DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington

CHIP REPORT | REPORT #20-01262-191 | AUGUST 4, 2021

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Figure 1. *Mann-Grandstaff VA Medical Center in Spokane, Washington.*

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

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
FPPE	focused professional practice evaluation
FY	fiscal year
HRS	high risk for suicide
LIP	licensed independent practitioner
LST	life-sustaining treatment
LSTD	life-sustaining treatments decisions
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
RME	reusable medical equipment
SAIL	Strategic Analytics for Improvement and Learning
SLB	state licensing board
SPC	suicide prevention coordinator
SPS	Sterile Processing Services
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WVPM	women veterans program manager

Report Overview

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

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

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

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

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

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

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

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued 13 recommendations to the Director, Chief of Staff, and Associate Director for Patient Care Services. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

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

When the team conducted this inspection, the leadership team had worked together for about one month. The Associate Director for Patient Care Services and Associate Director had served in an acting capacity since August 2020. The Director and Chief of Staff had served in their roles since November 2017 and April 2020, respectively.

The OIG reviewed employee satisfaction survey results and found medical center averages for selected survey leadership questions were similar to VHA averages. Leaders' scores were generally similar to or better than those for VHA and the medical center as a whole. Aggregate patient experience survey data indicated overall satisfaction with the care provided. However, gender-specific results showed some opportunities to improve appointment scheduling experiences for female veterans needing patient-centered medical home and specialty care clinic services.

The inspection team also reviewed accreditation agency findings and disclosures of adverse patient events and did not identify any substantial organizational risk factors. However, the Director discussed the medical center's expected implementation of the new VA/Department of Defense electronic health record system on October 24, 2020. The Director acknowledged that challenges may occur but remained optimistic and verbalized excellent ongoing communication with the Secretary, VA Office of Electronic Health Record Modernization; Cerner; VA Central Office; and Veterans Integrated Service Network (VISN) 20.

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning Value Model (SAIL) 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.[2]

The Director and Chief of Staff were knowledgeable within their scope of responsibilities about VHA data and/or medical center-level factors contributing to specific poorly performing SAIL and Community Living Center SAIL measures.[3] In individual interviews, the Director and Chief of Staff 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.

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The medical center met requirements for a committee responsible for quality, safety, and value oversight functions and its review of aggregated data; as well as most patient safety elements reviewed. However, the OIG identified weaknesses in peer reviews, utilization management, and root cause analyses.[5]

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[2] "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.)

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

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

[5] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a "critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. In the context of protected peer reviews, "protected" refers to the designation of review as a confidential quality management activity under 38 U.S.C. § 5705 as "a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department" for improving the quality of medical care or improving the utilization of healthcare resources in VA healthcare facilities. VHA Directive 1117, *Utilization Management Program*, October 8, 2020. Utilization management involves the assessment of the "appropriateness, medical necessity, and efficiency of health care services according to evidence-based criteria." VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

Medical Staff Privileging

The medical center met expectations for ongoing professional practice evaluations and healthcare provider exit reviews. However, the OIG identified a deficiency with focused professional practice evaluations.[6]

Medication Management

The medical center was compliant with some of the indicators of expected performance, including pain screening and the use of a multidisciplinary pain management committee to oversee and monitor required quality measures. However, the OIG identified concerns with aberrant behavior risk assessments, urine drug testing, informed consent, and patient follow-up.

Mental Health

The OIG found compliance with the requirements for a designated suicide prevention coordinator, and tracking and follow-up of high-risk veterans. However, areas of concern included completion of follow-up visits, suicide safety plans, monthly outreach activities, and staff training.

Women's Health

The medical center complied with some of the requirements for women's health, including designation of a Women's Health Patient Aligned Care Team and women's health primary care providers. However, the OIG identified weaknesses with gynecologic care coverage, Women Veterans Health Committee membership and attendance, quality assurance data collection and tracking, and the Women Veterans Program Manager's duties.

High-Risk Processes

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

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

Conclusion

The OIG conducted a detailed inspection across nine key areas (two administrative and seven clinical) and subsequently issued 13 recommendations for improvement to the Medical Center Director, Chief of Staff, and Associate Director of Patient Care Services. The number of recommendations should not be used, however, as a gauge for the overall quality of care provided at this medical center. The intent is for medical center leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if not addressed, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans. (See appendixes G and H, pages 64–65, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendations 3, 11, and 12 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Abbreviations ii

Report Overview iii

Inspection Results iv

Purpose and Scope 1

Methodology 3

Results and Recommendations 4

Leadership and Organizational Risks 4

COVID-19 Pandemic Readiness and Response 21

Quality, Safety, and Value 22

Recommendation 1 25

Recommendation 2 26

Medical Staff Privileging 27

Recommendation 3 29

Medication Management: Long-Term Opioid Therapy for Pain 30

Mental Health: Suicide Prevention Program 33

Recommendation 4 37

Recommendation 5 38

Recommendation 6 39

Recommendation 7 39

Care Coordination: Life-Sustaining Treatment Decisions 41

Women's Health: Comprehensive Care 43

Recommendation 8 45

Recommendation 9 46

Recommendation 10 46

Recommendation 11 47

High-Risk Processes: Reusable Medical Equipment 48

Recommendation 12 50

Recommendation 13 51

Appendix A: Comprehensive Healthcare Inspection Program Recommendations 52

Appendix B: Medical Center Profile 55

Appendix C: VA Outpatient Clinic Profiles 56

Appendix D: Patient Aligned Care Team Compass Metrics 58

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions 60

Appendix F: Community Living Center (CLC) Strategic Analytics for Improvement and Learning (SAIL) Measure Definitions 62

Appendix G: VISN Director Comments 64

Appendix H: Medical Center Director Comments 65

OIG Contact and Staff Acknowledgments 66

Report Distribution 67

Purpose and Scope

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

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

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

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

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

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

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

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

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

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

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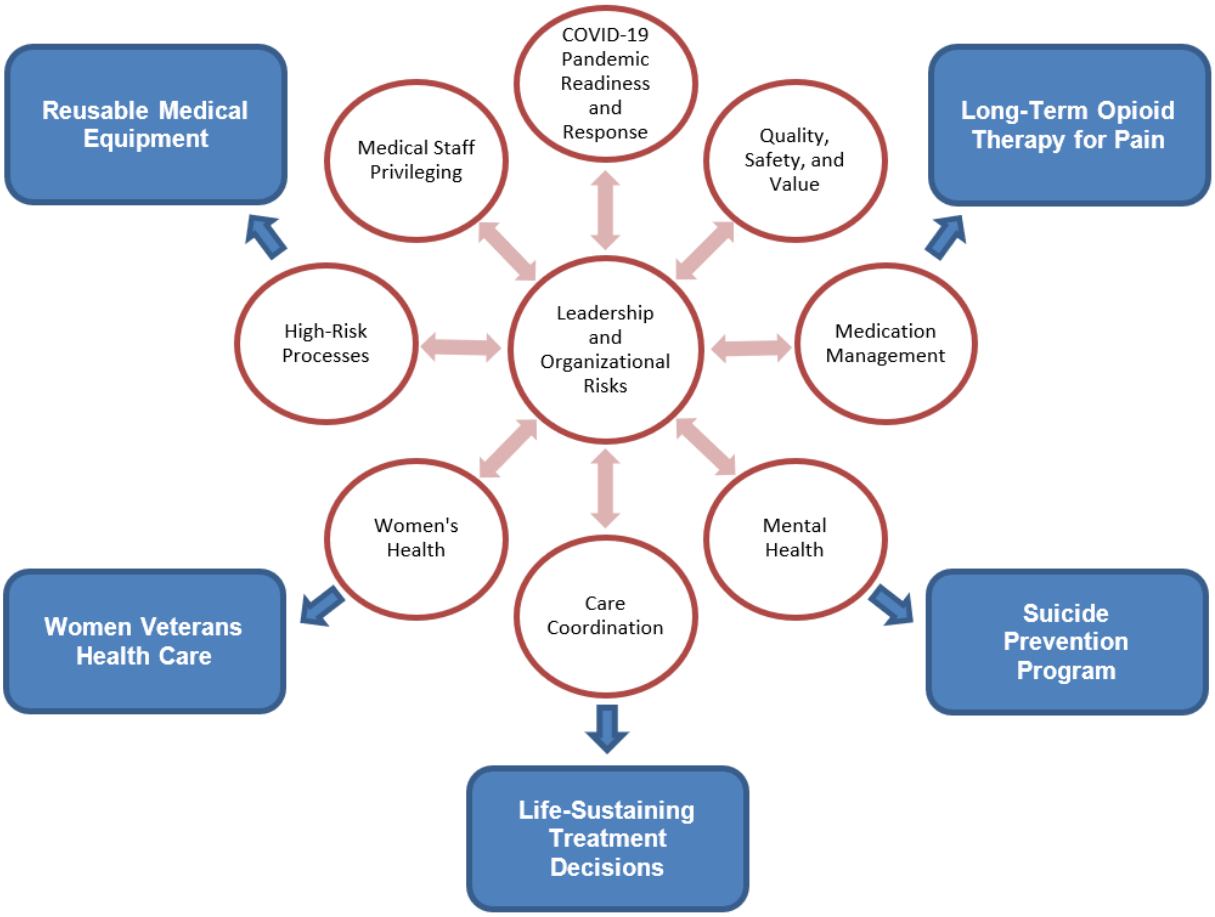

Figure 2. *Fiscal year (FY) 2020 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

Methodology

The Mann-Grandstaff VA Medical Center also provides care through multiple outpatient clinics in Idaho, Montana, and Washington. Additional details about the types of care provided by the medical center and its clinics can be found in appendixes B and C.

