DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Montana VA Health Care System in Fort Harrison

CHIP REPORT | REPORT #21-00232-205 | AUGUST 19, 2021

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Figure 1. *Montana VA Health Care System in Fort Harrison. Source: https://vaww.va.gov/directory/guide/ (accessed January 6, 2021).*

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Montana VA Health Care System and multiple outpatient clinics in Montana. 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 seven areas:

1. COVID-19 pandemic readiness and response[1]
2. Quality, safety, and value
3. Registered nurse credentialing
4. Medication management (targeting remdesivir use)
5. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
6. Care coordination (spotlighting inter-facility transfers)
7. High-risk processes (examining the management of disruptive and violent behavior)

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

[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)."

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

Inspection Results

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

Leadership and Organizational Risks

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

When the team conducted this review, two of the five executive leader positions were vacant. The Quality Management Officer was serving as acting Associate Director for Patient Care Services and acting Assistant Director. The permanently assigned leaders had worked together for over one year. The Director, who took on the role in June 2019, was the most tenured leader. The Chief of Staff and Associate Director had served in their positions since July and November 2019, respectively.

The OIG noted a budget increase of more than 33 percent in fiscal year 2020; according to executive leaders, this allowed the healthcare system to expand patient services, clinical resources, and access to community care. The increase also allowed leaders to hire more staff.

Employee satisfaction survey data revealed opportunities to improve attitudes toward leaders, the workplace, and workgroup relationships. Patient experience survey results highlighted opportunities to improve patient-centered medical home experiences for both genders and specialty care experiences for female veterans.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events. The OIG did not identify any substantial organizational risk factors.[2]

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within

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

VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[3]

The executive leaders were generally knowledgeable within their scope of responsibilities about VHA data and system-level factors contributing to specific poorly performing quality and efficiency measures. The leaders 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. However, the leaders have opportunities to improve quality of care and efficiency at the healthcare system and should continue to take actions to improve performance.

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The OIG identified opportunities for improvement with the Systems Redesign and Improvement Program, Surgical Work Group, and several committees' monitoring of implemented actions for quality and patient safety process oversight.

Registered Nurse Credentialing

The OIG reviewers found that registered nurses hired between January 1 and October 26, 2020, were free from potentially disqualifying licensure actions. However, primary source verification of each license was not consistently performed prior to appointment of registered nurses who held licenses in multiple states.

Medication Management

The OIG team observed compliance with many elements of expected performance, including staff availability to receive remdesivir shipments, required testing prior to remdesivir administration, and staff reporting adverse events. However, the OIG noted concerns with patient/caregiver education.

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

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

Mental Health

The healthcare system generally complied with requirements for suicide prevention screening within the emergency department and urgent care center. However, the OIG identified a deficiency with required staff training.

Care Coordination

Generally, the healthcare system met expectations for an inter-facility transfer policy, monitoring and evaluation of inter-facility transfers, completion of the required VA *Inter-Facility Transfer Form*, transmission of patients' active medication lists, and nurse-to-nurse communication between facilities.[5] However, the OIG noted that transfer documentation did not include patients' advance directives.

High-Risk Processes

The healthcare system met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies in Disruptive Behavior Committee meeting attendance and staff training.

Conclusion

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

[5] VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017. A completed VA *Inter-Facility Transfer Form* or an equivalent note communicates critical information to facilitate and ensure safe, appropriate, and timely transfer. Critical elements include documentation of patients' informed consent, medical and/or behavioral stability, mode of transportation and appropriate level of care required, identification of transferring and receiving physicians, and proposed level of care after transfer.

Comments

The Veterans Integrated Service Network Director and System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 62–63, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendations 1–3 and 5–7 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
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Contents

Purpose and Scope

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

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

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

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

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

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

[2] Anam Parand et al., "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014), https://doi.org/10.1136/bmjopen-2014-005055.

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

[4] Virtual CHIP site visits address these processes during fiscal year 2021 (October 1, 2020, through September 30, 2021); they may differ from prior years' focus areas.

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

5. Medication management (targeting remdesivir use)
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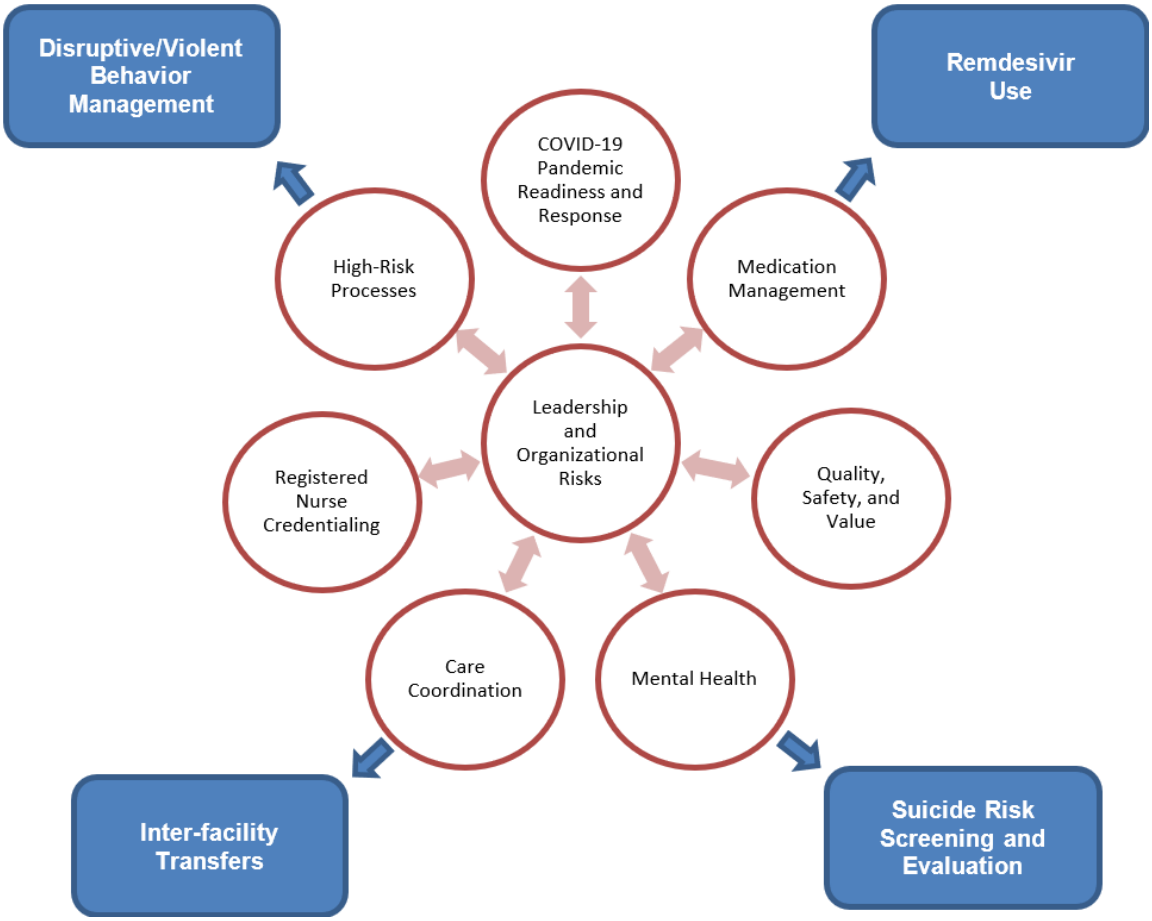


Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

Methodology

The Montana VA Health Care System includes multiple outpatient clinics in Montana. Additional details about the types of care provided by the healthcare system can be found in appendixes B and C.

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

The inspection examined operations from March 11, 2017, through December 4, 2020, the last day of the unannounced multiday evaluation.[7] During the virtual site visit, the OIG did not receive any complaints beyond the scope of the inspection.

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[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 healthcare system completes corrective actions. The System Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that system leaders developed based on the reasons for noncompliance.

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

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

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

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

[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 a healthcare system's ability to provide care in the clinical focus areas.[10] To assess this healthcare system's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the healthcare system response
8. VHA performance data (healthcare system)
9. VHA performance data (community living center (CLC))[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 healthcare system's reported organizational structure. The healthcare system's leadership team consisted of the Director, Chief of Staff, acting Associate Director for Patient Care Services (ADPCS), Associate Director, and acting Assistant Director. The Chief of Staff and acting ADPCS oversaw patient care, which required 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.

