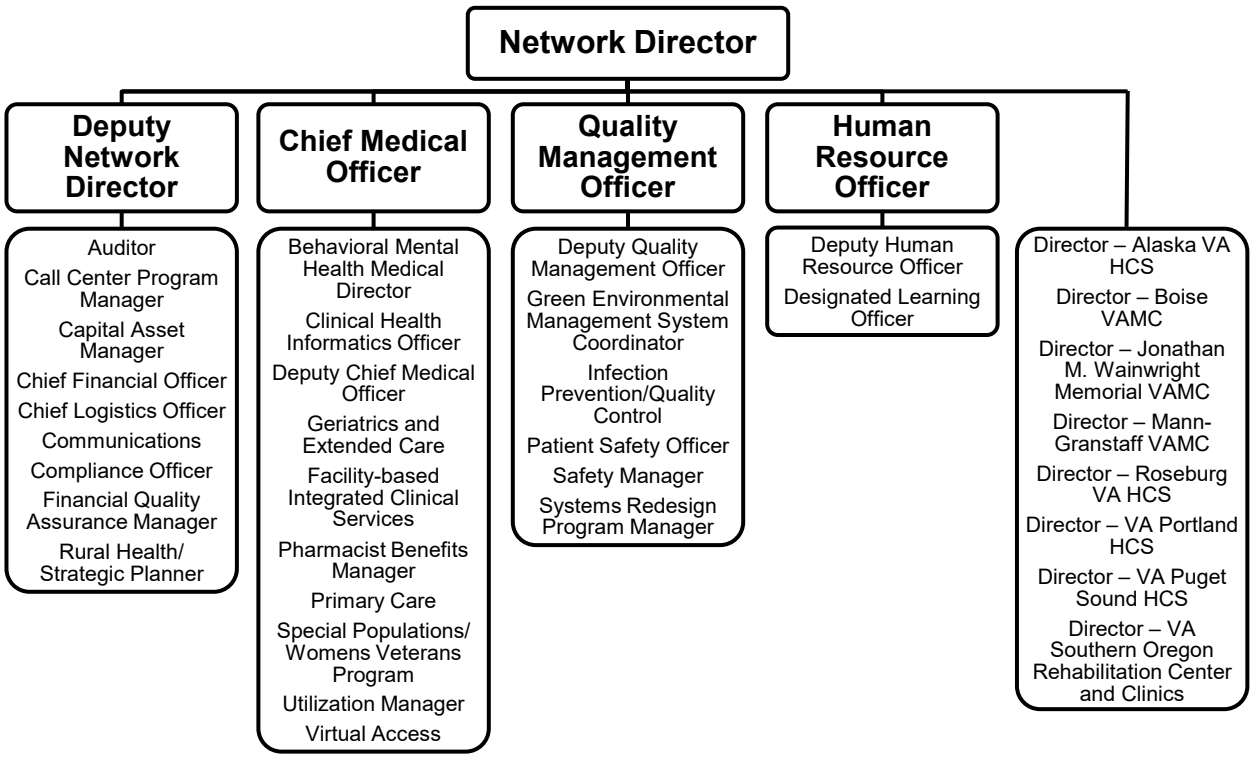


Figure 2. *VISN 20 organizational chart.*

Source: VA Northwest Health Network (received September 21, 2020).

At the time of the OIG's virtual site visit, the VISN's leadership team had worked together for one month. The newest members, the CMO and Network Director, were assigned in April and August 2020, respectively. The longest-tenured member, the HRO, had served since 2012. The Deputy Network Director and QMO were assigned in 2014 and 2018, respectively (see table 1).

[12] For this VISN, the Network Director is responsible for the directors of the Alaska VA HCS (Anchorage); Boise VAMC (Idaho); Jonathan M. Wainwright Memorial VAMC (Walla Walla, Washington); Mann-Grandstaff VAMC (Spokane, Washington); Roseburg VA HCS (Oregon); VA Portland HCS (Oregon); VA Puget Sound HCS (Seattle, Washington); and VA Southern Oregon Rehabilitation Center and Clinics (White City).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network Director	August 30, 2020
Deputy Network Director	November 16, 2014
Chief Medical Officer	April 12, 2020
Quality Management Officer	April 29, 2018
Human Resource Officer	August 26, 2012

Source: VA Northwest Network, (received September 21, 2020).

To help assess VISN executive leaders' engagement, the OIG interviewed the Network Director, Deputy Network Director, CMO, and QMO regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

Due to their short tenures, the Network Director and CMO deferred to subject matter experts for detailed information. However, the rest of the executive leaders were generally knowledgeable within their scope of responsibilities about VHA data and/or factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. The executive leaders also understood Community Living Center (CLC) SAIL metrics, and in individual interviews, were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and patient experiences. These are discussed in greater detail below.

The OIG recognizes that significant and widespread changes in the delivery of healthcare services have occurred during the COVID-19 pandemic and notes that the interpretation of productivity data and supporting reports may be skewed by events and, therefore, may require further analysis to reach specific actionable conclusions.

Organizational communication and accountability were managed through a committee reporting structure, with the VISN's Governance Board overseeing several councils and working groups. The VISN's Governance Board was responsible for processes that enhance network performance through

- organizational values and strategic direction,
- policy development and decision making,
- compliance and financial performance,
- creation and balancing of values for patients and other stakeholders,
- regular review of organizational performance and capabilities,
- priorities for improvement and opportunities for innovation, and

- communication and development of organizational goals/objectives across the network.

The Network Director served as the chairperson of the Governance Board, which had oversight of the Health Care Delivery, Health Care Operations, Quality Safety Value, and Organizational Health Councils (see figure 3).