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

The inspection examined operations from July 21, 2018, through September 18, 2020, the last day of the unannounced multiday evaluation.[7] During the virtual review, the OIG did not receive any complaints beyond the scope of the inspection.

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

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

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

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

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

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

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

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

Results and Recommendations

Leadership and Organizational Risks

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

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

Executive Leadership Position Stability and Engagement

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

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

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

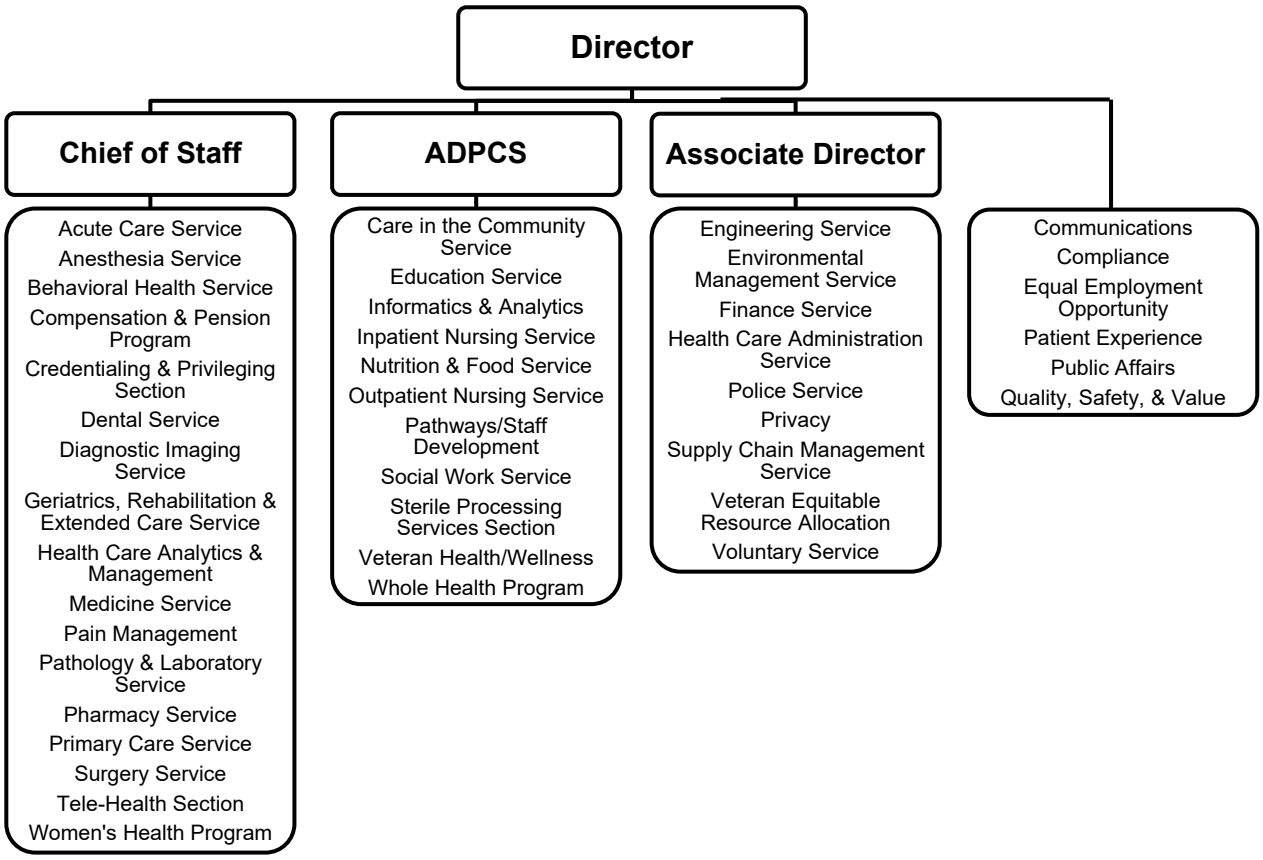

Figure 3. *Medical center organizational chart.*

Source: Mann-Grandstaff VA Medical Center (received September 15 and October 16, 2020).

At the time of the OIG virtual site visit, the leadership team had worked together for about one month. The Director was assigned in November 2017. The Chief of Staff had served as the Deputy Chief of Staff until being subsequently promoted in April 2020. Both the ADPCS and associate director positions had been vacant for one month, with employees serving in an acting capacity (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	November 26, 2017
Chief of Staff	April 26, 2020
Associate Director for Patient Care Services	August 22, 2020 (acting)
Associate Director	August 30, 2020 (acting)

Source: Mann-Grandstaff VA Medical Center Chief of Human Resources (received September 15, 2020).

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

The Director and Chief of Staff were knowledgeable within their scope of responsibilities about VHA data and/or medical center-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. In individual interviews, they were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below. The acting Associate Director and acting ADPCS were not knowledgeable about specific poorly performing SAIL measures or actions taken to maintain or improve performance because of their recent assignment to their positions.

The Director served as the chairperson of the Executive Leadership Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board oversaw various working groups such as the Clinical Executive, Administrative Executive, and Nurse Professional Councils. These leaders monitored patient safety and care through the Quality Council, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Leadership Board (see figure 4).

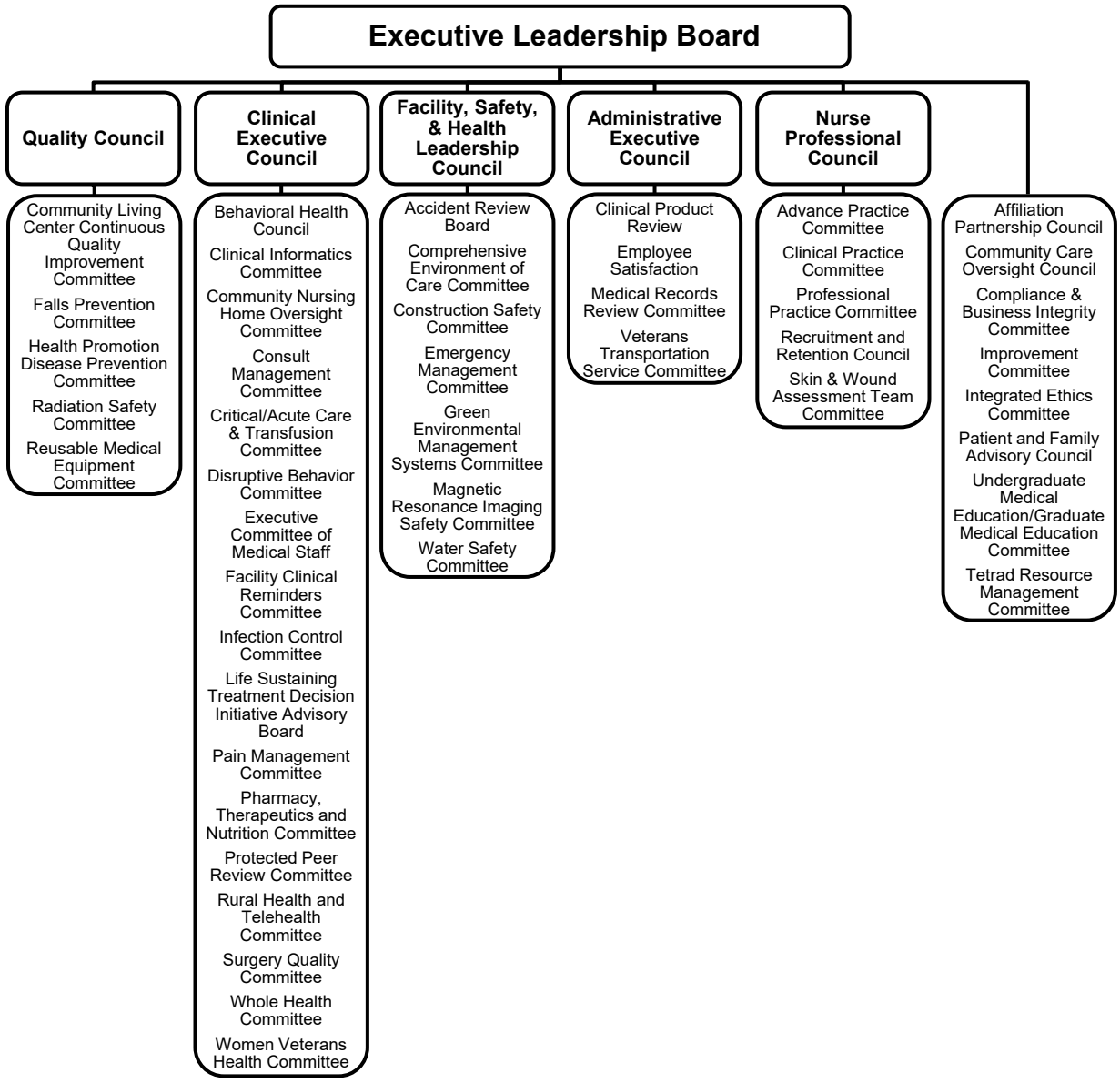

Figure 4. *Medical center committee reporting structure.*

Source: Mann-Grandstaff VA Medical Center (received September 15, 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.[12] Although

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

the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical center leaders.