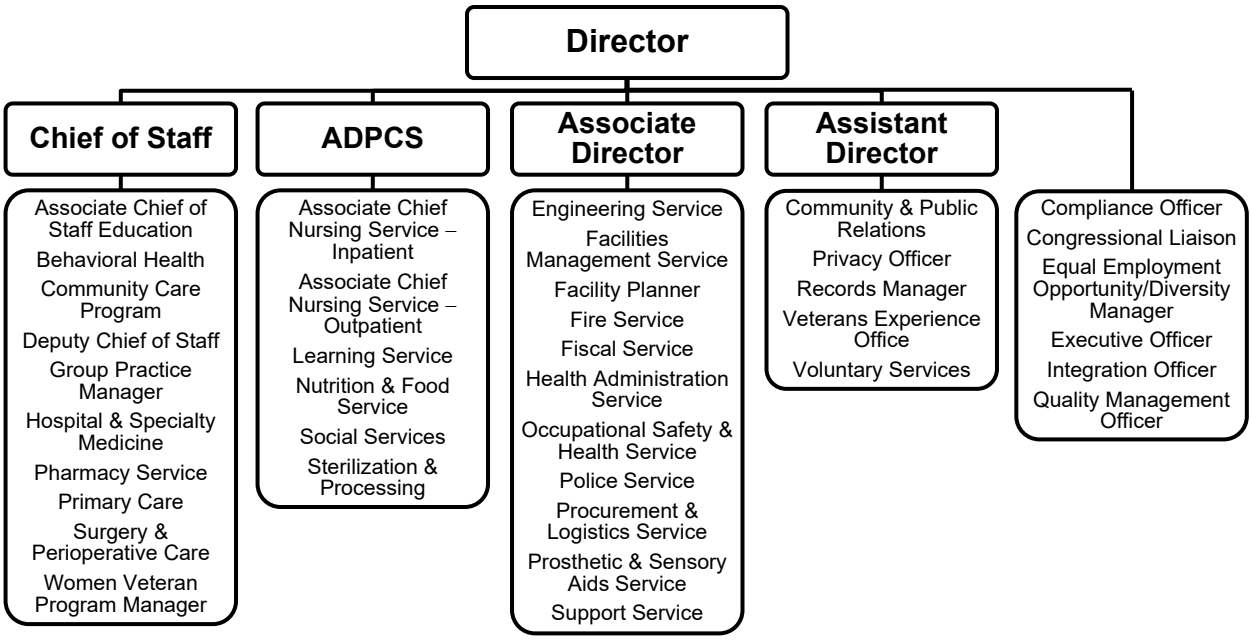


Figure 3. *Healthcare system organizational chart.*

Source: Montana VA Health Care System (received December 1, 2020).

At the time of the OIG virtual review, two of the five executive leader positions at the healthcare system were vacant. The Quality Management Officer, who had served in the position for 10 years, was serving as acting ADPCS and acting Assistant Director. The Director, permanently assigned in June 2019, was the most tenured leader. The Chief of Staff and the Associate Director had served in their positions since July and November 2019, respectively (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	June 23, 2019
Chief of Staff	July 21, 2019
Associate Director for Patient Care Services	September 21, 2020 (acting)
Associate Director	November 10, 2019
Assistant Director	August 24, 2020 (acting)

Source: Montana VA Health Care System acting Senior Strategic Business Partner (received November 30, 2020).

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

The executive leaders were knowledgeable, within their scope of responsibilities, about VHA data and system-level factors contributing to specific poorly performing Strategic Analytics for Improvement and Learning (SAIL) measures. In individual interviews, the Director, Chief of Staff, acting ADPCS/Assistant Director, and Associate Director were able to speak in depth 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 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 Healthcare Delivery, Healthcare Operations, and Organizational Health Committees. These leaders monitored patient safety and care through the Quality, Safety, and Value Committee, which tracked and trended quality of care and patient outcomes and reported to the Executive Leadership Board (see figure 4).

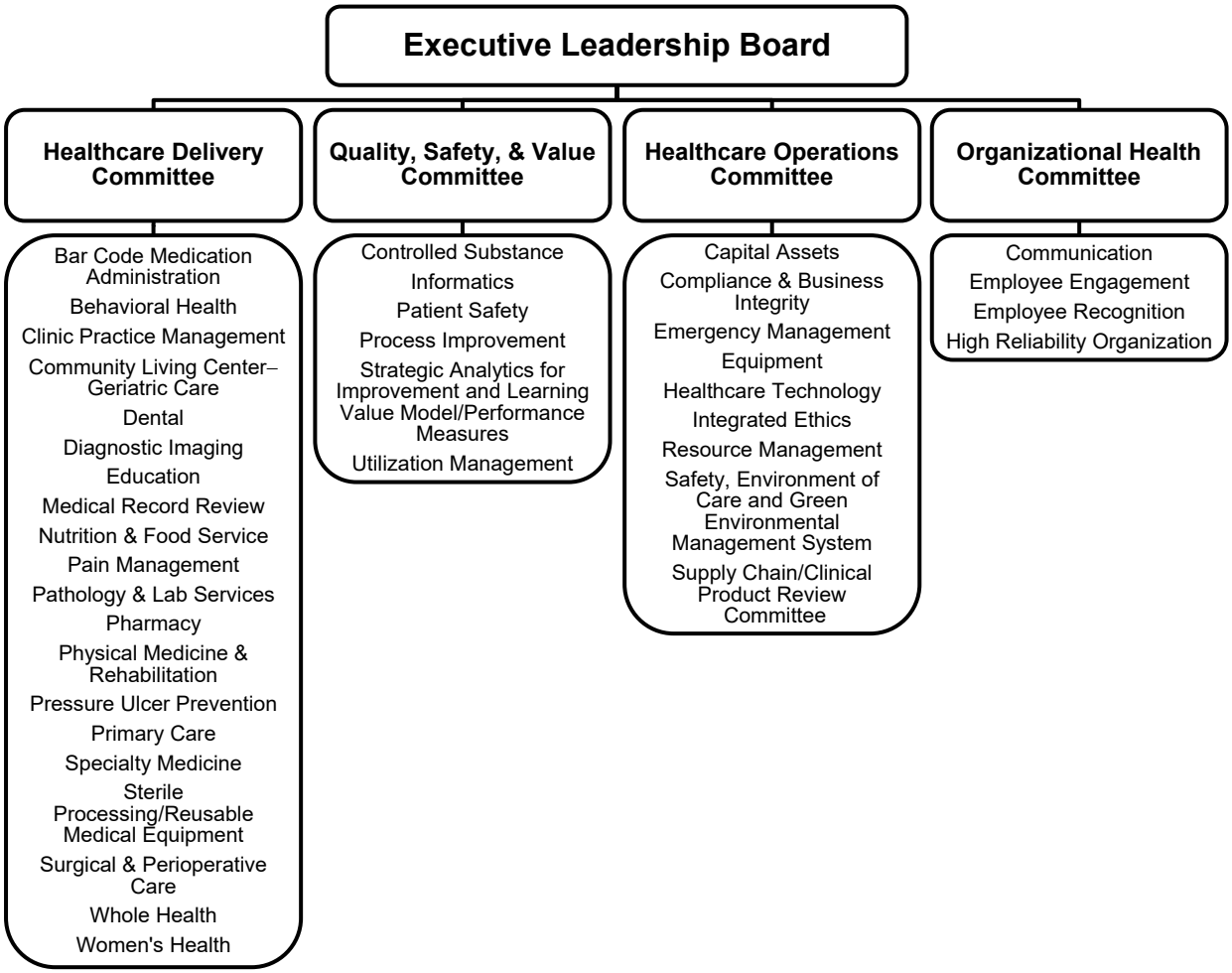


Figure 4. *Healthcare system committee reporting structure.*

Source: Montana VA Health Care System (received December 1, 2020).