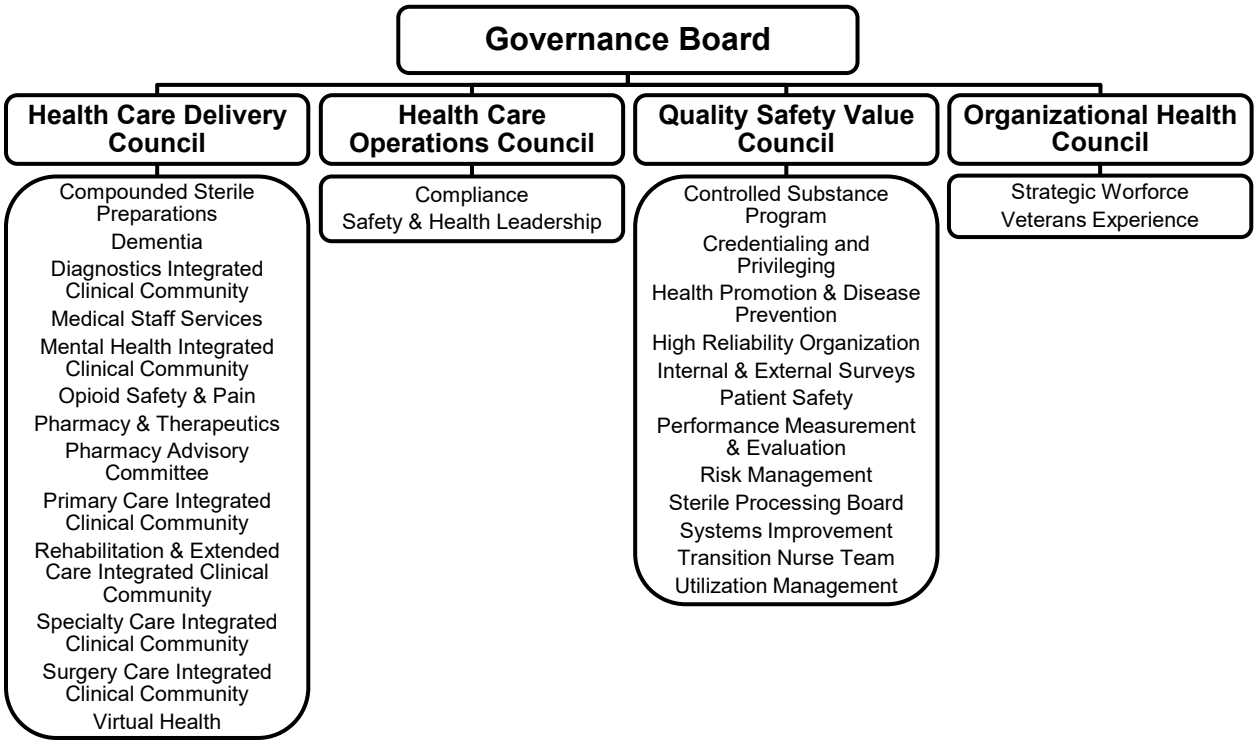


Figure 3. *VISN 20 committee reporting structure.*

Source: VA Northwest Health Network (received September 21, 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.[13] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on VISN leadership.

To assess employee attitudes toward VISN leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2018,

[13] "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.)

through September 30, 2019.[14] Table 2 summarizes employee attitudes as expressed in VHA's All Employee Survey for VHA, the VISN office, and leaders. Although the VISN office scores were generally better than those for VHA, the Deputy Network Director and CMO appeared to have opportunities to improve employee attitudes toward leadership.[15]

Table 2. Survey Results on Employee Attitudes toward VISN 20 Leadership (October 1, 2018, through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	VISN 20 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average	HRO Average
All Employee Survey: *Servant Leader Index Composite**	0–100 where HIGHER scores are more favorable	72.6	77.8	93.0	69.3	80.9	87.5	82.7
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.4	3.5	4.2	2.4	3.1	4.2	4.0
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.7	4.8	3.0	3.2	4.3	4.1

[14] Ratings are based on responses by employees who report to or are aligned under the Network Director, Deputy Network Director, CMO, QMO, and HRO. The scores are not reflective of the current Network Director or CMO, who assumed their roles after the survey was administered.

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

Questions/ Survey Items	Scoring	VHA Average	VISN 20 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average	HRO Average
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.6	4.0	2.6	3.1	4.3	4.2

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

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

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Except for the Deputy Network Director and CMO, the VISN office and leaders' averages were consistently better than those for VHA. Executive leaders shared survey results with staff and created employee workgroups to identify improvement goals for the coming year. VISN leaders generally appeared to maintain an environment where employees felt safe bringing forth issues and concerns.

Table 3. Survey Results on Employee Attitudes toward the VISN 20 Workplace (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	VISN 20 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average	HRO Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	4.1	4.8	3.6	3.9	4.6	4.3

Questions/Survey Items	Scoring	VHA Average	VISN 20 Office Average	Network Director Average	Deputy Network Director Average	CMO Average	QMO Average	HRO Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	4.0	–*	3.6	3.8	4.7	4.3
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) lower is better.	1.4	1.2	0.4	0.9	2.3	0.7	0.9

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

**Data were not available for the question.*

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to four relevant questions that reflect patients' attitudes toward the quality of health care received. Table 4 provides relevant survey results for VISN 20 and compares the results to overall VHA

averages.[16] The VISN average for each of the selected questions was similar to or higher than the VHA average, indicating that VISN 20 patients were generally as satisfied as the average VHA patient.

Table 4. Survey Results on Patient Attitudes within VISN 20 (October 1, 2018, through September 30, 2019)

Questions	Scoring	VHA Average	VISN 20 Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.3	72.3
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.9	86.3
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	77.3	77.8
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	78.0	77.9

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

VISN leaders acknowledged lower-than-average scores for various facilities (see appendix C). The VISN recently hired a Veteran Experience Officer to oversee patient satisfaction initiatives. The Veteran Experience Officer was responsible for implementing the Patient Advocate Tracking System Replacement tool, which is used by facility patient advocates to respond more

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

quickly to patient complaints and improve patients overall experience.[17] The Veteran Experience Officer also reviewed and developed corrective actions in response to issues identified by Veterans Signals, a survey sent to randomly selected veterans about recent encounters with outpatient services.[18]

Access to Care

Achieving and maintaining an optimal workforce to ensure timely access to the best care and benefits for our nation's veterans is a VA priority. VHA has the goal of providing patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date, if a clinically indicated date is not provided.[19] VHA has used various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates.[20] Wait time measures based on "create date" have the advantage of not relying on the accuracy of the "preferred date" entered into the scheduling system and are particularly applicable for new primary care patients where the care is not initiated by referral, or consultation, that includes a "clinically indicated date." The disadvantage of "create date" metrics is that wait times do not account for specific patient requests or availability. Wait time measures based on patient preferred dates consider patient preferences but rely on appointment schedulers accurately recording the patients' wishes into the scheduling software.[21]

When VHA facilities could not offer appointments within 30 days of clinically indicated or preferred dates, patients became eligible to receive non-VA (community) care through the VA

[17] VA, "New Patient Advocate Tracking System empowers VA employees to resolve issues on the spot," *VAntage Point* (blog), March 4, 2020, https://blogs.va.gov/VAntage/72212/patsr/#:~:text=Tracking%20and%20identifying%20issues&text=That%20information%20allows%20VA%20to,understanding%20the%20gaps%20in%20service. The VA recently rolled out the Patient Advocate Tracking System Replacement tool nationwide. The tool "helps VA's patient care teams at VA Medical Centers to work together to understand and address Veteran feedback and concerns…[for] better, faster service recovery and an improved customer experience."

[18] VA, "VA Customer Profile and Veterans Signals programs recognized by FedHealthIT," *VAntage Point* (blog), June 18, 2019, https://www.blogs.va.gov/VAntage/61703/va-customer-profile-veterans-signals-programs-recognized-fedhealth/. Veterans Signals is a VHA survey sent to veterans who received outpatient services within the previous week. Surveys remain open for two weeks after the invitation is sent. The feedback veterans submit is used to quickly help inform opportunities for service recovery and performance improvement.

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

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

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

Choice program. Eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.[22] However, with the passage of the VA MISSION Act of 2018 on June 6, 2018, and subsequent enactment on June 6, 2019, eligibility criteria for obtaining care in the community now include average drive times and appointment wait times:[23]

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

To examine access to primary and mental health care within VISN 20, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health clinics for the most recently completed quarter. Tables 5 and 6 provide wait time statistics for completed primary care and mental health appointments from April 1 through June 30, 2020.[24]

Table 5. Primary Care Appointment Wait Times (April 1 through June 30, 2020)

Facility	New Patient Appointments	Average New Patient Wait from Create Date (Days)
VA Northwest Health Network	1,597	12.9
Alaska VA HCS (Anchorage)	216	8.4
Boise VAMC (Idaho)	214	17.2

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

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

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

Facility	New Patient Appointments	Average New Patient Wait from Create Date (Days)
Jonathan M. Wainwright Memorial VAMC (Walla Walla, Washington)	47	5.3
Mann-Grandstaff VAMC (Spokane, Washington)	62	14.3
Roseburg VA HCS (Oregon)	90	28.4
VA Portland HCS (Oregon)	501	8.6
VA Puget Sound HCS (Seattle, Washington)	456	13.6
VA Southern Oregon Rehabilitation Center and Clinics (White City)	11	8.5

Source: VHA Support Service Center (accessed August 20, 2020).
Note: The OIG did not assess VA's data for accuracy or completeness.