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2018, through September 30, 2019.[13] Table 2 provides relevant survey results for VHA, the medical center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center averages for the selected survey leadership questions were similar to the VHA averages.[14] Scores related to the Director and Chief of Staff were consistently higher than those for VHA and the medical center. The ADPCS scores were similar to, and the Associate Director scores were similar to or higher than VHA and medical center scores.

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	72.6	72.0	76.7	80.7	71.1	75.0
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.4	3.3	3.7	3.7	3.3	3.2

[13] Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, and Associate Director. The OIG notes that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current Chief of Staff, acting ADPCS, or acting Associate Director.

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.5	3.8	4.0	3.5	4.2
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.5	3.7	3.8	3.5	3.5

Source: VA All Employee Survey (accessed August 11, 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.[15] The medical center averages for the selected survey questions were similar to the VHA averages. Scores related to the Director, Chief of Staff, and Associate Director were consistently better than those for VHA and the medical center, and the ADPCS scores were similar to VHA and medical center scores.[16]

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

[16] As mentioned above, the OIG notes that the survey results do not reflect employee attitudes toward the current Chief of Staff, acting ADPCS, and acting Associate Director.

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

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.0	4.2	3.7	4.4
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.7	4.0	3.9	3.6	4.0
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day)	1.4	1.4	1.2	1.0	1.4	0.5

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

Patient Experience

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

experiences with their health care and support benchmarking its performance against the private sector.

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 4 provides survey results for VHA and the medical center.[17] The medical center results indicated more positive patient experiences than the average of all VHA facilities combined.

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	68.3	77.2
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	88.0
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	78.7
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	82.0

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

In 2015, women represented 9.4 percent of the total veteran population in the United States, and it is projected that women will represent 16.3 percent of living veterans by 2043. Further, from 2005 to 2015, the number of women veterans using VA health care increased by 46.4 percent,

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

from almost 240,000 to 455,875.[18] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients' experiences by gender (see tables 5–7), including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. Results for male and female inpatient respondents were generally more favorable than the corresponding VHA averages; however, opportunities appear to exist to improve appointment scheduling experiences for female veterans needing patient-centered medical home and specialty care services.

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	82.8	86.3	100.0
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.8	83.1	91.1	100.0
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	68.7	61.8	76.2	89.0

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

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

† The medical center averages are based on 377–381 male and 26 female respondents, depending on the question.

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

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.2	43.3	56.2	52.5
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.9	49.7	58.6	39.9
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.6	65.7	77.1	79.8

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

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

† The medical center averages are based on 326–959 male and 26–53 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.5	44.7	49.5	21.8
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	55.0	60.1	42.3
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	70.4	70.1	72.6	73.4

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

**The VHA averages are based on 68,968–208,722 male and 3,460–11,072 female respondents, depending on the question.*

†The medical center averages are based on 332–1,013 male and 19–27 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[19] Table 8 summarizes the relevant medical center inspections most recently performed by the OIG and The

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

Joint Commission (TJC).[20] At the time of the OIG virtual review, the medical center had closed all recommendations for improvement issued since the previous comprehensive healthcare inspection conducted in July 2018. The Chief of Quality, Safety, and Value reported continued work with medical center managers to address two open recommendations from a January 2020 OIG report on staffing concerns and two open recommendations from an April 2020 OIG report on electronic health record system transition.[21]

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

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the Mann-Grandstaff VA Medical Center, Spokane, Washington*, Report No. 18-01144-24, December 6, 2018)	July 2018	7	0

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

[21] VA OIG, *Review of Staffing and Access Concerns at the Mann-Grandstaff VA Medical Center, Spokane, Washington*, Report No. 19-09017-64, January 8, 2020; 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 in Spokane, Washington*, Report No. 19-09447-136, April 27, 2020.

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

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*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	2	2*
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)	November 2019	2†	2‡
TJC Hospital Accreditation	September 2019	34	0
TJC Behavioral Health Care Accreditation		6	0
TJC Home Care Accreditation		1	0

Source: OIG and TJC (inspection/survey results verified with the Chief of Quality, Safety, and Value on September 16, 2020).

**As of July 2021, both recommendations were closed.*

†*Although the report included eight recommendations, two were directed to the medical center, and the remaining six were directed to various VHA and VISN leaders.*

‡*As of July 2021, both medical center recommendations remained open.*

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

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

Table 9 lists the reported sentinel events and disclosures from July 21, 2018 (the prior OIG comprehensive healthcare inspection), through September 14, 2020.[24] The Risk Manager reported no sentinel events for this period and 11 adverse events that underwent institutional disclosure.

Table 9. Summary of Selected Organizational Risk Factors (July 21, 2018, through September 14, 2020)

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

Source: Mann-Grandstaff VA Medical Center's Chief of Quality Safety, and Value (received September 16, 2020).

The OIG review did not identify substantial organizational risk factors. However, the Director discussed the medical center's expected implementation of the new VA/Department of Defense electronic health record system on October 24, 2020. The Director acknowledged that challenges may occur but remained optimistic and verbalized excellent ongoing communication with the Secretary, VA Office of Electronic Health Record Modernization; Cerner; VA Central Office; and Veterans Integrated Service Network (VISN) 20.

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

[24] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The OIG noted that the Mann-Grandstaff VA Medical Center is a low complexity (3) medical center as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." Lastly, in VHA Directive 1004.08, VHA defines a large-scale disclosure of adverse events (sometimes referred to as a "notification") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."

clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[25]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of March 31, 2020. Figure 5 uses blue and green data points to indicate high performance for the Mann-Grandstaff VA Medical Center (for example, in the areas of rating (of) hospital, health care (HC) associated (assoc) infections, and rating (of) primary care (PC) provider). Metrics that need improvement are denoted in orange and red (for example, All Employee Survey (AES) data use, mental health (MH) continuity (of) care, and mental health (MH) population (popu) coverage).[26]

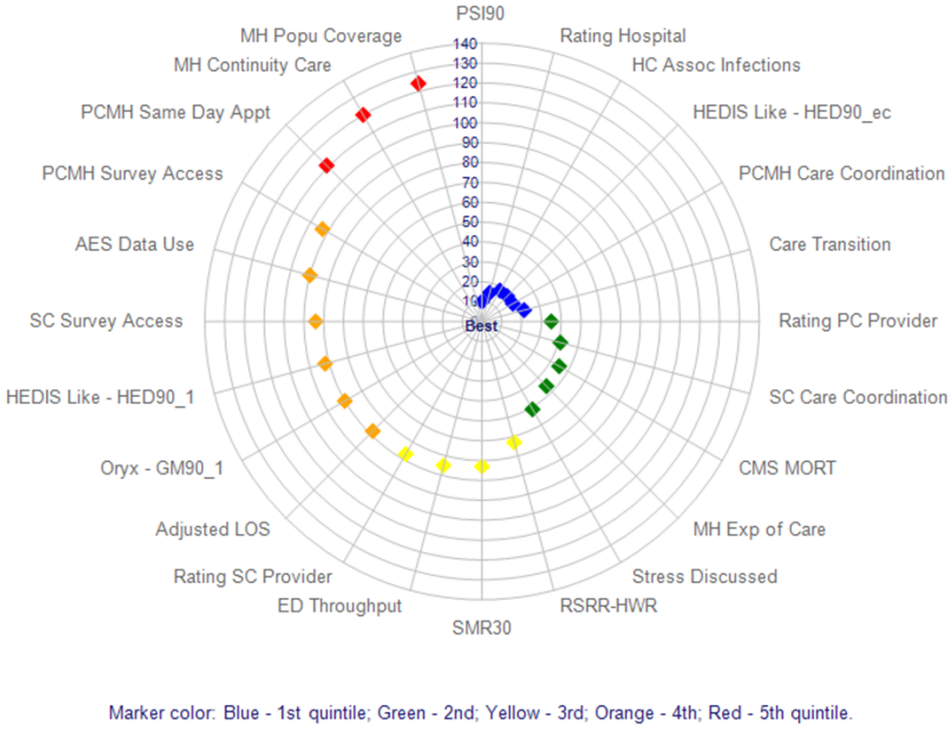

Figure 5. *Medical center quality of care and efficiency metric rankings for FY 2020 quarter 2 (as of March 31, 2020).*

Source: VHA Support Service Center.

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

[25] "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.)