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of $439,525,849 increased by over 33 percent compared to the previous year's budget of $329,194,081.[12] When asked about the effect of this change on the healthcare system's operations, the Director indicated that the additional funds helped expand patient services, clinical resources, and community care access via the VA Choice program and VA MISSION Act.[13] In addition, the increased budget allowed the healthcare system to hire more staff.

[12] VHA Support Service Center.

[13] VHA Directive 1700, *Veterans Choice Program*, October 25, 2016. The VA MISSION Act of 2018, Pub. L. No. 115-182, Stat. 1393. VA Office of Public Affairs Media Relations, *Fact Sheet: Veteran Community Care – Eligibility, VA MISSION Act of 2018*, April 2019.

Staffing

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

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[17] The executive leaders confirmed that occupations listed in table 2 remained the top clinical and nonclinical shortages at the time of the OIG inspection. The Director reported implementing strategies to address the shortage of medical officers by offering recruitment incentives for primary care physicians and psychiatrists, employing gap (contract or temporary) providers, and using community care resources. The Director also spoke about a shortage of licensed practical nurses in Montana and offering special salary rates to retain staff while recruiting new nurses. As for custodial workers, the Director reported eliminating contracted employees and hiring 10–12 staff.

The Chief of Staff also verified that the healthcare system offered recruitment incentives to address the shortage of primary care physicians. This resulted in hiring enough physicians to staff all 15 community-based outpatient clinics. In addition, the Chief of Staff reported ongoing hiring challenges for nurses, medical instrument technicians, and police.

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

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

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

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

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Medical Officer	1. Police
2. Practical Nurse	2. Maintenance Mechanic
3. Nurse	3. Medical Support Assistance
4. Medical Instrument Technician	4. Custodial Worker
5. Diagnostic Radiologic Technologist	5. –*

Source: VA OIG.

**Not applicable.*

Employee Satisfaction

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

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2018, through September 30, 2019.[19] Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. Except for the Director and Chief of Staff's high servant leader index composite scores, healthcare system and leader averages for the selected survey leadership questions were generally below VHA averages.[20] Although there appear to be opportunities to improve employee attitudes, the 2019 All Employee Survey results are not fully reflective of employee satisfaction with current leaders.[21]

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

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

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

[21] The 2019 All Employee Survey results are not reflective of employee satisfaction with the acting ADPCS/ Assistant Director and current Associate Director, who assumed their roles after the survey was administered. Results are also not fully reflective of satisfaction scores for the Director and Chief of Staff, who assumed their roles just prior to survey administration.

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	72.6	72.3	79.6	87.9	61.7	59.6	58.1
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	3.0	3.3	3.0	3.1	2.8	2.8
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.1	3.4	3.0	2.8	3.1	2.9
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.1	3.2	2.9	3.6	3.1	3.0

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

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[22] The healthcare system and leader averages for the selected survey questions were generally similar to or worse than the VHA averages. Although the 2019 All Employee Survey results are not fully reflective of attitudes toward current leaders, there appear to be opportunities to improve employee satisfaction and create a culture where staff feel safe reporting concerns and doing the right thing.

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. 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	3.6	4.1	3.4	3.8	3.9	3.6
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.7	3.9	4.3	3.3	3.3	3.7

[22] Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director. The 2019 All Employee Survey results are not reflective of employee satisfaction with the acting ADPCS/Assistant Director and current Associate Director, who assumed their roles after the survey was administered. Results are also not fully reflective of satisfaction scores for the Director and Chief of Staff, who assumed their roles just prior to survey administration.

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
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	1.7	2.0	2.3	2.7	2.7	1.9

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

VHA leaders have articulated that the agency "is committed to a harassment-free healthcare environment." To this end, leaders initiated the "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[23] The Director also reported requiring all staff to complete a two hour Equal Employment Opportunity training.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The scores for the Director, Chief of Staff, and Associate Director were similar to or higher than the VHA averages. The OIG notes that the 2019 All Employee Survey results are not fully reflective of employee satisfaction with the current leaders, and opportunities appear to exist for the executive team to promote an environment where discrimination is not tolerated, and staff feel safe bringing up problems and tough issues.

[23] "Stand Up to Stop Harassment Now!" Department of Veterans Affairs, accessed December 8, 2020, https://vaww.insider.va.gov/stand-up-to-stop-harassment-now/. Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*, October 23, 2019.

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

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	3.8	4.7	3.3	3.8	4.0
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree) –5 (Strongly Agree)	4.0	4.0	4.2	4.1	3.2	3.9	3.5
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	3.8	4.7	3.5	3.2	3.4

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

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the healthcare system.[24] For this healthcare system, survey data results reflected similar or higher care ratings than VHA averages, except in

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

the patient-centered medical home setting. Patients appeared generally satisfied with the care provided.

During the interview, the Director mentioned several factors that may have affected patients' experiences. These factors included noise level, poor wireless internet connections for inpatients, and veterans' frustrations with seeing multiple providers in outpatient settings. The Director reported installing *Yacker Tracker* (a device that measures sound levels) in the inpatient units; improving internet connections; hiring additional primary care providers; conferring with the VA Veterans Experience Office to improve patient experiences; and implementing the *Commit to Sit* practice, where physicians sit eye-to-eye with patients during visits.

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

Questions	Scoring	VHA Average	Healthcare System Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.6	73.9
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.8	79.8
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.9	85.4

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[25] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

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

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender (see tables 7–9), including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys.

The OIG noted that male and female patients would recommend the hospital to friends and family and felt that inpatient nurses treated them with courtesy and respect. However, patient-centered medical home survey results were lower for both genders when compared to the corresponding VHA averages. Specialty care survey results related to female veterans obtaining needed clinic appointments were lower than VHA female respondents nationally. Despite this, female respondents at the healthcare system rated their specialty care providers more favorably when compared to all female respondents nationally. Leaders appear to have opportunities to improve patient experiences for both genders in the patient-centered medical home and for female veterans in specialty care. During interviews with the OIG, leaders acknowledged that women veterans do not feel comfortable entering the campus and waiting in the lobby with older male veterans. Leaders reported a plan to create a dedicated entrance and waiting area for women veterans.

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

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.9	73.5	82.4
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	85.5	86.7	82.6
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	82.9	89.7	90.4

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

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

† The healthcare system averages are based on 209–213 male and 11–12 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.6	44.7	48.1	32.9
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	60.0	53.2	53.8	48.7
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.1	69.6	69.5	62.9

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

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

†*The healthcare system averages are based on 749–2,198 male and 57–142 female respondents, depending on the question.*

Table 9. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2019, through July 31, 2020)

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.8	46.2	51.0	33.4
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.7	54.0	61.5	39.5
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.1	74.8	93.1

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

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

† *The healthcare system averages are based on 279–868 male and 13–65 female respondents, depending on the question.*

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.[26] Table 10 summarizes the relevant healthcare system inspections most recently performed by the OIG and

[26] 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."

The Joint Commission (TJC).[27] At the time of the OIG review, the healthcare system had closed all recommendations for improvement issued since the previous Clinical Assessment Program site visit conducted in March 2017.

The OIG team noted the healthcare system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities.[28] The OIG also noted the Long Term Care Institute's inspection of the system's CLC.[29]

Table 10. Office of Inspector General Inspection/The Joint Commission Surveys

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Clinical Assessment Program Review of the Montana VA Health Care System, Fort Harrison, Montana*, Report No. 16-00573-309, July 26, 2017)	March 2017	19	0
TJC Hospital Accreditation	August 2019	41	0
TJC Behavioral Health Care Accreditation		4	0
TJC Home Care Accreditation		13	0
TJC Laboratory	July 2019	11	0

Source: OIG and TJC (inspection/survey results received from the Accreditation Manager on November 30, 2020).

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

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be

[27] 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."

[28] VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017. The Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment "is supported through a system-wide, long-term joint collaboration with CARF [Commission on Accreditation of Rehabilitation Facilities] to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs."

[29] "About Us," Long Term Care Institute, accessed December 8, 2020, http://www.ltciorg.org/about-us/. The Long Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings."

able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms.