Table 6. Mental Health Appointment Wait Times (April 1 through June 30, 2020)

Facility	New Patient Appointments	Average New Patient Wait from Create Date (Days)
VA Northwest Health Network	1,032	8.6
Alaska VA HCS (Anchorage)	127	7.1
Boise VAMC (Idaho)	109	6.5
Jonathan M. Wainwright Memorial VAMC (Walla Walla, Washington)	12	7.6
Mann-Grandstaff VAMC (Spokane, Washington)	74	9.8
Roseburg VA HCS (Oregon)	21	5.1
VA Portland HCS (Oregon)	460	9.6
VA Puget Sound HCS (Seattle, Washington)	209	8.3
VA Southern Oregon Rehabilitation Center and Clinics (White City)	20	8.4

Source: VHA Support Service Center (accessed August 20, 2020).
Note: The OIG did not assess VA's data for accuracy or completeness.

Based on wait times alone, the MISSION Act may improve access to primary care for patients at the Roseburg VA HCS and Boise VAMC, where the average wait times for new primary care appointments were 28.4 and 17.2 days, respectively. VISN mental health wait times averaged 8.6 days (all facilities' wait times were less than 10 days). Wait time data also highlights opportunities for these facilities to improve the timeliness of primary care provided "in house" and thus decrease the potential for fragmented care among patients referred to community providers.

To ensure timely access to care, the VISN has a clinical resource hub (CRH) at the Boise VAMC that provides virtual gap coverage for primary care and mental health clinics in need of back-up staffing. Patient encounters with CRH clinicians are virtual, where providers interact remotely with patients via VA Video Connect.[25] In May 2020, a director was hired to oversee the realignment and organization of primary care and mental health providers within the CRH. As of September 24, 2020, the CRH had supported 35 primary care sites in the VISN. As shown in table 5 above, the Roseburg VA HCS had a 28-day wait time for new patient primary care appointments from April 1 through June 30, 2020. VISN leaders shared information about CRH efforts to reduce the Roseburg VA HCS wait times by providing 262 virtual primary care encounters.

Clinical Vacancies

Within the healthcare field, there is general acceptance that staff turnover—or instability—and high clinical vacancy rates negatively affect access to care, quality, patient safety, and patient and staff satisfaction. Turnover can directly affect staffing levels and further reduce employee and organizational performance through the loss of experienced staff.[26]

To assess the extent of clinical vacancies across VISN 20 facilities, the OIG held discussions with the HRO and reviewed the total number of vacancies by facility, position, service or section, and FTE. Table 7 provides the individual facility vacancies that are reflected in the VISN's 894.9 clinical vacancies (16.5 percent clinical vacancy rate) and 12.4 percent total vacancy rate across the VISN as of September 21, 2020.

Table 7. Reported Vacancy Rates for VISN 20 Facilities (as of September 21, 2020)

Facility	Clinical Vacancies	Clinical Vacancy Rate (%)	Total Vacancy Rate (%)
Jonathan M. Wainwright Memorial VAMC (Walla Walla, Washington)	53.7	23.6	17.2
VA Southern Oregon Rehabilitation Center and Clinics (White City)	79.8	25.0	16.8
Mann-Grandstaff VAMC (Spokane, Washington)	137.1	21.8	15.4

[25] "VA Mobile: Veterans VA Video Connect," accessed April 24, 2020, https://www.mobile.va.gov/app/va-video-connect. VA Video Connect allows veterans to see and talk with their health care team from anywhere. It uses encryption to ensure a secure and private session. This technology makes VA health care more convenient and reduces travel times for veterans, especially those in very rural areas with limited access to VA health care facilities. It also allows quick and easy health care access from any mobile or web-based device.

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

Facility	Clinical Vacancies	Clinical Vacancy Rate (%)	Total Vacancy Rate (%)
Roseburg VA HCS (Oregon)	116.6	22.9	15.0
VA Puget Sound HCS (Seattle, Washington)	236.3	11.4	13.6
Boise VAMC (Idaho)	66.4	9.2	11.4
VA Portland HCS (Oregon)	183.9	9.7	10.0
Alaska VA HCS (Anchorage)	21	8.4	7.9

Source: VISN 20 Human Resources Officer (received September 21, 2020).

The OIG noted the following primary care clinical vacancies across VISN 20:

- Physicians: ~130 FTE
- Physician assistants: ~14 FTE
- Nurse practitioners: ~17 FTE
- Nurses: ~437 FTE

Clinical staffing may be a contributing factor in wait time challenges at the Roseburg VA HCS, where 19.5 physician and 7 nurse practitioner FTE positions were vacant.

For mental health, the OIG found the following clinical vacancies:

- Psychiatrists: ~20 FTE
- Psychologists: ~64 FTE
- Nurses: ~59 FTE
- Social workers: ~155 FTE

None of the VISN facilities had mental health wait times over 10 days. The HRO noted challenges to recruiting in highly rural areas, competition with the private sector, and higher salaries in larger cities. To assist with recruitment efforts, the HRO reported using the VA's Education Debt Reduction Program and recruitment and relocation bonuses.[27] Also, the VISN Organizational Health Council was reportedly developing strategies to retain existing clinical staff, while human resources staff were creating special salary rates for clinical hybrid

[27] Department of Veterans Affairs, *Education Debt Reduction Program (EDRP)*, accessed March 11, 2020, https://www.vacareers.va.gov/Content/Documents/Print/EDRP_VA_Careers_Page.pdf. Education Debt Reduction Program (EDRP) authorizes VA to provide student loan reimbursement to employees with qualifying loans who are in difficult to recruit and retain direct patient care positions. Loans must be for the health professional's education that qualified the applicant for a specific position. Each Veterans Health Administration (VHA) facility determines which positions are hard to recruit and retain and when the facility will offer EDRP for these positions. EDRP is a recruitment and retention incentive only offered or approved for certain positions.

occupations to better align with private sector salaries. Since March 1, 2020, VISN 20 facility staffing levels increased by over 1,800 FTE using VA's rapid hiring processes.

VISN Efforts to Reduce Veteran Suicide

Suicide is a leading cause of death in the United States, and suicide rates in almost all states increased from 1999 through 2016.[28] Although the unadjusted rate of suicide among veterans decreased from 30.5 to 30.1 per 100,000 veterans from 2015 to 2016, the suicide rate for veterans age 18 to 34 has risen substantially since 2005. With approximately 20 million veterans in the United States, the number of veterans who die by suicide annually is significant.[29]

VA has made suicide prevention its top priority, with the Office of Mental Health and Suicide Prevention implementing significant suicide prevention initiatives: expansion of the Veterans Crisis Line to three call centers, release of a suicide prevention training video, launch of the Mayor's Challenge, and partnerships with the Departments of Defense and Homeland Security to support veterans during their transition from military to civilian life.[30]

The OIG found that VISN 20 leaders appeared engaged and supportive of facility efforts to prevent veteran suicides. The CMO reported that the VISN had hired two suicide prevention leads to coordinate suicide prevention efforts and oversee the VISN's suicide prevention community of practice. The VISN approved seven new FTE (social worker) positions for suicide prevention efforts and participated in the Washington Governor's Challenge team. Each facility had developed a suicide prevention action plan with specific locally-based actions. For example, the VA Southern Oregon Rehabilitation Center and Clinics (White City) is recruiting for additional suicide prevention coordinators and has instituted a "Caring Letter" project—an evidence-based approach to contacting at risk veterans. Also, the VISN created a joint workgroup to improve suicide screening in the emergent and urgent care settings.