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

Veterans Health Administration Performance Data for Community Living Centers

The CLC SAIL Value Model is a tool to "summarize and compare the performance of CLCs in the VA." The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[27]

Figure 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of March 31, 2020. Figure 6 uses blue and green data points to indicate high performance for the Spokane CLC (for example, in the areas of urinary tract infections (UTI)–long-stay (LS), physical restraints (LS), and rehospitalized after nursing home (NH) admission–short-stay (SS)). Metrics that need improvement are denoted in orange and red (for example, moderate-severe pain (SS), improvement in function (SS), and high risk pressure ulcer (PU) (LS)).[28]

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

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

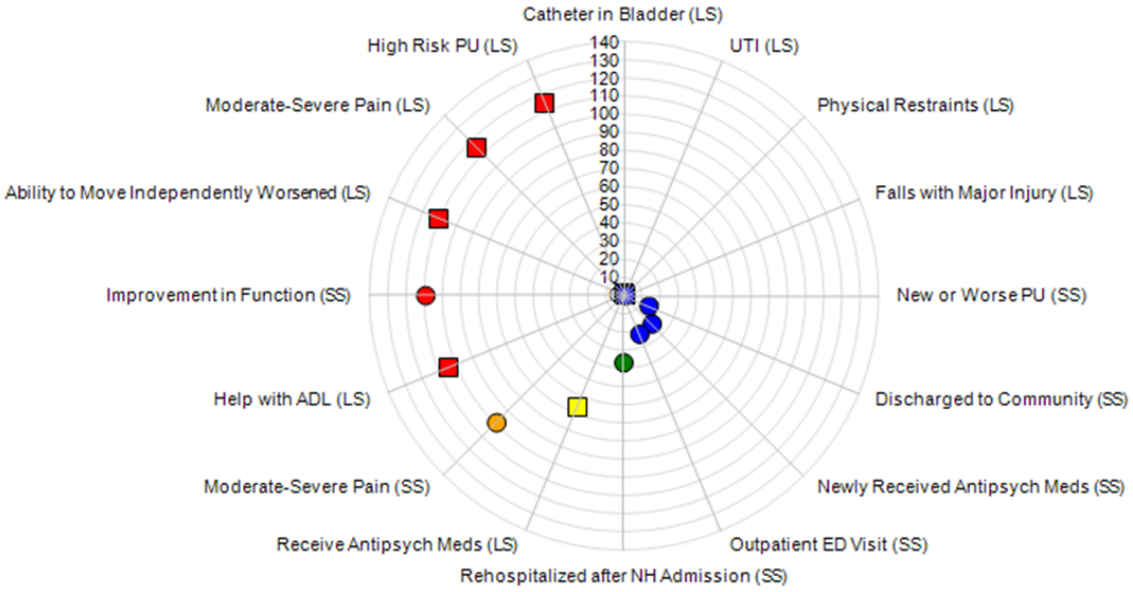

Figure 6. *Spokane CLC quality measure rankings for FY 2020 quarter 2 (as of March 31, 2020).*

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.

Leadership and Organizational Risks Conclusion

At the time of the OIG virtual visit, the medical center's executive leadership team had vacancies filled by acting leaders in two of the four key positions. The Director had been in the role for almost three years, and the Chief of Staff had been in the position for less than six months. The OIG found medical center averages for selected survey leadership questions were similar to VHA averages. Leaders' scores were generally similar to or better than those for VHA and the medical center. Aggregate patient experience survey data indicated overall satisfaction with the care provided. However, gender-specific results showed opportunities to improve appointment scheduling experiences for female veterans needing patient-centered medical home and specialty care services. The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify substantial organizational risk factors; however, the OIG noted potential risks with the medical center's expected implementation of the new VA/Department of Defense electronic health record system in October 2020. In individual interviews, the Director and Chief of Staff were able to speak in depth about actions taken during the previous 12 months to maintain or improve employee satisfaction and patient experiences. In addition, they were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models.

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.[29] 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.[30]

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 VA eligibility for such care and services."[31] "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."[32]

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

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

The OIG also surveyed medical center staff to solicit their feedback and potentially identify any problematic trends and/or issues that may require follow-up. The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[33]

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[29] "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.

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

[31] 38 U.S.C. § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the provision of hospital care and medical services during certain disasters and emergencies: "During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

[32] 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.

[33] 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.[34] 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.[35] 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."[36]

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

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

The OIG reviewers also assessed the medical center's processes for conducting protected peer reviews of clinical care.[37] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[38] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[39] The OIG team examined the completion of the following elements:

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

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

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

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

[38] VHA Directive 1190.

[39] VHA Directive 1190.

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[40]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Next, the inspection team assessed the medical center's utilization management (UM) program, a key component of VHA's framework for quality, safety, and value, which provides vital tools for managing the quality and the efficient use of resources.[41] It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[42] Inspectors reviewed several aspects of the UM program:

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

Finally, the OIG reviewers assessed the medical center's reports of patient safety incidents with related root cause analyses.[43] Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root

[40] VHA Directive 1190.

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

[42] VHA Directive 1117(2).

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

cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the medical center.[44] The medical center was assessed for its performance on several dimensions:

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

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents.[46]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for QSV oversight functions, review of aggregated data, and most patient safety elements reviewed. However, the OIG identified weaknesses in peer reviews, UM, and root cause analysis processes.

VHA requires peer review committees to complete a final review within 120 calendar days of determination of necessity, unless a written request for an extension is approved by the director.[47] The Risk Manager did not provide evidence that four of seven final peer reviews completed outside of 120 days included an approved written extension request. Lack of timely identification of issues in clinical practice or systemic procedures can affect the quality of patient care. The Chief of QSV could not provide a reason for noncompliance.

[44] VHA Handbook 1050.01.

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

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

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

Recommendation 1

1. The Medical Center Director determines reasons for noncompliance and ensures that the Protected Peer Review Committee completes final reviews within 120 calendar days or has a written extension request approved by the Director.

Medical center concurred.

Target date for completion: September 30, 2021

Medical center response: The Medical Center evaluated the findings and did not identify additional reasons for noncompliance in development of the implementation plan. The Medical Center established a process for the Risk Manager to utilize the Peer Review VISN 20 tracking spreadsheet to monitor status when extensions are approaching 120 days and in need of approval by the Director. During each Risk Management Committee meeting, the Risk Manager and Chief of Staff review for completeness of documentation. The Risk Manager also reports out to the Peer Review Committee any cases that are nearing the 120-day deadline.

The Risk Manager provides Quality, Safety and Value (QSV) with monthly audits to illustrate that all extensions past the 120 calendar days are approved in writing by the Director. 10 active peer reviews are audited monthly. If fewer than 10 active peer reviews, then 100% is audited. Audit target is performance of 90% or greater for six consecutive months.

At the time of the virtual review, VHA required that "UM data are reviewed on an ongoing basis by an interdisciplinary group, including but not limited to representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR [chief business office revenue-utilization review]."[48] The OIG reviewed UM Committee meeting minutes from April 4 through December 5, 2019, and did not find representation from social work or chief business office revenue-utilization review for two and three of eight meetings, respectively. Lack of consistent representation from all required disciplines may result in inefficient management of patient flow activities. The Chief of QSV reported that a chief business office revenue-utilization review representative came from the VISN 20 office but did not consistently attend UM Committee meetings due to conflicting duties. According to the Chief of QSV, the Chief of Social Work attributed the inconsistent representation to staff vacancies and workload. On October 8, 2020, VHA changed the representatives who review UM data to "a multidisciplinary committee, which may include representatives from" various services. Therefore, the OIG made no recommendation.[49]

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

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

TJC states that facilities are to measure and analyze performance so that improvement "effectiveness can be sustained, assessed, and measured."[50] In three of five root cause analyses with corresponding actions and outcome measures, there was no documented evidence of sustained improvement. This may have prevented identification and implementation of quality of care and patient safety process improvements. The Chief of QSV acknowledged a lack of program oversight as the reason for noncompliance.

Recommendation 2

2. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures root cause analyses' corresponding actions and outcome measures show sustained improvement.

Medical center concurred.

Target date for completion: September 30, 2021

Medical center response: The Medical Center evaluated the findings and did not identify additional reasons for noncompliance in development of the implementation plan. The Patient Safety Manager (PSM) implemented a process to ensure there is at least one root cause with a corresponding action and outcome measure that shows sustained improvement included with every Root Cause Analysis (RCA).

The PSM provides QSV with monthly audits to illustrate that all RCAs have at least one root cause with a corresponding measure included. 10 RCAs are audited monthly. If fewer than 10 RCAs, then 100% are audited. Audit target is performance of 90% or greater for six consecutive months.

[50] TJC. Rationale for Leadership standards LD.03.02.01 and 03.05.01, and Performance Improvement standard PI.03.01.01.

Medical Staff Privileging

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

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

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

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

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

[52] VHA Handbook 1100.19.

[53] VHA Handbook 1100.19.

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

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

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

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

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

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

- Six solo/few practitioners who underwent initial or reprivileging during calendar year 2019[58]
- Seven LIPs who completed an FPPE in calendar year 2019
- Ten LIPs reprivileged during calendar year 2019
- Fifteen LIPs who left the medical center in calendar year 2019

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

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

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

Medical Staff Privileging Findings and Recommendations

The OIG found general compliance with requirements for OPPEs and provider exit review processes. However, the OIG identified a deficiency with FPPEs.

VHA requires the criteria for the FPPE process "to be defined in advance, using objective criteria accepted by the practitioner."[59] In the seven practitioner profiles reviewed, the OIG did not find evidence that LIPs were aware of the evaluation criteria before service chiefs initiated the FPPE process. This could have resulted in LIPs misunderstanding FPPE expectations. The Chief of Staff could not provide a reason for noncompliance. The Medical Staff Coordinator reported deficient FPPE processes as the reason for noncompliance.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs define in advance, communicate, and document expectations for focused professional practice evaluations in practitioners' profiles.[60]

Medical Center concurred.