Table 11 lists the reported patient safety events from March 11, 2017 (the prior OIG Clinical Assessment Program site visit), through November 30, 2020.[30]

Table 11. Summary of Selected Organizational Risk Factors (March 11, 2017, through November 30, 2020)

Factor	Number of Occurrences
Sentinel Events	12
Institutional Disclosures	3
Large-Scale Disclosures	0

Source: Montana VA Health Care System's Patient Safety and Risk Managers (received November 30, 2020).

The OIG's review of the healthcare system's sentinel events and disclosures did not identify any substantial organizational risk factors. The OIG confirmed that for all sentinel events and institutional disclosures, program managers conducted required investigations, such as root cause analyses and peer review, and took corrective actions by developing and improving processes and enhancing staff education.

Veterans Health Administration Performance Data for the Healthcare System

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee

[30] 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 Montana VA Health Care System is a medium complexity (2) system as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

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.[31]

Figure 5 illustrates the healthcare system's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2020. Figure 5 shows the Montana VA Health Care System performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (patient safety indicator (PSI) 90 (a subset of the Agency for Healthcare Research and Quality patient safety indicators), emergency department (ED) throughput, and health care (HC) associated (assoc) infections). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, care transition, patient-centered medical home (PCMH) care coordination, rating (of) primary care (PC) provider, and All Employee Survey (AES) data use).[32]

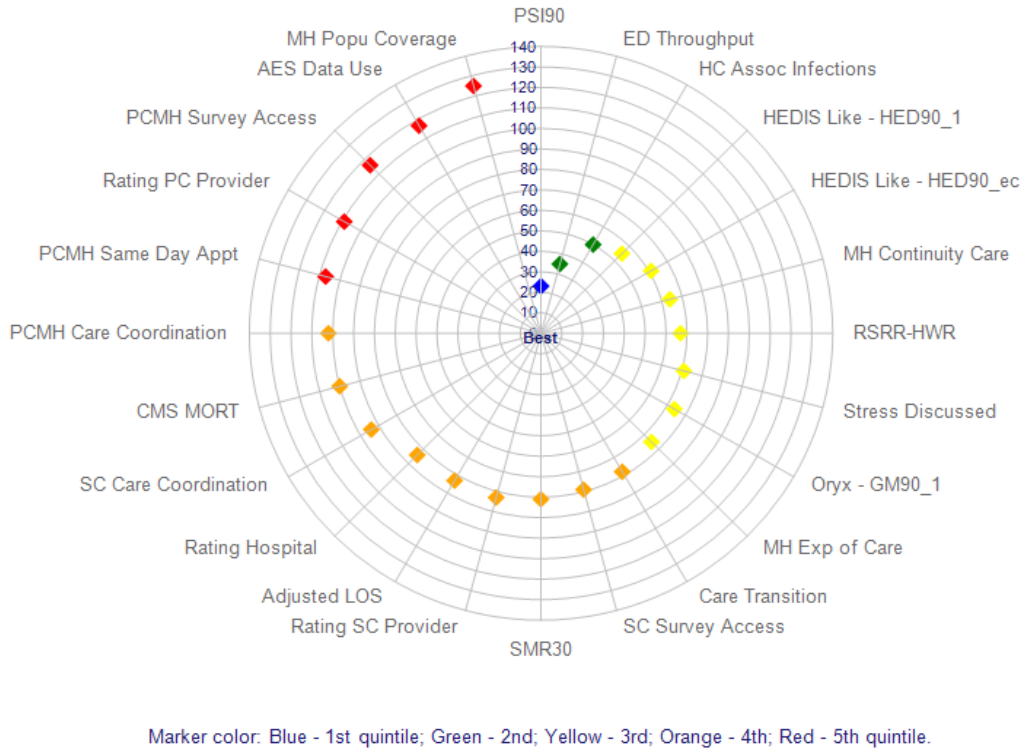


Figure 5. *Healthcare system quality of care and efficiency metric rankings for FY 2020 quarter 3 (as of June 30, 2020).*

Source: VHA Support Service Center.

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

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

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

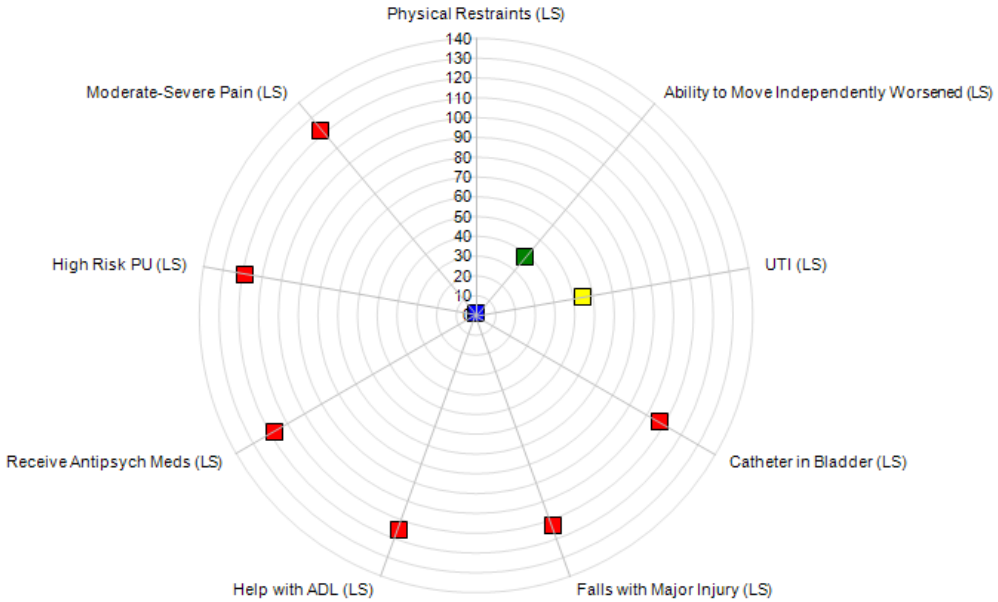
Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA." The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[33]

Figures 6 illustrates the healthcare system's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. Figure 6 displays the Montana VA Health Care System CLC metrics with high performance (blue and green data points) in the first and second quintiles (physical restraints–long-stay (LS) and ability to move independently worsened (LS)). Metrics in the fifth quintile need improvement and are denoted in red (for example, falls with major injury (LS), high risk pressure ulcer (PU) (LS), and moderate-severe pain (LS)).[34]

[33] 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."

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



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

Figure 6. *Montana VA Health Care System CLC quality measure rankings for FY 2020 quarter 3 (as of June 30, 2020).*

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

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

The healthcare system's executive leadership team had vacancies in two of the five executive leader positions at the time of the OIG review. The Quality Management Officer was serving as acting ADPCS and acting Assistant Director. The permanently assigned leaders had worked together in their positions for over one year. The healthcare system managed organizational communications and accountability through a committee reporting structure, with the Executive Leadership Board overseeing various working groups. Leaders monitored patient safety and care through the Quality, Safety, and Value Committee, which tracked and trended quality of care and patient outcomes.

A budget increase of over 33 percent in FY 2020 allowed the healthcare system to expand patient services, clinical resources, and access to community care. The increase also allowed leaders to hire more staff.

Specific survey data related to employees' satisfaction revealed opportunities for healthcare system leaders to improve employee attitudes toward leaders, the workplace, and workgroup relationships. Patient experience survey results highlighted opportunities to improve patient-centered medical home experiences for both genders and specialty care experiences for female

veterans. Leaders reported a plan to create a dedicated entrance and waiting area for women veterans given their discomfort with entering the campus and waiting in the lobby with older male veterans.

The OIG's review of the healthcare system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. In individual interviews, the executive leaders 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, the executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models. However, the leaders have opportunities to improve quality of care and efficiency at the healthcare system and should continue to take actions to improve performance.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[35] 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.[36]

During this time, VA continued providing care to veterans and engaged its fourth mission, the "provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have VA eligibility for such care and services."[37] "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."[38]

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

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

The OIG also surveyed healthcare system staff to solicit their feedback and potentially identify any problematic trends and/or issues that may require follow-up. The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[39]

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

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

[37] 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."

[38] 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.