Electronic Health Record Modernization

At the time of the OIG review, VISN 20 was focused on VHA's electronic health record (EHR) modernization effort at the Mann-Grandstaff VAMC and its community-based outpatient clinics

[28] VA Office of Mental Health and Suicide Prevention, *VA Suicide Data Report 2005–2016*, September 2018.

[29] VA Office of Mental Health and Suicide Prevention, *2019 National Veteran Suicide Prevention Annual Report*, September 2019.

[30] VA Office of Public and Intergovernmental Affairs, "VA continues community suicide-prevention challenge," news release, April 1, 2019, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5230. "The Mayor's Challenge was launched in March 2018, bringing together representatives of eight cities to develop local action plans to prevent Veteran suicide. Since then, the Mayor's Challenge program has expanded to a total of 24 cities. An inaugural Governor's Challenge that involved seven state teams took place in February, replicating the effort on the state level. Participants in both programs form interagency teams to bolster Veteran suicide-prevention efforts in their communities." VA Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005 - 2016,* September 2018.

in Wenatchee, Washington; Libby, Montana; Coeur d'Alene, Idaho; and Sandpoint, Idaho. Implementation of the new EHR was scheduled for October 24, 2020. The VISN leaders reported adequate and timely communication and coordination with the VA Office of Electronic Health Record Modernization for the transition and expressed confidence in the robust planning process to minimize potential impacts on patient care or safety.

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders respond to identified problems. Except for two recommendations made in one recently published report, VISN and facility leaders have closed all recommendations for improvement listed in appendix D.[31]

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[32]

Figure 4 illustrates the VISN's quality of care and efficiency metric rankings and performance as of March 31, 2020. The figure uses blue and green data points to indicate high performance (for example, in the areas of acute care 30-day standardized mortality ratio (SMR30) and rating (of) hospital). Metrics that need improvement are denoted in orange and red (for example, emergency department (ED) throughput, health care (HC) associated (assoc) infections, and mental health (MH) continuity (of) care).[33]

[31] A "closed" status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations. VA OIG, *Review of Access to Care and Capabilities during VA's Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center, Spokane, Washington*, Report No. 19-09447-136, April 27, 2020. This report also included four recommendations attributed to The Under Secretary for Health in conjunction with the Office of Electronic Health Records. As such, the VISN deferred response to those recommendations to The Under Secretary for Health in conjunction with the Office of Electronic Health Records.

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

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

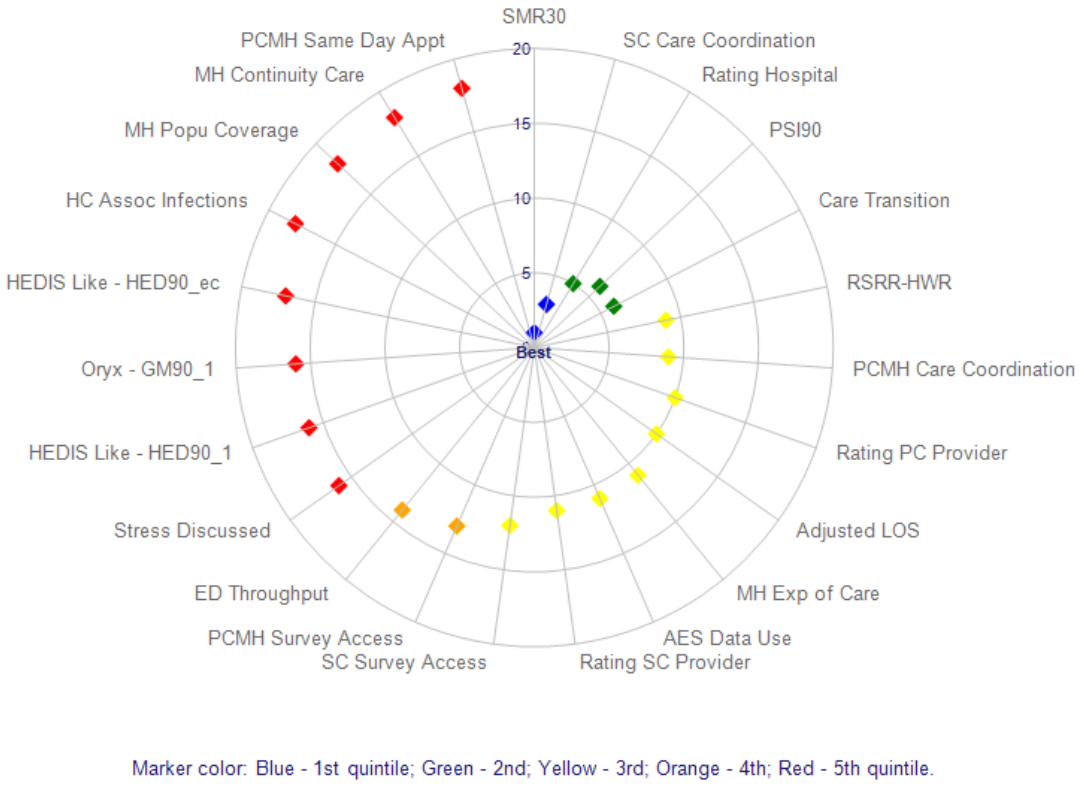


Figure 4. *Facility quality of care and efficiency metric rankings for FY 2020 quarter 2 (as of March 31, 2020).*

Source: VHA Support Service Center.

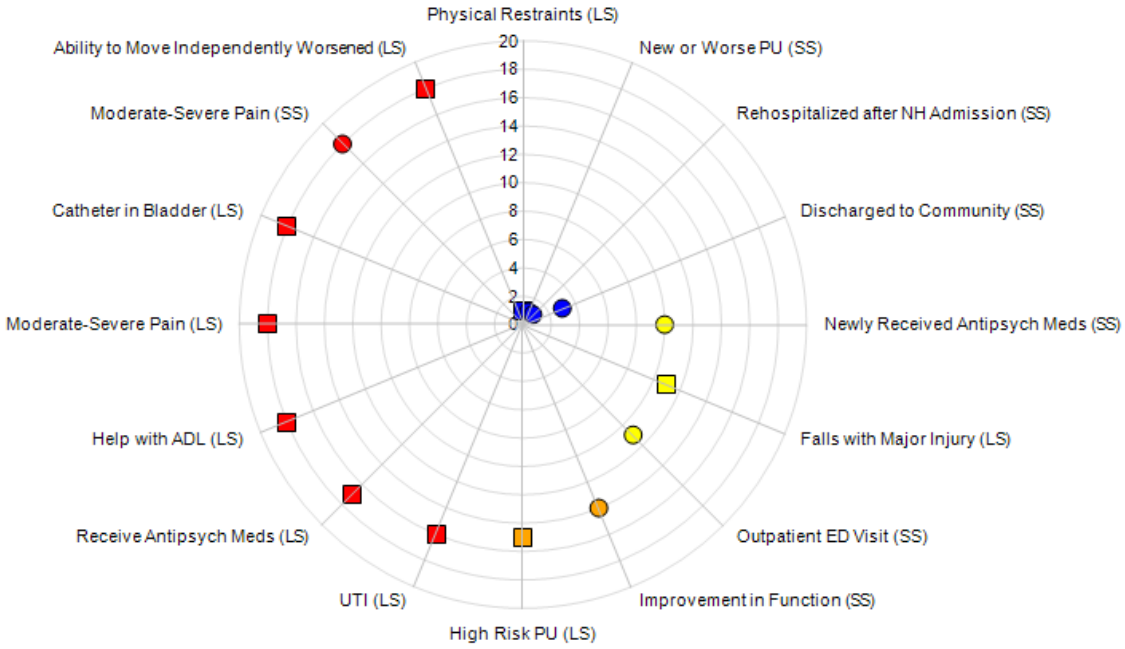
Note: The OIG did not assess VA's data for accuracy or completeness.