Target date for completion: Completed

Medical Center response: The Medical Center evaluated the findings and did not identify additional reasons for noncompliance in development of the implementation plan. Medical Staff Office educated Service Chiefs that they must alert Licensed Independent Practitioners (LIP) to the evaluation criteria prior to initiating a Focused Professional Practice Evaluation (FPPE).

Service Chiefs include a process to share the criteria for evaluation with LIPs prior to initiating an FPPE. LIPs sign an acknowledgement document, "Acknowledgement of Bylaws and Focused Professional Practice Evaluation," that they are aware of the criteria for evaluation prior to the service chief initiating an FPPE. These forms are then maintained in the LIP credentialing files.

Medical Staff Office performs an audit of all LIP folders that have FPPE initiated to ensure LIPs are aware of criteria prior to initiating FPPE. Audit target is performance of 90% or greater for six consecutive months.

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

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

Medication Management: Long-Term Opioid Therapy for Pain

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

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

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

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

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

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

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

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

[65] "Benzodiazepines, Street Names: Benzos, Downers, Nerve Pills, Tranks," U.S. Drug Enforcement Administration, accessed December 20, 2020, https://www.deadiversion.usdoj.gov/drug_chem_info/benzo.pdf. Benzodiazepines "are a class of drugs that produce central nervous system (CNS) depression and that are most commonly used to treat insomnia and anxiety."

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

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

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

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

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

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

The OIG interviewed key employees and managers and reviewed relevant documents and the electronic health records of 18 selected outpatients who had newly dispensed (no VA dispensing in previous six months) long-term opioids for pain, daily or intermittently for 90 or more calendar days through VA from July 1, 2018, through June 30, 2019. The team considered whether providers acted in accordance with guidelines for the provision of pain management and the medical center's oversight process for evaluating pain management outcomes and quality.

Medication Management Findings and Recommendations

The medical center addressed some of the performance indicators listed above. However, the OIG found deficiencies with aberrant behavior risk assessments, urine drug testing, informed consent, and patient follow-up.

VA/DoD clinical practice guidelines recommend completion of an aberrant behavior risk assessment that includes the patient's history of substance abuse, psychological disease, and aberrant drug-related behaviors prior to initiating long-term opioid therapy.[70] The OIG determined that providers did not assess 11 percent of patients for aberrant drug-related behaviors.[71] This may have resulted in the prescription of opioids for patients at high risk for misuse. The Chief of Primary Care stated that providers discussed pain management at length with each patient and performed and documented a detailed mental status exam. The Chief of

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

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

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

Primary Care also stated that, for one patient, the urine drug test served as a screening tool for aberrant behavior risk.

VA/DoD clinical practice guidelines recommend that providers "obtain UDT [urine drug testing] prior to initiating or continuing LOT [long-term opioid therapy] and periodically thereafter."[72] The OIG determined that providers did not conduct initial urine drug testing for 22 percent of the patients reviewed.[73] This may have resulted in providers' inability to identify patients' lack of adherence to opioid therapy or determine the potential for drug diversion. The Pain Management Specialist explained that patients who live in rural areas do not want to drive to Spokane for urine drug testing but could not provide a reason why providers did not refer patients for care in the community.

VHA requires providers to obtain and document informed consent prior to initiating long-term opioid therapy for pain.[74] VHA also recommends that an "informed consent conversation cover the risks and benefits of opioid therapy, as well as alternative therapies."[75] The OIG determined that providers did not obtain informed consent for 17 percent of the patients reviewed.[76] Failure to obtain informed consent could result in patients not fully understanding the risks or alternatives to long-term opioid use. The Chief of Primary Care attributed the noncompliance to a lack of oversight.

VA/DoD clinical practice guidelines recommend "evaluating benefits of continued opioid therapy and risk for opioid-related adverse events at least every three months."[77] The OIG determined that providers did not document patient follow-up evaluations within three months of initiating long-term opioid therapy in 22 percent of the electronic health records reviewed.[78] Lack of follow-up could result in missed opportunities to assess patients for adherence to and effectiveness of opioid therapy and any adverse reactions. The Chief of Primary Care attributed the noncompliance to a lack of oversight.

The OIG made no recommendations due to the low number of identified outpatients who had newly dispensed long-term opioids for pain during the review period.

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

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

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

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

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

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

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

Mental Health: Suicide Prevention Program

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[79] The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018. However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[80] VHA has identified suicide prevention as a top priority and implemented various evidence-based approaches to reduce the veteran suicide rate. In addition to expanded mental health services and community outreach, VHA has developed comprehensive screening and assessment processes to identify at-risk patients.[81]

VHA requires that each medical center and very large community-based outpatient clinic have a full-time suicide prevention coordinator (SPC) to track and follow up with high-risk veterans, develop a process for responding to referrals from hotlines such as the Veteran Crisis Line, and conduct community outreach activities.[82] The OIG examined various requirements related to SPCs:

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

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

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

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

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

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

in his or her electronic health record "as soon as possible but no later than 1 business day after such determination by the SPC."[83] According to VHA, "Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death…The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions."[84] The HRS PRF is reviewed at least every 90 days and depending on changes to the suicide risk status, will remain active or be removed.[85] Additionally, VHA requires designated high-risk patients to have a completed suicide safety plan and four face-to-face visits with an acceptable provider within the first 30 days of designation.[86]

The OIG noted that from July 1, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA required that "Any patient determined to be High Risk for Suicide [by the licensed independent provider] must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination."[87] However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management changed the requirement for the HRS PRF placement to be "as soon as possible but no later than 1 business day after determination by the SPC."[88] VHA further provided additional clarifying information:

- The "SPC exclusively controls the HRS-PRF and must limit their use to patients who meet the criteria of being placed on the facility high-risk suicide list."
- "The time frame of placing the flag begins once the SPC makes the determination that an HRS-PRF is warranted."
- The SPC's determination process "may be beyond 24 hours after a referral, due to case consultation and review."[89]

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

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

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

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

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

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

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

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

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

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

Inspectors examined the completion of several requirements:

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

All VHA employees must complete suicide risk and intervention training within 90 days of entering their position. Clinical staff (including physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and Vet Center counselors) must complete Suicide Risk Management Training for Clinicians, and nonclinical staff must complete Operation S.A.V.E. training.[91] VHA also requires that all staff receive annual refresher training.[92] In addition, SPCs are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[93]

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

- Relevant documents;

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

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

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

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

- The electronic health records of 14 outpatients whose electronic health records were flagged as high risk for suicide from July 1, 2018, to June 30, 2019; and
- Staff training records.

Mental Health Findings and Recommendations

The OIG found the medical center complied with requirements for a designated SPC, and tracking and follow-up of high-risk veterans. However, the OIG found deficiencies.

With VHA's original requirement that was in place when these patients received care—that "Any patient determined to be High Risk for Suicide must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination"[94]—the OIG determined that 14 percent of HRS PRFs were not placed within 24 hours of referral to the SPC.[95] Based on the current updated requirement that the SPC be responsible for determining placement of the HRS PRF (without a defined time frame for doing so), the OIG further calculated that the average time from referral to HRS PRF placement for the patients reviewed was 1 day (observed range was 0–7 days).

The OIG noted concerns with reviewing HRS PRFs within the required time frame. VHA required that all patients with an HRS PRF be re-evaluated at least every 90 days.[96] The OIG determined that 57 percent of patients with an HRS PRF were not re-evaluated every 90 days.[97] Based on the updated requirement that HRS PRFs be reviewed up to 10 days prior to or after the due date for re-evaluation, the OIG still found that clinical staff reviewed 57 percent of patients within the new time frame (observed range was 71-118 days).[98]

Additionally, the OIG noted deficiencies with follow-up visits, suicide safety plans, monthly outreach activities, and staff training.

VHA requires a veteran to have four follow-up visits with a qualified provider within 30 days of HRS PRF placement.[99] The follow-up visits should be face-to-face unless the veteran requests a telephonic visit, and there must be documentation identifying the patient's preference for a

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

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

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

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

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

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

telephone call.[100] The OIG determined that providers did not follow up with 14 percent of patients based on the electronic health records reviewed.[101] The Chief of Behavioral Health and SPC stated that visits were conducted telephonically but did not provide a reason why providers did not document the veterans' preference for telephone visits.

Recommendation 4

4. The Chief of Staff determines the reasons for noncompliance and makes certain that providers conduct four follow-up visits, either face-to-face or telephonic, with the veterans' preference documented, within the required time frame.

Medical center concurred.

Target date for completion: September 30, 2021

Medical center response: The Medical Center evaluated the findings and did not identify additional reasons for noncompliance in development of the implementation plan. Suicide Prevention staff provide regular trainings on the required mandates regarding the High-Risk Flag (HRF) list, including scheduling four follow-up visits within 30 days of being designated as high risk. Training includes the requirement to document whether the Veteran prefers face-to-face or telephonic appointments.

Suicide Prevention staff review the HRF list daily and remind the treatment team of the need for the required appointments and encourages appropriate documentation.

MGVAMC [Mann-Grandstaff VA Medical Center] utilizes the Transitional Psychiatric Service (TPS) which has a flexible schedule and ability to see Veterans in a timely manner.