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[40] 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.[41] 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."[42]

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

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

The OIG reviewers also assessed the healthcare system's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization." Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[43] The OIG team examined various requirements related to systems redesign and improvement:

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

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

Next, the OIG assessed the healthcare system's processes for conducting protected peer reviews of clinical care.[44] 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."[45] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[46] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[47]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[48]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

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

[44] 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."

[45] VHA Directive 1190.

[46] VHA Directive 1190.

[47] VHA Directive 1190.

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

(2) policy development; (3) data stewardship; and (4) fiduciary responsibility for select specialty programs."[49] The healthcare system's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (registered nurse)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events[50]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[51]

Quality, Safety, and Value Findings and Recommendations

The OIG identified opportunities for improvement with the Systems Redesign and Improvement Program, Surgical Work Group, and committees' monitoring of implemented action items for quality and patient safety processes.

VHA requires medical facility directors to assign a systems redesign and improvement coordinator who reports to the director or a supervisor one level below the director.[52] The Systems Redesign and Improvement Coordinator acknowledged reporting to the Supervisory Management and Program Analyst for the Systems Redesign and Improvement Program, which is two supervisory levels below the Director. This may have resulted in inadequate oversight and prioritization of continuous improvement projects. The Supervisory Management and Program Analyst stated a belief that the reporting structure met the intent of the requirement because the coordinator still had visibility and access to the Director.

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

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

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

[52] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures that the Systems Redesign and Improvement Coordinator reports directly to the Director or one supervisory level below the Director.[53]

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The System Director reviewed and evaluated additional reasons for noncompliance and confirmed the requirement for the Systems Redesign and Improvement Coordinator to report directly to the Director or one supervisory level below the Director. This position has been moved under the Chief, Quality Management, who reports directly to the Director. This places the Systems Redesign Improvement Coordinator one supervisory level below the Director. The organizational chart for the Quality, Safety, Value Service reflects this change in reporting structure. We would like to request closure for this recommendation prior to publication based on supporting evidence provided to the OIG.

VHA requires medical facility directors to ensure that facilities have a surgical work group that meets monthly and documents meeting minutes; this work group must be chaired by the Chief of Surgery and include the Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.[54] The OIG requested Surgical Work Group minutes for fiscal year 2020 (October 2019 through September 2020) and found that the work group did not meet during 5 of 11 months, as evidenced by lack of meeting minutes. For the remaining six months of meetings with documented minutes, the OIG found that members' attendance was not recorded for four sets of meeting minutes. The Chief of Surgery reportedly did not have other evidence that core members were present.[55] The lack of monthly meetings and core member attendance may have resulted in missed opportunities for oversight and review of surgery program activities with key staff. The Chief of Surgery stated that the group did not meet from October through December 2019 due to staffing issues. The Chief also stated that the group met approximately every other month from April through September 2020 due to the COVID-19

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

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

[55] DUSHOM Memorandum, *Coronavirus (COVID-19) – Guidance for Elective Procedures,* March 15, 2020. A Surgical Work Group meeting was not held in April 2020 because elective surgical cases were suspended beginning in March 2020 due to the COVID-19 pandemic; therefore, there were 11 required meetings during the review period.

pandemic. The Chief further reported that the group did not take attendance during virtual meetings as all mandated staff were present on the call.

Recommendation 2

2. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that the Surgical Work Group meets monthly and core members consistently attend meetings.[56]

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The System Director reviewed and evaluated additional reasons for noncompliance and confirmed the required core members in accordance with VHA Directive 1102.01(1). The Associate Chief of Staff, Surgical Services serves as the chair of the Surgical Work Group and began holding regular monthly meetings in January 2021. In addition to the chair, attendance included, and was recorded for, the required core members as follows: Chief of Staff, Surgical Quality Nurse, and facility OR Nurse Manager. The Acting Chief, Quality Management Service monitored the frequency of meetings and attendance until a 90% compliance rate was demonstrated for six consecutive months. We would like to request closure for this recommendation prior to publication based on supporting evidence provided to the OIG.

VHA requires medical facilities that have surgery programs to have a surgical work group responsible for the "monthly review of surgical deaths, an analysis of efficiency and utilization metrics, the review of NSO [National Surgery Office] surgical quality reports, and evaluation of critical surgical events."[57] The OIG requested the Surgical Work Group's meeting minutes from October 2019 through September 2020 and did not find evidence that the group analyzed efficiency and utilization metrics or reviewed surgical deaths and surgical quality reports, based on six months of available meeting minutes reviewed. Failure to review and analyze surgical data may have resulted in missed opportunities to improve patient safety in the surgical program. The Chief of Surgery noted that surgical deaths, efficiency and utilization metrics, and National Surgery Office reports were examined in other venues and acknowledged that not reviewing them within the Surgical Work Group was an oversight. Lack of analysis of surgical deaths by the Surgical Work Group is a repeat finding from the prior OIG Clinical Assessment Program inspection in March 2017.

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

[57] VHA Directive 1102.01(1).

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Surgical Work Group reviews surgical deaths and National Surgery Office surgical quality reports, analyzes efficiency and utilization metrics, and recommends appropriate actions to the System Director.[58]

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Chief of Staff reviewed and evaluated additional reasons for noncompliance and ensured the Surgical Work Group began meeting regularly in January 2021, utilizing a templated format for recording meeting minutes that included documented review of surgical deaths and National Surgery Office surgical quality reports, analysis of efficiency and utilization metrics, and recommendations for actions to the System Director as appropriate. The Acting Chief, Quality Management Service monitored content of meeting minutes to ensure inclusion of all required elements for reporting and committee discussion until a 90% compliance rate was demonstrated for six consecutive months. We would like to request closure for this recommendation prior to publication based on supporting evidence provided to the OIG.

VHA programs, including hospitals, are "required to achieve and maintain The Joint Commission Accreditation."[59] TJC standards state that facilities are to establish a governing body to provide oversight and support for quality and safety processes.[60] TJC standards also state that facilities should measure and analyze performance using data so that improvement "effectiveness can be sustained, assessed, and measured."[61] Although the Quality Executive Board (now known as the QSV Committee), Systems Redesign and Improvement Program staff, and Peer Review Committee identified improvement opportunities, the OIG did not find evidence that program leaders or the committees monitored implemented actions for effectiveness and sustained improvements.[62] Further, as previously reported, the OIG determined that the Surgical Work Group did not analyze surgical program data to identify improvement actions. Failure to analyze data and implement and monitor corrective actions may have resulted in missed opportunities to improve quality care and patient safety processes. Program managers

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

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

[60] TJC. Leadership standard rationales LD.01.01.01 and LD.01.03.01.

[61] TJC. Leadership standard rationales LD.03.02.01 and LD.03.05.01.

[62] The Quality Executive Board was renamed the Quality, Safety, and Value Committee in September 2020.

stated that monitoring was performed by other committees or methods and believed current practices met requirements.

Recommendation 4

4. The System Director evaluates and determines any additional reasons for noncompliance and ensures that specific action items are implemented and monitored when problems or opportunities for improvement are identified.

Healthcare system concurred.

Target date for completion: October 2021

Healthcare system response: The System Director reviewed and evaluated additional reasons for noncompliance and the Acting Chief, Quality Management implemented the following actions to improve the facility's process in identifying opportunities for improvement and monitoring for sustained compliance with closed corrective actions. 1. A retrospective review of Quality Executive Board (now known as Quality, Safety, Value Committee) meeting minutes for closed action items completed. 2. Development of a Sustainability Tracker that serves as a living document with a schedule for reporting sustained compliance with action items, following until closure. 3. Addition of standing reporting line item in the Quality, Safety, Value Committee meeting minutes. The Acting Chief, Quality Management will monitor compliance until evidence of sustained improvement is achieved for a minimum of six consecutive months.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[63] Licensure is defined by VHA as "the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration."[64]

VA requires all RNs to hold at least one active, unencumbered license.[65] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[66] When an action has been "taken against [an] applicant's sole license or against any of the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA's licensure requirements," and documented as required.[67] Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA's electronic credentialing system, prior to appointment to a VA medical facility.[68]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 28 RNs hired from January 1 through October 26, 2020. The OIG determined whether

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

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

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

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

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

[66] 38 U.S.C. § 7402.

[67] VHA Directive 2012-030.