The OIG noted VISN oversight of fifth quintile items and the requirement for facilities to provide action plans for improvement. Facility-specific progress was monitored and reported at the Quality Safety Value Council.

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

[34] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, August 22, 2019. "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."

The SAIL CLC includes a radar diagram showing CLC performance relative to other CLCs for all quality measures. Figure 5 illustrates the VISN's CLC quality rankings and performance as of March 31, 2020. The figure uses blue data points to indicate high performance (for example, in the areas of physical restraints–long-stay (LS), new or worse pressure ulcers (PU)–short-stay (SS), and rehospitalized after nursing home (NH) admission (SS)). Measures that need improvement are denoted in orange and red (for example, improvement in function (SS), moderate-severe pain (LS and SS), and ability to move independently worsened (LS)).[35]



Blue - 1st Quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th Quintile

Figure 5. *CLC quality measure rankings for FY 2020 quarter 2 (as of March 31, 2020).*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center.
Note: The OIG did not assess VA's data for accuracy or completeness.

Additionally, the OIG noted that the Long Term Care Institute's unannounced survey scores were four and five stars (the highest score) and staffing scores were five stars.[36] The OIG found VISN-level monitoring of survey scores and facility plans for improvement of fifth quintile quality indicators.

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

[36] "About Us," The Long Term Care Institute, accessed May 5, 2020, https://www.ltciorg.org/about-us/. The Long Term Care Institute provides evaluation and monitoring of patient care services for healthcare entities and government agencies.

Observed Trends in Noncompliance

The OIG identified that the Network Director, CMO, and QMO had opportunities to improve their oversight of facility-level quality, safety, and value; medical staff privileging; medication management; mental health; care coordination; women's health; and high-risk process functions.

During virtual CHIP visits of the VISN 20 facilities initiated during the weeks of September 14 and September 21, 2020, the OIG noted trends in noncompliance for the following areas:

- Quality, safety, and value
  - Root cause analyses
- Medical staff privileging
  - Focused professional practice evaluation criteria defined in advance
  - Timely completion of provider exit review forms
- Medication management (targeting long-term opioid therapy for pain)
  - Assessment of aberrant behavior risk
  - Completion of urine drug testing with intervention, when indicated
  - Documentation of informed consent
  - Timely follow-up with patients included required elements
- Mental health (focusing on the suicide prevention program)
  - Tracking and follow-up of high-risk veterans
  - Annual suicide prevention training for staff
  - Completion of at least five outreach activities per month
- Care coordination (spotlighting life-sustaining treatment decisions)
  - Completion of goals of care conversations and life-sustaining treatment progress notes
- Women's health (examining comprehensive care)
  - Gynecologic care coverage available 24/7
  - Attendance by required members of women veterans health committees
- High-risk processes (emphasizing reusable medical equipment)
  - Maintenance of temperature and relative humidity in reprocessing areas
  - Staff training, competency, and continuing education

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

Leadership and Organizational Risks Conclusion

The VISN's executive leadership team had recently achieved stability with the assignment of the CMO in April 2020 and the Network Director in August 2020. The longest-tenured executive team member, the HRO, had served since 2012, while the Deputy Network Director and QMO were assigned in 2014 and 2018, respectively.

Selected survey scores related to employees' satisfaction with the VISN executive team leaders highlighted opportunities for the Deputy Network Director and CMO to improve employee attitudes toward leadership and the workplace. In review of patient experience survey data, the OIG noted VISN averages for the selected survey questions were generally similar to or better than VHA averages, indicating that VISN 20 patients are as satisfied as the average VHA patient.

The OIG's review of access metrics and clinician vacancies identified potential organizational risks at select facilities, with wait times greater than or approaching 20 days and clinical vacancies in certain specialties. Interviewed leaders were knowledgeable about facility efforts taken to reduce veteran suicide in VISN 20 and shared information that highlighted efforts to develop and implement strategies for high-risk veterans. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and CLC metrics; due to their short tenure, the Network Director and CMO only had general knowledge of the current status of problematic metrics but were able to identify subject matter experts who could address specific questions about actions taken prior to their appointments. The leaders should continue to take actions to sustain and improve performance of measures (for example, continuing to focus oversight on fifth quintile items and requiring facilities provide action plans for improvement).

Further, the OIG identified that the Network Director and CMO had opportunities to improve their oversight of facility-level quality, safety, and value; medical staff privileging; medication management; mental health; care coordination; women's health; and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[37] VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.[38]

During this time, VA continued providing for veterans' healthcare needs and engaged its fourth mission, "the provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have eligibility to receive such care and services."[39] "In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans."[40]

Due to VHA's mission-critical work in supporting both veteran and civilian populations during the pandemic, the OIG conducted an evaluation of the pandemic's effect on VISN 20 and its leaders' subsequent response. The OIG analyzed performance in the following domains:

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

The results of the OIG's evaluation of the COVID-19 pandemic readiness and response were compiled and reported with the results from other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[41]

---

[37] "WHO Director General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, accessed March 23, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

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

[39] 38 U.S.C. § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission for the provision of hospital care and medical services during certain disasters and emergencies: "During and immediately following a disaster or emergency…VA under 38 U.S.C. §1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

[40] VA OIG, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness, March 19–24, 2020*, Report No. 20-02221-120, March 26, 2020.

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.[42] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[43] Designated leaders are directly accountable for program integration and communication within their level of responsibility. Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[44]

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

- Written utilization management plan[45]
- Annual utilization management program summary reviews[46]
- Collection, analysis, and action, as appropriate, in response to VISN peer review data[47]
    - Facility outlier data monitored and follow-up actions communicated to VISN Director and System/VAMC Director
    - Quarterly VISN peer review data analysis reports submitted to the Office of Quality, Safety, and Value
- Institutional disclosures for each facility reported quarterly[48]

Quality, Safety, and Value Findings and Recommendations

The VISN complied with many of the requirements listed above. However, the OIG identified the lack of a written utilization management plan.

---

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

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

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

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

[46] VHA Directive 1117(2).

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

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

At the time of the OIG virtual site visit, VHA required each VISN to have a written utilization management plan.[49] The OIG did not find evidence of a utilization management plan, which could have resulted in the failure to identify facilities' program weaknesses or opportunities for improvement that warrant VISN intervention. The QMO reported that the Utilization Management Coordinator was unaware of the requirement to have a written plan. The QMO acknowledged this finding as an opportunity for improvement and completed the FY 2020 utilization management plan during the week of the OIG virtual review. However, VHA published a new directive on October 8, 2020, that removed the above requirement. Therefore, the OIG made no recommendation.[50]

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

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

Medical Staff Credentialing

VHA has defined procedures for the credentialing of medical staff—"the systematic process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training and experience, and current competence and health status."[51] When certain actions are taken against a provider's licenses, the Chief of Human Resources Management Service, or Regional Counsel, must determine whether the physician meets licensure requirements for VA employment.[52] Further, physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued, and/or placed on probational status, or denied upon application, must not be appointed without a through documented review" by Regional Counsel and concurrence and approval of the appointment by the VISN CMO. The Deputy Under Secretary for Health for Operations and Management is responsible for "ensuring that VISN directors maintain an appropriate credentialing and privileging process consistent with VHA policy" which includes VISN CMO oversight of facility processes.[53]

The OIG inspection team reviewed VISN facility physicians hired after January 1, 2018.[54] When reports from the National Practitioner Data Bank and/or Federation of State Medical Boards appear to confirm that a physician has a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined evidence of the

- Chief of Human Resources Management Service or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements,
- Regional Counsel or designee's documented review to determine if the physician meets appointment requirements, and
- VISN CMO concurrence and approval of the Regional Counsel or designee's review.