Suicide Prevention staff audit 10 charts monthly to ensure that Veterans that have been flagged as high risk have four follow-up appointments scheduled within 30 days of being designated as high risk. The Suicide Prevention [staff] also audit to ensure the Veteran preference for face-to-face or telephonic appointments is documented. Audit target is performance of 90% or greater for six consecutive months.

VHA specifies "that for patients with a new or reactivated HRS-PRF, the safety plan should be completed within 7 days before or after the current HRS-PRF date."[102] The OIG determined that 64 percent of patients did not have a safety plan completed within seven days before or after the

[100] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care Suicide Prevention Coordinator Guide*.

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

[102] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care Suicide Prevention Coordinator Guide*; VHA suicide subject matter expert response to timing of safety plan completion, July 8, 2019.

high-risk designation.[103] When safety plans are not completed in a timely manner, patients may not be able to access critical resources when needed. According to the SPC, the safety plan deficiencies were attributable to a lack of oversight.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that clinicians complete suicide safety plans within the required time frame for patients with High Risk for Suicide Patient Record Flags.

Medical center concurred.

Target date for completion: September 30, 2021

Medical center response: The Medical Center evaluated the findings and did not identify additional reasons for noncompliance in development of the implementation plan. The Suicide Prevention Coordinator (SPC) has conducted trainings in the areas of Behavioral Health, Social Work Service, Urgent Care, and on the inpatient units. Education includes how to do Safety Plans, who can complete a Safety Plan, along with the mandates regarding Safety Plans in each department.

Safety Plans are now done in the Urgent Care [Center], at time of intake into Behavioral Health services, within 24 hours of discharge from inpatient units, and within 7 days of the placement of a flag.

Suicide Prevention tracks the HRF and ensures staff are aware of the safety plan requirements.

Timely completion of Safety plans was added to all relevant BHS [Behavioral Health Service] staff performance plans for FY21.

Suicide Prevention staff conduct monthly audits of 10 HRS Veterans to ensure safety plans are in place. Audit target is performance of 90% or greater for six consecutive months.

VHA requires SPCs to conduct five community outreach activities each month.[104] The OIG found that the SPC did not conduct the required outreach activities for October or December 2019. Failure to conduct outreach could negatively affect at-risk veterans who may not be aware of available mental health services at the VA. The SPC cited scheduling conflicts as the reason for noncompliance.

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

[104] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care Suicide Prevention Coordinator Guide.*

Recommendation 6

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

Medical center concurred.

Target date for completion: September 30, 2021

Medical center response: The Medical Center evaluated the findings and did not identify additional reasons for noncompliance in development of the implementation plan. Program Support Assistants (PSAs) have been provided with a list of VA community care providers in the catchment area. PSAs send emails to these providers offering to mail them Veterans Crisis Line educational material along with offering virtual S.A.V.E. trainings conducted by the SPC.

The three providers in Suicide Prevention have also offered a standing time each month to provide the trainings virtually.

Suicide Prevention staff provide a list of 5 outreach activities each month to QSV. Target is performance of 90% or greater for six consecutive months.

VHA requires that all employees complete suicide risk and intervention training within 90 days of entering their position and annual refresher training thereafter.[105] The OIG found that 1 of 8 employees did not complete suicide risk and intervention training within 90 days of entering their position, and 1 of 20 employees did not complete annual refresher training on time. Lack of training could prevent employees from recognizing the signs of suicidal ideation and providing optimal treatment to at-risk veterans. The SPC indicated a lack of attention to detail as the reason for noncompliance.

Recommendation 7

7. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures employees complete suicide risk and intervention training within 90 days of entering their position and annual refresher training.

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

Medical center concurred.

Target date for completion: September 30, 2021

Medical center response: The Medical Center evaluated the findings and did not identify additional reasons for noncompliance in development of the implementation plan. Suicide Prevention conducts S.A.V.E. training at each New Employee Orientation.

Suicide Prevention training has also been mandated in Talent Management System (TMS). Education Service ensures that TMS is set to remind staff annually to complete the training.

QSV conducts an audit of Suicide Prevention training to ensure that training is completed within 90 days of hire and annually. Ten training records are selected for audit monthly (5 new hires and 5 annual trainings) for review. The target is performance of 90% or greater for six consecutive months.

Care Coordination: Life-Sustaining Treatment Decisions

Life-sustaining treatments (LSTs) are intended to extend the life of a patient expected to die soon without medical intervention. LSTs may include artificial nutrition, hydration, and mechanical ventilation. VHA issued the life-sustaining treatment decision (LSTD) handbook to standardize practices related to discussing and documenting goals of care and LSTD. Per VHA, the goal is to encourage personalized, proactive, patient-driven treatment plans for veterans with serious illness by "eliciting, documenting, and honoring patients' values, goals, and preferences."[106]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD handbook by July 12, 2018.[107] Implementation requirements included initiating conversations about the goals of care. A goals of care conversation is a discussion between a healthcare provider and a patient or surrogate to help define the patient's values, goals, and preferences for care and, based on the discussion, make choices about starting, limiting, or ceasing LSTs.[108] VHA requires practitioners to initiate goals of care conversations with high-risk patients—including hospice patients or their surrogates—within a time frame that meets the medical needs of the patient or at the time of a triggering event.[109]

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

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

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

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

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

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

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

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

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

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

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

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[110] Inspectors examined if the medical center established an LSTD committee that was comprised of a multidisciplinary membership, which included representation from the Ethics Consultation Service, and reviewed proposed LST plans.

To determine whether the medical center complied with the OIG-selected requirements related to LSTD for hospice patients, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 39 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

Care Coordination Findings and Recommendations

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

[110] VHA Handbook 1004.03(1).

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[111] 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.[112] To help the VA better understand the needs of the growing women veterans population, efforts have been made by VHA to identify and address the urgent needs "by examining health care use, preferences, and the barriers Women Veterans face in access to VA care."[113] Additionally, a VA report in 2016 on suicide among veterans pointed out concerning trends in suicide among women veterans and discussed "the importance of understanding suicide risk among women veterans and developing gender-tailored suicide prevention strategies."[114]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment. Facilities must, therefore, ensure availability of appropriate resources, services, and staffing ratios.[115] VHA also requires delivery of quality care to all women veterans accessing VA emergency services. In addition, VHA requires facilities to establish a multidisciplinary women veterans health committee that "develops and implements a Women's Health Program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans."[116]

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

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

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

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

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

[114] 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.

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

[116] VHA Directive 1330.01(3).

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

Women's Health Findings and Recommendations

The medical center complied with requirements for some of the provision of care indicators. However, the OIG identified weaknesses with gynecologic care coverage, Women Veterans Health Committee membership and attendance, quality assurance data collection and tracking, and the WVPM's duties.

VHA requires facilities to have "processes and procedures in place for 24 hours per day and 7 days per week (24/7) for ED [Emergency Department] and facility call coverage for gynecologic care." This includes development and implementation of "written policies and standard operating procedures for managing obstetric and gynecologic emergencies." VHA further states that the policies "must clearly describe on-site capabilities and processes/protocols for emergent patient transfer."[117] The WVPM reported that the medical center does not provide 24 hours a day, 7 days per week coverage for gynecological care or have written policies and procedures for managing obstetric and/or gynecologic emergencies. This could have resulted in the medical center not providing high-quality, comprehensive women's healthcare. The WVPM stated that the medical

[117] VHA Directive 1330.01(3), *Health Care Services for Women Veterans,* February 15, 2017, amended June 29, 2020. (This directive was last amended on January 8, 2021, but the requirements have not changed.)

center follows the VHA directive for inter-facility transfers and believed adherence to national guidance met the requirement.

Recommendation 8

8. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that written processes and procedures are in place for 24 hours per day, 7 days per week gynecological care.

Medical center concurred.

Target date for completion: September 30, 2021

Medical center response: The Medical Center evaluated the findings and did not identify additional reasons for noncompliance in development of the implementation plan. A Standard Operating Procedure (SOP) has been developed by the Acute Care Chief and the Urgent Care Center (UCC) Nurse Manager to address processes for gynecological care during UCC regular business hours.

Women's Health has developed a policy for gynecological care to address 24/7 care in the facility.

The SOP and policy were implemented by March 31, 2021.

VHA requires that the Women Veterans Health Committee meets quarterly, reports to executive leaders, and has a core membership "to guide the women's health program and [assist] with carrying out improvements for providing high quality equitable care for women Veterans." That membership includes a WVPM; a women's health medical director; and "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED, radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership."[118]

The OIG reviewed the Women Veterans Health Committee charter dated August 23, 2017, and found that representatives from all areas except the WVPM, Women's Health Medical Director, mental health, laboratory, and an executive leader were missing from the charter. Additionally, the OIG reviewed the committee minutes for August and December 2019 and found no representation from mental health, pharmacy, business office/non-VA medical care, or executive leadership. This likely resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality care. The WVPM assumed responsibility for not assigning the required members. The program manager also stated

[118] VHA Directive 1330.01(2). (This directive was in place for the time frame of the minutes reviewed in this report. It was amended on June 29, 2020 (1330.01(3)), and again on January 8, 2021 (1330.01(4)). All three directives contain the same or similar language regarding the Women Veterans Health Committee.)

that staff had conflicting priorities due to the medical center's implementation of the new electronic health record and patient care demands.