[68] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

The OIG determined that all 28 RNs reviewed were free from potentially disqualifying licensure actions. However, the OIG identified a deficiency with primary source verification.

VHA requires all current and previously held licenses to be verified from primary sources prior to an individual's initial appointment or transfer from another medical facility.[69] For three RNs with licenses in multiple states, the OIG found that some licenses were not primary source verified. For example, one RN had eight licenses and only four were primary source verified. The remaining two RNs had licenses from two states and only one was primary source verified. This could lead to inappropriate hiring of nurses and subsequently affect the provision of quality care. The Credentialing and Privileging Supervisor reported believing that verifying licenses disclosed by the applicant was sufficient and acknowledged the lack of a formal process to determine if the candidate held additional nursing licenses in other states.

Recommendation 5

5. The System Director evaluates and determines any additional reasons for noncompliance and ensures that credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.[70]

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

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

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The System Director reviewed and evaluated additional reasons for noncompliance. The Supervisory Health Systems Specialist, Credentialing conducted a comprehensive review of licensure verification preceding the OIG CHIP visit and developed a standard process for ensuring primary source verification of all licenses held by a Registered Nurse (RN) is performed prior to appointment. Nursys is a national Clearing House that identifies all licenses past and present held by an RN. Credentialing staff established use of Nursys as the standard for identifying and primary source verification for each of an RN's licenses. For California, Michigan and Pennsylvania, the states that do not use Nursys, Credentialing will use the system specified by each of those States to ensure Licensure. Use of Nursys ensures all RN licenses are primary source verified whether disclosed on application or not. Verification of all RN licenses occurring prior to appointment was monitored for six consecutive months showing 100% compliance. We would like to request closure for this recommendation prior to publication based on supporting evidence provided to the OIG.

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[71] The FDA provided information on specific laboratory tests to be ordered prior to and during the administration of remdesivir. Additionally, the FDA required providers to report potentially related adverse events.[72]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[73] Due to the limited supply and specific storage requirements of remdesivir, VA needed someone to be available 24 hours a day, 7 days a week to accept overnight, cold-chain shipments of the drug and report any unused medication to the Emergency Pharmacy Services group.[74]

On August 28, 2020, the FDA amended the Emergency Use Authorization criteria for remdesivir to include "suspected or laboratory-confirmed COVID-19 in all hospitalized adult and pediatric patients."[75] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[76]

To determine whether VHA facilities complied with requirements related to the administration of remdesivir, the OIG interviewed key employees and managers and reviewed the electronic health records of 11 patients who were administered remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. The OIG assessed the following performance indicators:

- Staff availability to receive medication shipments
- Medication orders used proper name

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[71] Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*, May 1, 2020, revised August 2020. Food and Drug Administration, *Frequently Asked Questions for Veklury (remdesivir),* updated February 4, 2021.

[72] Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*.

[73] Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*, May 8, 2020.

[74] Centers for Disease Control and Prevention, *Vaccine Storage and Handling Kit*, May 2014. "The cold chain begins with the cold storage unit at the manufacturing plant, extends through transport of vaccine(s) to the distributor, then delivery and storage at the provider facility, and ends with administration of vaccine to the patient. Appropriate storage conditions must be maintained at every link in the cold chain." Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*.

[75] Food and Drug Administration, "FDA News Release: COVID-19 Update: FDA Broadens Emergency Use Authorization for Veklury (remdesivir) to Include All Hospitalized Patients for Treatment of COVID-19," August 28, 2020.

[76] Food and Drug Administration, "FDA News Release: FDA Approves First Treatment for COVID-19," October 22, 2020.

- Staff determined patients met criteria for receiving medication prior to administration
- Required testing completed prior to medication administration for
  - Potential pregnancy
  - Kidney assessment (estimated glomerular filtration rate)[77]
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[78]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG team observed compliance with many elements of expected performance, including staff availability to receive remdesivir shipments, required testing prior to remdesivir administration, and staff reporting adverse events. However, the OIG identified deficiencies with patient/caregiver education.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the "Fact Sheet for Patients and Parents/Caregivers," inform patients and/or caregivers that remdesivir was not an FDA-approved medication, provide the option to refuse the medication, and advise patients and/or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[79] Of the 11 patients who received remdesivir, the OIG determined that healthcare providers did not

- provide 27 percent of patients and/or caregivers with the "Fact Sheet for Patients and Parents/Caregivers,"
- inform 18 percent of patients and/or caregivers that remdesivir was not an FDA-approved drug, and
- advise 36 percent of patients and/or caregivers of alternatives to receiving remdesivir prior to administration.

[77] "Estimated Glomerular Filtration Rate (eGFR)," National Kidney Foundation, accessed December 9, 2020, https://www.kidney.org/atoz/content/gfr. "Estimated glomerular filtration rate [eGFR] is the best test to measure your level of kidney function and determine your stage of kidney disease."

[78] "Alanine transferase," National Cancer Institute, accessed December 9, 2020, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/alanine-transferase. Alanine transferase, also referred to as serum glutamate pyruvate transaminase, is "an enzyme found in the liver and other tissues," of which a high level may be indicative of liver damage.

[79] VA Pharmacy Benefits Management Services, *Remdesivir Emergency Use Authorization (EUA) Requirements*, May 2020.

This could have resulted in patients and/or caregivers not being fully aware of the known and potential risks, which may have affected their decision to receive the medication. The Associate Chief of Staff for Inpatient Medicine and the Associate Chief for Clinical Pharmacy acknowledged awareness of the requirements; however, both leaders reported believing the current practice of providing patients with general drug education met the intent.

Given the FDA's approval of remdesivir for use in adult patients hospitalized with COVID-19, the OIG made no recommendations related to the Emergency Use Authorization requirements.[80]

[80] Food and Drug Administration, "FDA News Release: FDA Approved First Treatment for COVID-19," October 22, 2020.

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[81] 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.[82] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[83]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[84] The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.[85] The healthcare system was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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

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

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

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

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

- the electronic health records of 50 randomly selected patients who were seen in the emergency department/urgent care center from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

The healthcare system generally complied with requirements for completing the Columbia-Suicide Severity Rating Scale and suicide safety plans. However, the OIG identified a deficiency in staff training.

VHA requires staff to complete mandatory suicide safety plan training prior to developing suicide safety plans with patients.[86] The OIG reviewed the training records for 30 staff responsible for suicide safety plan development and found that none contained evidence that staff completed the mandatory training. Lack of staff training may lead to inadequate safety planning with patients who are at risk for suicide. The Associate Chief of Staff, Behavioral Health; Deputy Associate Chief of Staff, Behavioral Health; and Suicide Prevention Coordinator reported not being aware that the training was required and believed staff received adequate information for suicide plan development through the *Skills Training for Evaluation and Management of Suicide* course.

Recommendation 6

6. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that staff complete mandatory training prior to developing suicide safety plans.[87]

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

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

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Chief of Staff reviewed and evaluated additional reasons for noncompliance. The Associate Chief of Staff, Behavioral Health reviewed and confirmed the training requirement for VA 36232, Suicide Safety Planning Recording. Staff responsible for suicide safety plan development were assigned this training beginning in December 2020 and a process for assigning to appropriate staff upon hire moving forward was developed. The Suicide Prevention Coordinator monitored compliance with completion of this training until a compliance rate of greater than 90% was demonstrated for six consecutive months. We would like to request closure for this recommendation prior to publication based on supporting evidence provided to the OIG.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[88]

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients." Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.[89]

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

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

To determine whether the healthcare system complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 47 patients who were transferred from the healthcare system due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

Generally, the healthcare system met expectations for an inter-facility transfer policy, monitoring and evaluation of inter-facility transfers, completion of the required VA *Inter-Facility Transfer Form*, transmission of patients' active medication lists, and nurse-to-nurse communication between facilities. However, the OIG noted that transfer documentation did not include patients' advance directives.

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

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

VHA requires the Chief of Staff and Associate Director for Patient Care Services to ensure that transferring physicians or the assigned designees "send all pertinent medical records available, including…documentation of the patient's advance directive made prior to transfer, if any" to the receiving facility.[90] The OIG estimated that for 69 percent of transfers involving patients with completed advanced directives, physicians did not send a copy to the receiving facility.[91] As a result, there was no assurance that receiving facility staff could determine patients' healthcare preferences at transfer. The Registered Nurse Transfer Coordinator reported that nursing staff were unaware of how to access advance directives for the transferring physicians, which resulted in physicians transferring patients without sending copies. Due to the low number of patients identified for this review element, the OIG made no recommendation.