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

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

[53] VHA Handbook 1100.19.

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

Medical Staff Credentialing Findings and Recommendations

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

VHA policy states that physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review."[55] The physicians' "credentials file[s] must be reviewed with Regional Counsel, or designee, [and]…the review and the rationale for the conclusions must be forwarded to the VISN CMO for concurrence and approval of the appointment."[56]

The OIG reviewed licensure information for 319 physicians, using publicly-available data and VetPro, and did not find evidence that the CMO reviewed the credentials files and approved the VA appointments for two physicians who had potentially disqualifying licensure actions.[57] One physician's license was placed on probation in 1984, and another physician had a license suspended in 2006. Failure to conduct documented reviews could lead to inappropriate hiring of physicians, which could subsequently affect the provision of quality care. The CMO was recently appointed and reported being unaware of the reason why the cases were not forwarded to the VISN for review.

Recommendation 1

1. The Chief Medical Officer determines the reasons for noncompliance and makes certain to review the credentials file and approve the VA appointment for physicians who had a potentially disqualifying licensure action.

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

[56] VHA Handbook 1100.19.

[57] "Physician Data Center," The Federation of State Medical Boards, accessed April 21, 2021, https://www.fsmb.org/PDC/. This is a publicly available website with a database representing state medical and osteopathic regulatory boards. It is designed to "protect the public and promote quality health care" by listing formal actions taken against physicians. VHA Handbook 1100.19. "VetPro is an Internet enabled data bank for the credentialing of VHA health care practitioners that facilitates completion of a uniform, accurate, and complete credentials file."

VISN concurred.

Target date for completion: January 30, 2022

VISN response: The VISN 20 Chief Medical Officer (CMO) determined the reason for noncompliance as inconsistent awareness of the requirement and process for requesting CMO review prior to appointment of physicians that have potentially disqualifying licensure action(s). This reason for noncompliance was considered in the development of the following action plan. The CMO makes certain facilities submit these types of credentialing files by communicating and tracking status of completion for notification process outlined in the national Standard Operating Procedure (SOP). The SOP will be communicated by the VISN CMO or Deputy CMO in an email communication to all facility Chiefs of Staff and Medical Staff Office leads. An audit will be performed by the CMO Office of all 8 facilities on a monthly basis to track status of notification completion. This audit will be a 100% review of all facility level appointments of physicians that have a potentially disqualifying licensure actions to determine if CMO review and approval was achieved prior to the appointment. The target for audit compliance is set to 90% or greater for six consecutive months. Audit data will be reported monthly to the VISN 20 Health Care Delivery Council (HCDC).

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires that veterans, their families, visitors, and employees in VHA healthcare facilities be provided a safe, clean, and functional environment of care in accordance with applicable Joint Commission Environment of Care standards, federal regulatory requirements, and applicable VA and VHA requirements.[58] The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.[59] VHA also provides policy, mandatory procedures, and operational requirements for implementing an effective VHA supply chain management program at VA medical facilities which includes VISN-level oversight responsibility.[60]

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

- Establishment of a policy that maintains a comprehensive environment of care program at the VISN level
- Establishment of a VISN Emergency Management Committee[61]
    - Met at least quarterly
    - Documented an annual review within the previous 12 months of the VISN's
        - Emergency Operations Plan
        - Continuity of Operations Plan
        - Hazards Vulnerability Analysis
    - Conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leaders for review and approval

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

[59] VHA Directive 1608.

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

[61] VHA Directive 0320.01.

- Assessment of inventory management programs through a quality control review once per FY[62]

Environment of Care Findings and Recommendations

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

[62] VHA Directive 1761(2).

Medication Management: Long-Term Opioid Therapy for Pain

VHA has established pain management as a national priority. The VHA National Pain Management Strategy was initiated in November 1998, with its main objective being to "develop a comprehensive, multicultural, integrated, system-wide approach to pain management that reduces pain and suffering and improves quality of life for Veterans experiencing acute and chronic pain associated with a wide range of injuries and illnesses, including terminal illness."[63]

The VHA National Pain Management Program Office is responsible for policy development, coordination, oversight, and monitoring of the VHA National Pain Management Strategy. VHA requires VISNs to implement the Pain Management Strategy throughout VISN facilities. VHA also requires a VISN-level pain management point of contact to annually "describe [the] progress in implementing the Pain Management Strategy" to the VISN director and establish a "VISN pain committee to develop timelines for achieving and maintaining pain management standards." In addition, VHA requires VISNs have at least one Commission on Accreditation of Rehabilitation Facilities-accredited tertiary, interdisciplinary pain care program.[64]

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

- Appointment of a VISN-level pain management point of contact
- Annual reporting of the Pain Management Strategy implementation progress
- Establishment of a VISN-level pain committee
    - Monitoring of pain management standards
- Availability of a Commission on Accreditation of Rehabilitation Facilities-accredited tertiary interdisciplinary pain care program

Medication Management Findings and Recommendations

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

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

[64] VHA Directive 2009-053. VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017. The Commission on Accreditation of Rehabilitation Facilities (CARF) "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 the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

Women's Health: Comprehensive Care

Women were estimated to represent approximately 10 percent of the veteran population as of September 30, 2019.[65] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans are anticipated to increase.[66] To help the VA better understand the needs of the growing women veterans population, VHA has made efforts to examine "health care use, preferences, and the barriers Women Veterans face in access to VA care."[67] Additionally, a 2016 VA report on suicide among veterans pointed out concerning trends in suicide among women veterans and discussed "the importance of understanding suicide risk among women veterans and developing gender-tailored suicide prevention strategies."[68]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive health care services in all VA medical facilities.[69] VHA also requires that VISNs appoint a lead women veterans program manager to serve as the VISN representative on women veterans' issues and identify gaps through "VISN-wide needs assessments, site visits, surveys, and/or other means, including conducting yearly site visits at each facility within the VISN."[70]

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

- Appointment of a lead women veterans program manager
- Establishment of a multidisciplinary team for comprehensive care
- Execution of interdisciplinary comprehensive strategic planning for women's health at the VISN level

[65] "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.

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

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

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

[69] VHA Directive 1330.01(4), *Health Care Services for Women Veterans,* February 15, 2017, amended January 8, 2021.