Recommendation 9

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

Medical center concurred.

Target date for completion: September 30, 2021

Medical center response: The Medical Center evaluated the findings and did not identify additional reasons for noncompliance in development of the implementation plan. The Women's Health (WH) Charter has been completed and updated to reflect the required members.

The Women's Health Program Manager (WVPM) has reminded the Women Veterans Health Committee members about the importance of participating as well as providing a surrogate in their absence.

Attendance is audited monthly by QSV. The target is performance of 90% or greater for six consecutive months.

VHA requires facility staff to collect and track data related to women's healthcare services, including follow-up of abnormal mammogram and cervical cytology reports and the timeliness of breast and cervical cancer treatment.[119] The OIG found no evidence that the WVPM tracked follow-up of abnormal mammogram and cervical cytology reports or the timeliness of breast and cervical cancer treatment from July through December 2019. This could have resulted in a potential delay of cancer diagnosis and treatment. The WVPM reported a belief that the medical center met the requirements but could not provide the OIG with documentation to validate the tracking process.

Recommendation 10

10. The Medical Center Director evaluates and determines the reasons for noncompliance and makes certain the Women Veterans Program Manager collects and tracks data for follow-up of abnormal mammogram and cervical cytology reports and the timeliness of breast and cervical cancer treatment.

[119] VHA Directive 1330.01(2). (This directive was in effect for the time frame of the data reviewed. It was amended on June 29, 2020 (1330.01(3)) and again on January 8, 2021 (1330.01(4)). All three directives contain the same or similar language regarding the data review.)

Medical center concurred.

Target date for completion: September 30, 2021

Medical center response: The Women's Health Clinical Navigator implemented a process to track all results through the Care Management Tool (CMT) and through the Women Veterans Health Committee.

Women's Health monitors and reports the % of Veterans receiving timely results notification with a performance target of 90% or greater achieved for 2 consecutive quarters.

VHA requires facilities to have a WVPM who is full-time and free of collateral duties.[120] The WVPM reported also working as the Women Veterans Nurse Manager. This could negatively affect the medical center's ability to deliver the best quality healthcare services to its women veteran patients. The WVPM reported believing that additional duties were permissible because the Women Veterans Nurse Manager's role of supervising and providing clinical oversight for three nursing staff fell under the medical center's Women's Health Program.

Recommendation 11

11. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Women Veterans Program Manager is full-time and free of collateral duties.[121]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Medical Center evaluated the findings and did not identify additional reasons for noncompliance in development of the implementation plan. The Position Description (PD) for the Women's Health Program Manager was written with consultation of the Chief of Staff to ensure the language is clear that the WHPM [Women's Health Program Manager] does not have any ancillary duties assigned. The PD was approved and signed by Leadership.

[120] VHA Directive 1330.01(3). (This directive was in effect at the time of the virtual review. It was last amended on January 8, 2021, but the requirements for the WVPM have not changed.)

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

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have Sterile Processing Services (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment."[122] The goal of SPS is to "provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[123] To ensure this, VHA requires facilities to conduct the following activities:

- Maintain a current inventory list of all RME
- Have standard operating procedures that are based on current manufacturers' guidelines and reviewed at least triennially
- Use CensiTrac® Instrument Tracking System for tracking reprocessed instruments[124]
- Perform annual risk analysis and report results to the VISN SPS Management Board
- Monitor data for reprocessing and storing RME
- Conduct annual airflow/ventilation system inspections[125]

VHA requires strict controls that closely monitor climate, storage, and sterilization parameters and additionally requires that quality assurance documentation of this monitoring be maintained for a minimum of three years.[126] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[127]

In addition, RME reprocessing areas must be clean, restricted, and airflow-controlled. All areas where RME reprocessing occurs must have safety data sheets, an unobstructed eyewash station, personal protective equipment available for immediate use, and standard operating procedures readily available to guide the reprocessing of RME.[128]

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

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

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

[125] VHA Directive 1116(2).

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

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

[128] VHA Directive 1116(2).

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued annual and essential staff competency assessments, and monthly continuing education. This ensures that staff have sufficient aptitude, knowledge, and skills to effectively and safely reprocess and sterilize RME.[129]

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

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

[129] VHA Directive 1116(2).

High-Risk Processes Findings and Recommendations

The medical center complied with many elements of expected performance for reprocessing RME. However, the OIG identified deficiencies with an annual risk analysis and competency assessments.

VHA requires the Chief of SPS to perform an annual risk analysis and report the results to the VISN SPS Management Board.[130] The OIG found that the FY 2019 annual risk analysis was performed; however, the medical center could not provide evidence that the results were reported to the VISN SPS Management Board. Failure to report risk analysis results can delay or prevent the identification of problems or process failures, and opportunities for awareness and assistance at the VISN level. The Chief of SPS stated that efforts were concentrated on staff development and reporting the annual risk analysis results to the VISN was inadvertently omitted.

Recommendation 12

12. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that the Chief of Sterile Processing Services reports the annual risk analysis results to the Veterans Integrated Service Network Sterile Processing Services Management Board.[131]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Medical Center evaluated the findings and did not identify additional reasons for noncompliance in development of the implementation plan. The FY20 Sterile Processing Services (SPS) Risk Analysis has been completed and submitted to the VISN SPS Management Board. To avoid non-compliance in the future, the following has been put in place:

-Annual Risk Analysis will be reviewed no later than October 30 each year by the RME committee.

-Once reviewed, the Annual Risk Analysis will be submitted to the VISN. Receipt by the VISN will be requested from Spokane.

The FY20 SPS Risk Analysis results were reported to the VISN SPS Management Board prior to November 2020.

[130] VHA Directive 1116(2).

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

Additionally, VHA requires the Chief of SPS to ensure that staff who reprocess RME complete competency assessments.[132] The OIG found that 3 of 10 SPS staff lacked competency assessments for the reviewed ultrasound probe and all lacked assessments for the corresponding ultrasound transducer.[133] This could result in improper cleaning of the RME and subsequently compromise patient safety. The SPS educator stated that the three staff members could not demonstrate competence for the ultrasound probe and required additional training, which had not been completed. The SPS educator also acknowledged inadvertently omitting competency assessments for the ultrasound transducer.

Recommendation 13

13. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that staff who reprocess reusable medical equipment complete competency assessments.

Medical center concurred.

Target date for completion: September 30, 2021

Medical center response: The Medical Center evaluated the findings and did not identify additional reasons for noncompliance in development of the implementation plan. A new tracker has been put in place that will alert the Chief of SPS 30 days prior to a competency expiring.

SPS staff perform an audit review of 10 staff records monthly to ensure all competencies are current. The target for performance is 90% or greater for six consecutive months.

[132] VHA Directive 1116(2).

[133] "SonoSite Edge II User Guide," FUJIFILM, accessed May 13, 2021, https://www.sonosite.com/support/user-documents. Ultrasound transducers are intended to be used "for evaluation by ultrasound imaging or fluid flow analysis of the human body." The transducer is placed "onto (or into for invasive procedures) the patient's body where needed to obtain the desired ultrasound image."

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

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

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• Root cause analyses' actions and outcome measures show sustained improvement.	• Protected Peer Review Committee completes final reviews within 120 calendar days or has a written extension request approved by the Director.
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• Service chiefs define in advance, communicate, and document expectations for FPPEs in practitioners' profiles.	• None
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• None	• None
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Tracking and follow-up of high-risk veterans • Provision of suicide prevention care • Completion of suicide prevention training requirements	• Providers conduct four follow-up visits, either face-to-face or telephonic with documented consent, within the required time frame. • Clinicians complete suicide safety plans within the required time frame for patients with High Risk for Suicide Patient Record Flags.	• Suicide Prevention Coordinator conducts at least five outreach activities each month. • Employees complete suicide risk and intervention training within 90 days of entering their positions and annual refresher training.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• None	• None
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• Written processes and procedures are in place for 24 hours a day, 7 days per week gynecological care.	• Required members are assigned to and consistently attend Women Veterans Health Committee meetings. • The WVPM collects and tracks data for follow-up of abnormal mammogram and cervical cytology reports and the timeliness of breast and cervical cancer treatment. • The WVPM is full-time and free of collateral duties.
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Quality assurance • Staff training	• Staff who reprocess reusable medical equipment complete competency assessments.	• The Chief of SPS reports the annual risk analysis results to the VISN SPS Management Board.

Appendix B: Medical Center Profile

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

Table B.1. Profile for the Mann-Grandstaff VA Medical Center (668) (October 1, 2016, through September 30, 2019)

Profile Element	Medical Center Data FY 2017*	Medical Center Data FY 2018†	Medical Center Data FY 2019‡
Total medical care budget	$218,480,118	$246,571,464	$253,550,500
Number of:			
• Unique patients	33,249	34,925	35,765
• Outpatient visits	345,769	366,282	378,794
• Unique employees	893	1,022	1,024
Type and number of operating beds:			
• Community living center	34	34	34
• Medicine	22	22	22
• Mental health	12	12	12
• Surgery	2	2	2
Average daily census:			
• Community living center	31	29	27
• Medicine	9	8	8
• Mental health	7	8	7
• Surgery	0	0	0

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

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

**October 1, 2016, through September 30, 2017.*

†*October 1, 2017, through September 30, 2018.*

‡*October 1, 2018, through September 30, 2019.*

[1] Associated with a medical residency program. The VHA medical centers are classified according to a facility complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs."