[90] VHA Directive 1094.

[91] The OIG estimated that 95 percent of the time, the true compliance rate is between 8.3 and 55.5 percent, which is statistically significantly below the 90 percent benchmark.

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[92] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[93] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team[94]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[95]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[96]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[97]

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

[93] VHA Directive 2012-026.

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

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

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

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

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[98] Additionally, VHA requires that employee threat assessment team members complete the appropriate team-specific training.[99] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The OIG determined that the healthcare system complied with many of the requirements for the management of disruptive and violent behavior. However, the OIG found deficiencies in Disruptive Behavior Committee meeting attendance and staff training.

VHA requires the Chief of Staff and Nurse Executive (Associate Director for Patient Care Services) to be responsible for establishing a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; a patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and the Union Safety Committee.[100]

The OIG found that of the 24 Disruptive Behavior Committee meetings held from October 2019 through September 2020, representatives from the Prevention and Management of Disruptive Behavior Program and VA police did not attend 7 (29 percent) and 4 (17 percent), respectively. This may have resulted in a lack of knowledge and expertise when assessing patients' disruptive behavior. The Disruptive Behavior Committee chair reported that the Prevention and Management of Disruptive Behavior Program representative position was vacant, and the Deputy Chief of Police cited staffing issues as the reason for the lack of attendance.[101]

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

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

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

[101] The Disruptive Behavior Committee reports to the Behavioral Health Committee.

Recommendation 7

7. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure all required representatives attend Disruptive Behavior Committee meetings.[102]

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Chief of Staff and Associate Director for Patient Care Services reviewed and evaluated additional reasons for noncompliance. They confirmed the attendance requirements for the Disruptive Behavior Committee meetings according to VHA Directive 2010-53, Patient Record Flags, and committee charter. The Chief, VA Police ensures that a designee attends when the regularly appointed representative for the police is not on duty. The Workplace Violence Prevention Program Manager monitored attendance until a greater than 90% compliance rate was demonstrated for six consecutive months. We would like to request closure for this recommendation prior to publication based on supporting evidence provided to the OIG.

VHA requires that staff are assigned part 1 of the prevention and management of disruptive behavior training at hire and additional levels of training, based on the risk level assigned to their work area.[103] The OIG found that 20 of 26 (77 percent) selected staff did not complete the required part 2 training based on the work area's risk level. This could result in lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Workplace Violence Prevention Program Manager and the Designated Learning Officer reported following executive leaders' guidance to cease hands-on training, which is required for part 2, to prevent staff exposure to COVID-19.

Recommendation 8

8. The System Director evaluates and determines any additional reasons for noncompliance and ensures staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[104]

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

[103] DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments, February 24, 2020.* DUSHOM Memorandum*, Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018.

[104] The OIG recognizes that COVID-19 has affected facility operations and makes no comment on the timeline for safely accomplishing this important training.

Healthcare system concurred.

Target date for completion: December 2021

Healthcare system response: The System Director reviewed and evaluated additional reasons for noncompliance. The Workplace Violence Prevention Program Manager and the Designated Learning Officer reviewed and confirmed the requirements for Prevention and Management of Disruptive Behavior (PMDB) training. Virtual classes for new staff were conducted in December 2020 following approval of the virtual platform. The Designated Learning Officer developed a schedule for face to face training to resume in January 2021 for required staff based on the Workplace Behavioral Risk Assessment results. In addition to New Employee Orientation, class offerings have been increased to train staff in all facilities across the healthcare system. The Designated Learning Officer will monitor training completion rates until a 90% compliance rate is demonstrated for six consecutive months.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines eight OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, and ADPCS. The intent is for the 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	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Budget and operations • Staffing • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Identified factors related to possible lapses in care and healthcare system response • VHA performance data (healthcare system) • VHA performance data (CLC)	• None	• None
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback	The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• The Surgical Work Group reviews surgical deaths and National Surgery Office quality reports, analyzes efficiency and utilization metrics, and recommends appropriate actions to the System Director. • Specific action items are implemented and monitored when problems or opportunities for improvement are identified.	• Systems Redesign and Improvement Coordinator reports directly to the Director or one supervisory level below the Director. • The Surgical Work Group meets monthly and core members consistently attend meetings.
RN Credentialing	• RN licensure requirements • Primary source verification	• Credentialing staff complete primary source verification for all registered nurses' licenses prior to initial appointment.	• None
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• Staff complete mandatory training prior to developing suicide safety plans.	• None
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• None	• None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• None	• Required representatives attend Disruptive Behavior Committee meetings. • Staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.

Appendix B: Healthcare System Profile

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

Table B.1. Profile for Montana VA Health Care System (436)
(October 1, 2017, through September 30, 2020)

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019†	Healthcare System Data FY 2020‡
Total medical care budget	$299,059,829	$329,194,081	$439,525,849
Number of:			
• Unique patients	37,785	38,066	38,578
• Outpatient visits	420,029	438,450	421,725
• Unique employees§	1,057	1,111	1,157
Type and number of operating beds:			
• Community living center	30	20	20
• Domiciliary	24	24	24
• Medicine	30	16	16
• Surgery	4	2	2
Average daily census:			
• Community living center	16	16	16
• Domiciliary	19	17	11
• Medicine	9	8	10
• Surgery	1	1	1

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

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

**October 1, 2017, through September 30, 2018.*
†*October 1, 2018, through September 30, 2019.*
‡*October 1, 2019, through September 30, 2020.*
§*Unique employees involved in direct medical care (cost center 8200).*

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

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Anaconda, MT	436GA	4,221	361	Dermatology Endocrinology Nephrology Neurology Rheumatology Vascular	EKG	Nutrition Weight management
Great Falls, MT	436GB	10,034	2,681	Dermatology Endocrinology Gastroenterology Nephrology Neurology Poly-Trauma Rheumatology	EKG	Pharmacy Weight management

[1] 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
Missoula, MT	436GC	16,984	4,209	Dermatology Endocrinology Nephrology Neurology Poly-Trauma Pulmonary/ Respiratory disease Urology Vascular	EKG	Nutrition Pharmacy Weight management
Bozeman, MT	436GD	6,741	3,743	Dermatology Endocrinology Eye Nephrology Neurology Poly-Trauma Rheumatology Vascular	EKG	Pharmacy Weight management
Kalispell, MT	436GF	12,785	3,366	Dermatology Endocrinology Eye General surgery Nephrology Neurology Poly-Trauma Rheumatology	EKG	Nutrition Pharmacy Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Billings, MT	436GH	2,121	4,153	Anesthesia Cardiology Dermatology Endocrinology Eye Gastroenterology General surgery GYN Nephrology Neurology Orthopedics Podiatry Urology Vascular	EKG Laboratory & Pathology Radiology	Dental Weight management
Glasgow, MT	436GI	1,404	92	Dermatology Endocrinology Nephrology Neurology	EKG	–
Glendive, MT	436GK	539	618	Dermatology Endocrinology Neurology	EKG	–
Cut Bank, MT	436GL	1,197	122	Dermatology Neurology	EKG	Weight management

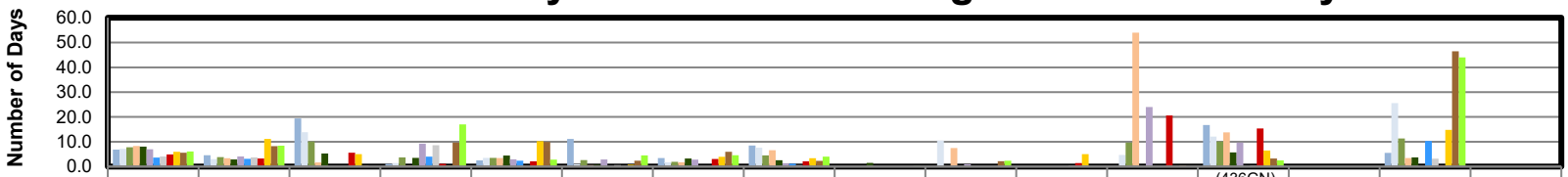
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Lewistown, MT	436GM	1,777	99	Dermatology Endocrinology Neurology	EKG	Weight management
Billings, MT	436GN	14,579	9	Endocrinology Poly-Trauma Pulmonary/ Respiratory disease	EKG	Nutrition Pharmacy
Havre, MT	436HC	1,475	480	Dermatology Endocrinology Nephrology Neurology Poly-Trauma	EKG	–
Hamilton, MT	436QA	3,791	263	Dermatology Endocrinology Gastroenterology Neurology	EKG	Nutrition Pharmacy Weight management
Plentywood, MT	436QB	306	22	Endocrinology Nephrology Neurology	EKG	–