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

- Provision of quarterly program updates to executive leaders
- Monthly calls held with facility women veterans program managers and women's health medical directors
- Completion of annual site visits
  - Needs assessment conducted
  - Progress towards implementation of recommended interventions tracked
- Assessments to identify staff education gaps
  - Development of educational program and/or resources when needs identified
- Availability of VISN-level support staff for implementing performance improvement projects
- Analysis of women veterans access and satisfaction data
  - Implementation of improvement actions when recommended

Women's Health Findings and Recommendations

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

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. The goal of Sterile Processing Services (SPS) is to "provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[71]

VHA requires VISNs to appoint and maintain a VISN SPS management board charged with oversight of SPS and all reprocessing of critical and semi-critical RME at VISN facilities.[72] VHA also requires VISNs to conduct facility inspections using the RME Inspection Tool, provide the results for review by a VISN-level committee or board, and post the results to the RME SharePoint site within 30 days of the completed inspection. VISN SPS leads must ensure development of corrective action plans within 30 days of the completed inspections and track the action plans until all items are closed.[73]

The OIG examined relevant documents and interviewed key managers to determine the VISN's compliance with the following requirements:

- Establishment of a VISN SPS management board
- VISN-led RME inspection at each facility
  - Use of RME Inspection Tool
  - Documentation review of climate control
  - Reporting of inspection results to executive leaders
  - Posting of inspection results within the required time frame
  - Tracking of corrective action plans

High-Risk Processes Findings and Recommendations

The VISN complied with the requirements for a VISN SPS management board. However, the OIG identified weaknesses with VISN-led RME inspections.

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

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

[73] VHA Deputy Under Secretary for Health and Operations Management (DUSHOM) Memorandum, *Information and Instructions for Fiscal Year 2019 Sterile Processing Services Inspections*, December 11, 2018.

VHA requires that VISN-led facility RME inspection results be provided to executive leaders for review.[74] The OIG found that these results were not provided to VISN leaders. Lack of communication about RME inspection findings could prevent VISN leaders from appropriately allocating resources to address issues. The SPS Lead reported that the QMO and Deputy QMO attend the onsite inspections, and the team holds informal meetings at the end of each day to review the site visit data, but admitted to misinterpreting the requirement.

Recommendation 2

2. The Network Director evaluates and determines any additional reasons for noncompliance and ensures that the Veterans Integrated Service Network Sterile Processing Services Lead provides network-led facility reusable medical equipment inspection results to executive leaders.

VISN concurred.

Target date for completion: July 31, 2021

VISN response: VISN Sterile Processing Services (SPS) Lead provides network-led facility reusable medical equipment (RME) inspection results to executive leaders and [the] SPS Management Committee.

An evaluation was completed in the development of the corrective action plan below and no additional reasons for noncompliance were identified. VA instructions have changed with the new FY21 NPOSP [National Program Office for Sterile Processing] Memorandum, dated 12/29/2020, *Information and Instructions for Fiscal Year 2021 Reusable Medical Equipment Program Audits*. The memorandum outlines requirements for reporting of audit results to VISN leadership and the SPS Management Committee, noting there is no timeline defined as a requirement for this activity.

VISN will conduct RME inspection audits in VISN 20 facilities starting October 1, 2020. Each site visit's inspection results will be provided to VISN Leadership and the VISN SPS Management Committee for review prior to uploading to the NPOSP SharePoint site and will be noted in the VISN SPS Management minutes.

Status of inspection results reporting is tracked by the VISN 20 SPS Lead with a target compliance rate of 90% for six consecutive months. To date, 6 site visits have been conducted with 100% compliance.

[74] VHA DUSHOM Memorandum, *Information and Instructions for Fiscal Year 2019 Sterile Processing Services Inspections*, December 11, 2018.

VHA also requires that VISN-led inspection results be posted to the RME SharePoint site within 30 days of completion.[75] The OIG found that VISN staff did not post results for the Roseburg VA HCS and Jonathan M. Wainwright Memorial VAMC to the RME SharePoint site within the required time frame. Failure to post results on time could delay the implementation of risk mitigation measures. The SPS Lead stated that their VISN-led RME inspection cycle began in October 2018, and noted that the National Program Office for Sterile Processing RME SharePoint site was not accessible to upload inspection results until December 2018. The SPS Lead stated that the availability of the RME SharePoint site and the corresponding holiday period delayed the Roseburg VA HCS inspection result upload. The SPS Lead also reported that the failure to post the Jonathan M. Wainwright Memorial VAMC inspection results in a timely manner was an oversight.

Recommendation 3

3. The Network Director evaluates and determines any additional reasons for noncompliance and ensures that Veterans Integrated Service Network staff post inspection results to the reusable medical equipment SharePoint site within the required time frame.

VISN concurred.

Target date for completion: July 31, 2021

VISN response: VISN SPS Lead posts SPS inspection results to the RME/NPOSP SharePoint site within the required time frame of 30 days.

An evaluation was completed in the development of the corrective action plan below and no additional reasons for noncompliance were identified. VISN will conduct RME inspection audits in VISN 20 facilities starting October 1, 2020. The inspection results will be provided to VISN Leadership and the VISN SPS Management Committee for review prior to uploading to the NPOSP SharePoint site within 30 days of the inspection. Each site's RME inspection results will be posted to the RME/NPOSP SharePoint site within 30 days.

Status of inspection results to the RME SharePoint site within the required timeframe is tracked by the VISN 20 SPS Lead with a target compliance rate of 90% for six consecutive months. To date, 6 site visits have been conducted with 100% compliance.

[75] Microsoft SharePoint is a secure web-based software used for internal tracking from any device. VHA DUSHOM Memorandum, *Information and Instructions for Fiscal Year 2019 Sterile Processing Services Inspections*, December 11, 2018.

Additionally, VHA requires that corrective action plans are developed within 30 days of the completed VISN-led RME inspection and the VISN SPS Lead tracks action items until closure.[76] The OIG found that none of the facilities had action plans developed within 30 days of inspection. Lack of timely action plan development could delay corrective measures to prevent adverse events. The SPS Lead reported misunderstanding the requirement.

Recommendation 4

4. The Network Director evaluates and determines any additional reasons for noncompliance and ensures that the Veterans Integrated Service Network Sterile Processing Services Lead oversees facility development of corrective action plans within the required time frame and tracks action items until closure.

VISN concurred.

Target date for completion: July 31, 2021

VISN response: VISN SPS Lead ensures facility corrective action plans are developed for each SPS audit within 30 days of the completed audit for all non-conformities identified.

An evaluation was completed in the development of the corrective action plan below and no additional reasons for noncompliance were identified. VA issued new instruction for management of corrective action plans in the FY 21 NPOSP Memorandum, dated 12/29/2020, *Information and Instructions for Fiscal Year 2021 Reusable Medical Equipment Program Audits*. The memorandum outlines [the] requirement of corrective action plans developed for each SPS audit, noting there is no timeline defined as a requirement for this activity.

VISN will conduct RME inspection audits in VISN 20 facilities starting October 1, 2020. The VISN SPS Lead oversees [that] facility corrective action plans are developed and tracks action items until closure of all items; VISN leadership and SPS Management Committee are informed of closure status.

The VISN 20 SPS Lead tracks status of facility development of corrective action plans and tracks items until closure with a target compliance rate of 90% for six consecutive months. To date, 6 site visits have been conducted with 100% compliance for 5 of the 6 sites; compliance for the 6th site inspection is targeted for completion before 6/28/2021.