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Wenatchee, WA	668GA	6,483	2,436	Dermatology Eye Infectious disease	EKG	Nutrition Pharmacy Weight management
Coeur d'Alene, ID	668GB	11,662	5,092	Dermatology Eye Infectious disease Pulmonary/ Respiratory disease	–	Nutrition Pharmacy Social work Weight management
Spokane, WA	668HK	482	–	–	–	–
Libby, MT	668QB	1,790	74	–	–	Pharmacy

[1] Includes outpatient clinics that were in operation as of August 27, 2019. The OIG omitted (668QE) Spokane 2nd Avenue, WA as no workload/encounters or services were reported. VHA Directive 1230(4), *Outpatient Scheduling Processes And Procedures*, July 15, 2016, amended June 17, 2021. An encounter is a "professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition." Specialty care services refer to non-primary care and non-mental health services provided by a physician.

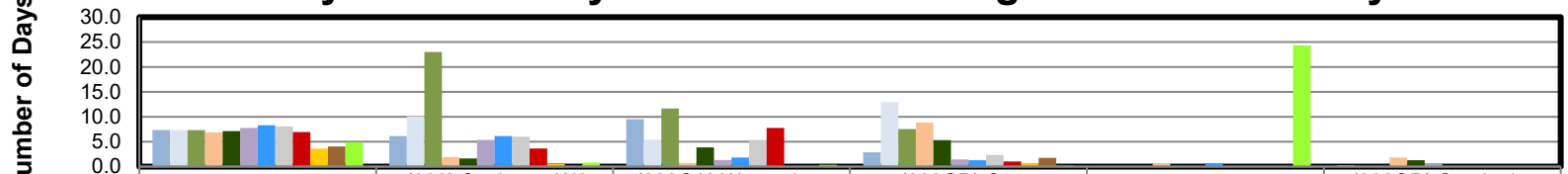
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Ponderay, ID	668QD	4,172	9	–	–	Pharmacy Weight management

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

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

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days

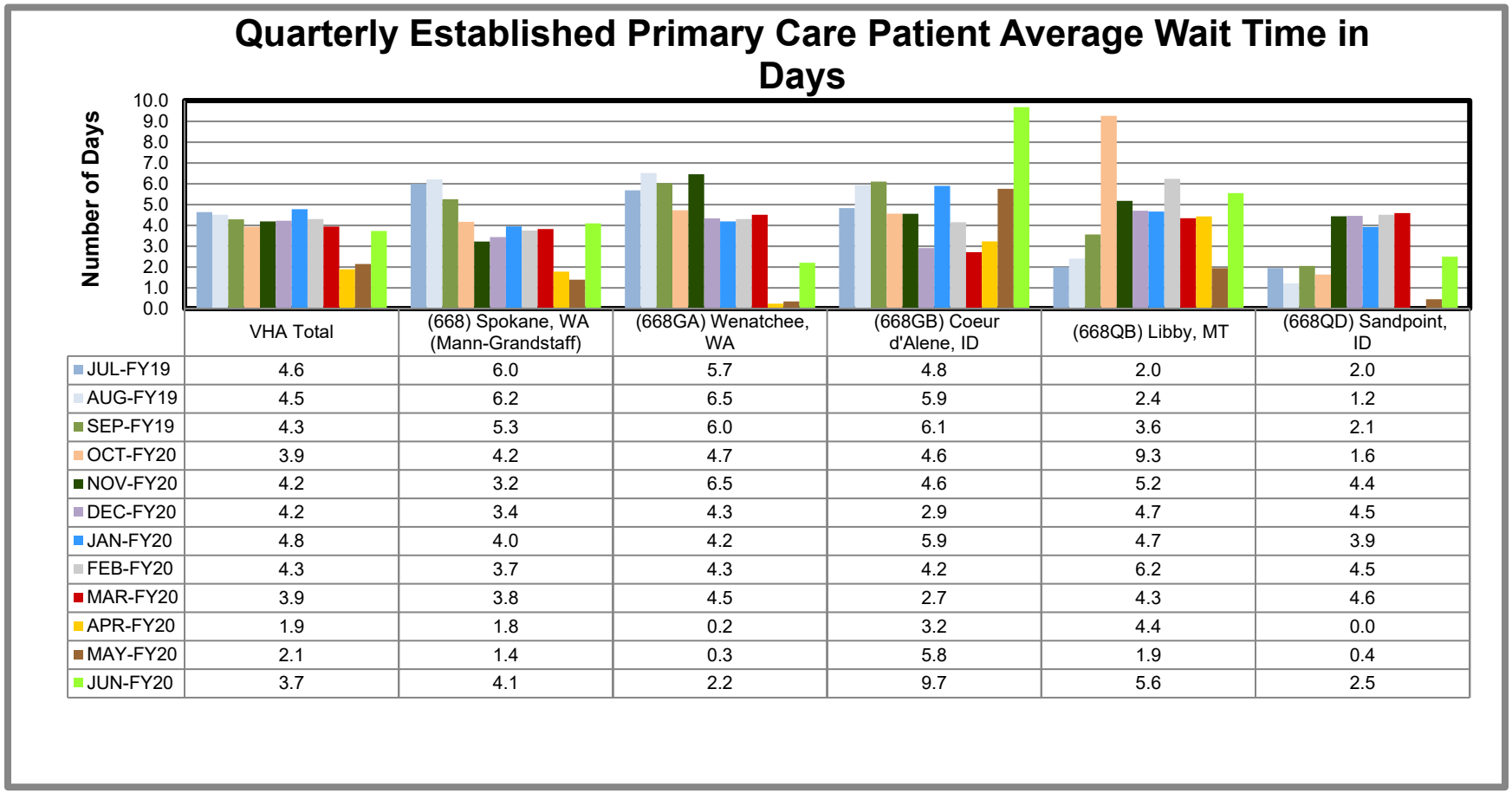


	VHA All	(668) Spokane, WA (Mann-Grandstaff)	(668GA) Wenatchee, WA	(668GB) Coeur d'Alene, ID	(668QB) Libby, MT	(668QD) Sandpoint, ID
JUL-FY19	7.3	6.1	9.5	2.9	0.0	0.3
AUG-FY19	7.4	10.1	5.4	12.9	0.0	0.0
SEP-FY19	7.3	23.0	11.7	7.5	0.0	0.0
OCT-FY20	6.9	1.9	0.7	8.8	0.7	1.8
NOV-FY20	7.1	1.6	3.9	5.3	0.0	1.3
DEC-FY20	7.8	5.4	1.3	1.5	n/a	0.6
JAN-FY20	8.3	6.2	1.8	1.3	0.7	0.0
FEB-FY20	8.1	6.0	5.4	2.3	0.0	0.1
MAR-FY20	6.9	3.6	7.8	1.0	0.0	0.1
APR-FY20	3.6	0.5	n/a	0.7	n/a	n/a
MAY-FY20	4.0	0.0	0.0	1.8	0.0	n/a
JUN-FY20	4.9	0.8	0.4	0.2	24.3	0.0

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (668QE) Spokane 2nd Avenue, WA as no workload/encounters or services were reported.

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



	VHA Total	(668) Spokane, WA (Mann-Grandstaff)	(668GA) Wenatchee, WA	(668GB) Coeur d'Alene, ID	(668QB) Libby, MT	(668QD) Sandpoint, ID
JUL-FY19	4.6	6.0	5.7	4.8	2.0	2.0
AUG-FY19	4.5	6.2	6.5	5.9	2.4	1.2
SEP-FY19	4.3	5.3	6.0	6.1	3.6	2.1
OCT-FY20	3.9	4.2	4.7	4.6	9.3	1.6
NOV-FY20	4.2	3.2	6.5	4.6	5.2	4.4
DEC-FY20	4.2	3.4	4.3	2.9	4.7	4.5
JAN-FY20	4.8	4.0	4.2	5.9	4.7	3.9
FEB-FY20	4.3	3.7	4.3	4.2	6.2	4.5
MAR-FY20	3.9	3.8	4.5	2.7	4.3	4.6
APR-FY20	1.9	1.8	0.2	3.2	4.4	0.0
MAY-FY20	2.1	1.4	0.3	5.8	1.9	0.4
JUN-FY20	3.7	4.1	2.2	9.7	5.6	2.5

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (668QE) Spokane 2nd Avenue, WA as no workload/encounters or services were reported.

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

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

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

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

Source: VHA Support Service Center.

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

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
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 4, 2021

From: Director, Northwest Network (10N20)

Subj: Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, WA

To: Director, Office of Healthcare Inspections (54CH02)

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 Mann-Grandstaff VA Medical Center in Spokane, WA.

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

(Original signed by:)

Teresa D. Boyd, DO

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: June 1, 2021

From: Director, Mann-Grandstaff VA Medical Center, (668/00)

Subj: Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington

To: Director, Northwest Network (10N20)

1. Thank you for the opportunity to provide a response to the findings from the Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington.

2. I concur with the findings and recommendations and will ensure that actions to correct these finding are completed as described in responses to the draft report.

(Original signed by:)

Robert J. Fischer, MD

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