[76] VHA DUSHOM Memorandum, *Information and Instructions for Fiscal Year 2019 Sterile Processing Services Inspections*, December 11, 2018.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Healthcare Processes	Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Access to care • Clinical vacancies • VISN efforts to reduce veteran suicides • Electronic health record modernization • Oversight inspections • VHA performance data • Observed trends in noncompliance	Four OIG recommendations that can lead to patient and staff safety issues or adverse events are attributable to the Network Director and Chief Medical Officer. See details below.
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback	The results of the OIG's evaluation of the COVID-19 pandemic readiness and response were compiled and reported with other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Written utilization management plan • Annual utilization management program summary reviews • Collection, analysis, and action, as appropriate, in response to VISN peer review data • Quarterly VISN peer review data analysis reports submitted • Institutional disclosures for each facility reported quarterly	• None	• None
Medical Staff Credentialing	• Chief of Human Resources Management Service or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements • Regional Counsel or designee's documented review to determine the physician meets appointment requirements • VISN CMO concurrence and approval of the Regional Counsel or designee's review	• The Chief Medical Officer reviews the credentials file and approves the VA appointment for physicians who had a potentially disqualifying licensure action.	• None
Environment of Care	• Establishment of VISN policy that maintains a comprehensive environment of care program at the VISN level • Establishment of a VISN Emergency Management Committee • Assessment of inventory management programs through a quality control review once per FY	• None	• None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	• Pain management point of contact appointed • Pain Management Strategy implementation progress reported • Pain committee established • Tertiary interdisciplinary pain care services available	• None	• None
Women's Health: Comprehensive Care	• Lead women veteran program manager position filled • Multidisciplinary team established • Interdisciplinary comprehensive strategic planning at the VISN level • Quarterly program updates provided to executive leaders • Monthly calls held with facility women veterans program managers and women's health medical directors • Annual site visits completed • Staff education gap assessed • Support staff available • Women veterans access and satisfaction data analyzed	• None	• None
High-Risk Processes: Reusable Medical Equipment	• VISN SPS management board established • VISN-led facility inspection conducted	• VISN SPS Lead provides network-led facility reusable medical equipment inspection results to executive leaders.	• VISN staff post inspection results to the RME SharePoint site within the required time frame. • VISN SPS Lead oversees timely facility development of corrective action plans and tracks action items until closure.

Appendix B: VISN 20 Profile

The table below provides general background information for VISN 20.

Table B.1. Profile for VISN 20
(October 1, 2016, through September 30, 2019)

Profile Element	VISN Data FY 2017*	VISN Data FY 2018	VISN Data FY 2019‡
Total medical care budget	$2,747,512,387	$3,054,921,682	$3,088,384,556
Number of:			
• Unique patients	316,589	328,813	337,921
• Outpatient visits	3,542,568	3,628,592	3,684,494
• Unique employees§	11,474	11,943	12,154
Type and number of operating beds:			
• Community living center	305	309	313
• Domiciliary	591	455	455
• Hospital	472	472	472
• Residential rehabilitation	43	43	43
Average daily census:			
• Community living center	236	227	234
• Domiciliary	349	343	308
• Hospital	307	288	296
• Residential rehabilitation	20	20	25

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

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

*****October 1, 2016, through September 30, 2017.*
October 1, 2017, through September 30, 2018.
‡*October 1, 2018, through September 30, 2019.*
§*Unique employees involved in direct medical care (cost center 8200).*

Appendix C: Survey Results

Table C.1. Survey Results on Patient Attitudes within VISN 20 (October 1, 2018, through September 30, 2019)

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	VHA	68.3
		VISN 20	72.3
		Anchorage, Alaska	–*
		Boise, Idaho	76.3
		Portland, Oregon	75.6
		Roseburg, Oregon	63.6
		Seattle, Washington	64.4
		Spokane, Washington	77.2
		Walla Walla, Washington	–*
		White City, Oregon	n/a
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	84.9
		VISN 20	86.3
		Anchorage, Alaska	–*
		Boise, Idaho	89.7
		Portland, Oregon	87.6
		Roseburg, Oregon	89.6
		Seattle, Washington	81.2
		Spokane, Washington	88.0
		Walla Walla, Washington	–*
		White City, Oregon	–*

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	77.3
		VISN 20	77.8
		Anchorage, Alaska	84.7
		Boise, Idaho	84.2
		Portland, Oregon	76.2
		Roseburg, Oregon	77.8
		Seattle, Washington	75.4
		Spokane, Washington	78.7
		Walla Walla, Washington	75.9
		White City, Oregon	75.4
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	78.0
		VISN 20	77.9
		Anchorage, Alaska	66.8
		Boise, Idaho	84.1
		Portland, Oregon	81.2
		Roseburg, Oregon	78.1
		Seattle, Washington	74.7
		Spokane, Washington	81.9
		Walla Walla, Washington	75.5
		White City, Oregon	70.1

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

**Data were not available for the question.*

Appendix D: Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Combined Assessment Program Review of the Boise VA Medical Center, Boise, Idaho, Report No. 13-04241-78, February 25, 2014	December 2013	0	13	–	0
Clinical Assessment Program Review of the Boise VA Medical Center, Boise, Idaho, Report No. 16-00557-134, March 8, 2017	October 2016	0	5	–	0
Clinical Assessment Program Review of the VA Portland Health Care System, Portland, Oregon, Report No. 16-00547-156, March 16, 2017	December 2016	0	14	–	0
Comprehensive Healthcare Inspection Program Review of the VA Puget Sound Health Care System, Seattle, Washington, Report No. 18-00334-164, May 8, 2018	January 2018	0	5	–	0
Comprehensive Healthcare Inspection Program Review of the Roseburg VA Health Care System, Oregon, Report No. 18-00620-277, September 17, 2018	March 2018	0	7	–	0
Comprehensive Healthcare Inspection Program Review of the Mann-Grandstaff VA Medical Center, Spokane, Washington, Report No. 18-01144-24, December 6, 2018	July 2018	0	7	–	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Review of Staffing and Access Concerns at the Mann-Grandstaff VA Medical Center, Spokane, Washington, Report No. 19-09017-64, January 8, 2020	July 2019 August 2019	0	2	–	0
Review of Access to Care and Capabilities during VA's Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center, Spokane, Washington, Report No. 19-09447-136, April 27, 2020*	November 2019	2	2	0	2

Source: Inspection/survey results verified with the Deputy Quality Management Officer on September 23, 2020.

**This report also includes four recommendations under the purview of the VHA Under Secretary for Health and the Executive Director, Office of Electronic Health Records Modernization. For the purpose of CHIP visits, the OIG references only those recommendations under the scope of the VISN and its facilities.*

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
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
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value

Measure	Definition	Desired Direction
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: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 15, 2021

From: Director, VA Northwest Network (10N20)

Subj: Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 20: VA Northwest Health Network in Vancouver, Washington

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

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

1. Thank you for the opportunity to provide an initial response to the findings from the Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 20: VA Northwest Health Network in Vancouver, Washington.

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

(Original signed by:)

Teresa D. Boyd, DO

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Randall Snow, JD, Team Leader Tishanna McCutchen, DNP, MSPH
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Kaitlyn Delgadillo, BSPH Ashley Fahle Gonzalez, MPH, BS Justin Hanlon, BAS LaFonda Henry, MSN, RN-BC Cynthia Hickel, MSN, CRNA Scott McGrath, BS Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH, BS Yurong Tan, Ph.D.

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 20: VA Northwest Health Network

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate
  Alaska: Lisa Murkowski, Dan Sullivan
  Idaho: Mike Crapo, James E. Risch
  Oregon: Jeff Merkley, Ron Wyden
  Washington: Maria Cantwell, Patty Murray
U.S. House of Representatives
  Alaska: Don Young
  Idaho: Russ Fulcher, Mike Simpson
  Oregon: Cliff Bentz, Earl Blumenauer, Suzanne Bonamici, Peter DeFazio, Kurt Schrader
  Washington: Suzan DelBene, Jaime Herrera Beutler, Pramila Jayapal, Derek Kilmer, Rick Larsen, Cathy McMorris Rodgers, Dan Newhouse, Kim Schrier, Adam Smith, Marilyn Strickland

OIG reports are available at www.va.gov/oig.