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

New Primary Care Patient Average Wait Time in Days



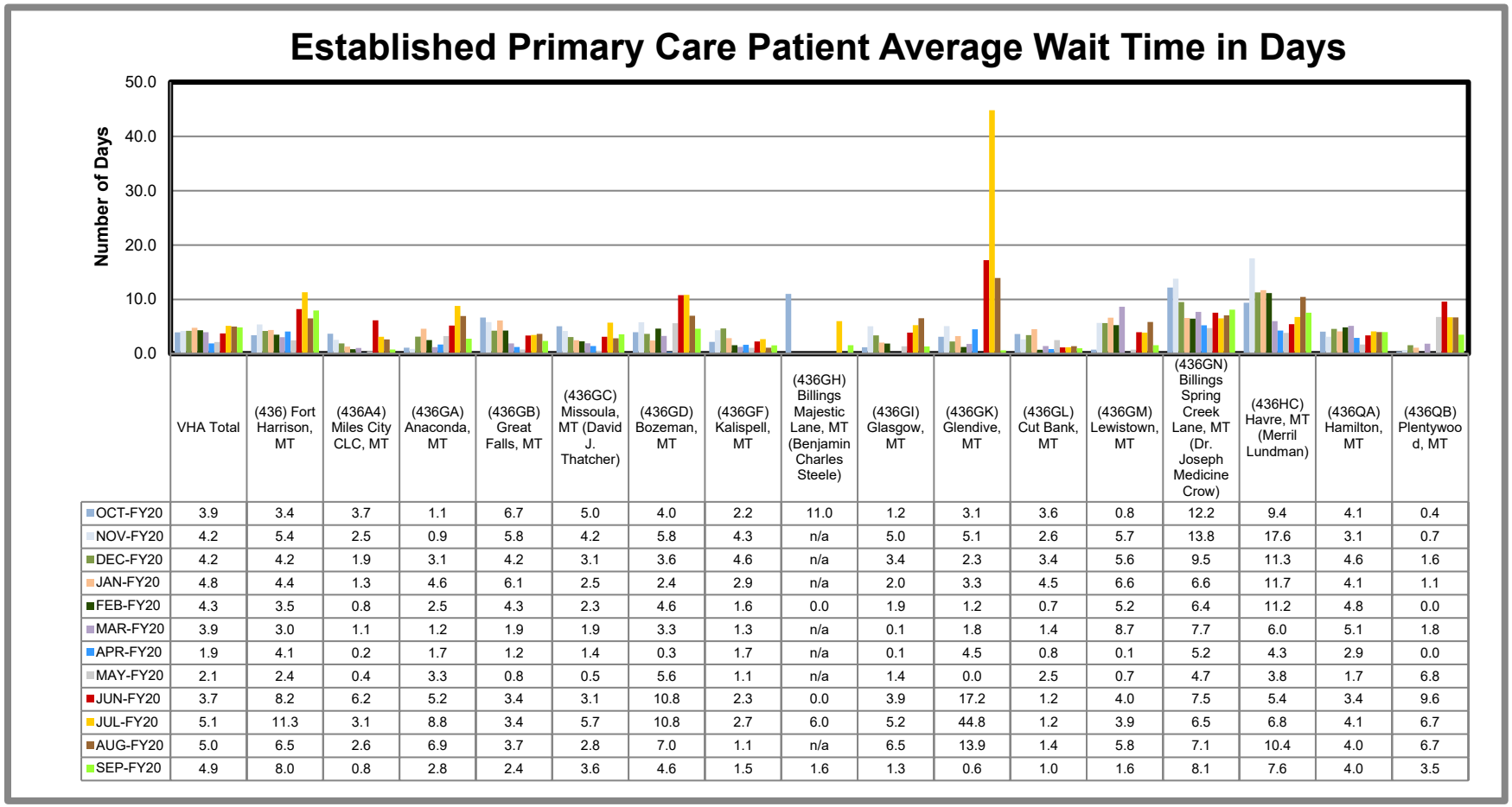
	VHA Total	(436) Fort Harrison, MT	(436A4) Miles City CLC, MT	(436GA) Anaconda, MT	(436GB) Great Falls, MT	(436GC) Missoula, MT (David J. Thatcher)	(436GD) Bozeman, MT	(436GF) Kalispell, MT	(436GI) Glasgow, MT	(436GK) Glendive, MT	(436GL) Cut Bank, MT	(436GM) Lewistown, MT	(436GN) Billings Spring Creek Lane, MT (Dr. Joseph Medicine Crow)	(436HC) Havre, MT (Merril Lundman)	(436QA) Hamilton, MT	(436QB) Plentywood, MT
OCT-FY20	6.9	4.6	19.4	1.1	2.5	11.1	3.4	8.5	0.0	0.0	0.0	0.0	16.7	0.0	5.5	0.0
NOV-FY20	7.1	3.0	13.9	1.4	3.5	1.0	1.7	7.6	0.0	10.5	0.0	4.7	12.1	0.0	25.6	n/a
DEC-FY20	7.8	3.8	10.1	3.7	3.5	2.6	1.9	4.5	n/a	0.0	0.0	9.7	10.1	0.0	11.3	0.0
JAN-FY20	8.3	3.4	1.7	0.5	3.4	0.6	1.7	6.6	0.0	7.5	0.0	54.0	13.8	0.0	3.4	0.0
FEB-FY20	8.1	2.9	5.3	3.5	4.4	0.7	3.3	2.5	1.5	n/a	0.0	n/a	5.7	0.0	3.7	0.0
MAR-FY20	6.9	4.1	0.0	9.2	3.0	2.9	2.8	1.3	0.0	1.0	0.0	24.0	9.7	0.0	0.0	n/a
APR-FY20	3.6	3.1	0.0	4.0	2.4	0.2	0.0	1.2	n/a	n/a	0.0	n/a	0.0	0.0	10.3	n/a
MAY-FY20	4.0	3.7	0.0	8.6	0.0	0.6	0.0	0.6	0.0	n/a	0.3	n/a	0.4	0.0	3.2	0.0
JUN-FY20	4.9	3.2	5.6	1.1	2.1	0.0	3.1	2.1	0.0	n/a	1.4	20.6	15.4	0.0	0.5	0.0
JUL-FY20	5.9	11.1	5.0	0.4	10.3	0.8	4.0	3.4	0.0	n/a	5.0	0.0	6.5	0.0	14.8	0.0
AUG-FY20	5.6	8.3	0.5	9.7	9.9	2.4	5.9	2.3	0.0	2.1	0.0	0.5	3.2	0.0	46.5	0.0
SEP-FY20	6.1	8.4	0.0	17.0	2.8	4.5	4.5	4.0	0.2	2.3	0.0	0.0	2.5	0.0	44.0	n/a

Source: VHA Support Service Center.

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the healthcare system's explanation for the increased wait times for the Hamilton and Lewistown clinics. The OIG omitted (436GH) Billings Majestic Lane, MT (Benjamin Charles Steele) as no data were reported.

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



	VHA Total	(436) Fort Harrison, MT	(436A4) Miles City CLC, MT	(436GA) Anaconda, MT	(436GB) Great Falls, MT	(436GC) Missoula, MT (David J. Thatcher)	(436GD) Bozeman, MT	(436GF) Kalispell, MT	(436GH) Billings Majestic Lane, MT (Benjamin Charles Steele)	(436GI) Glasgow, MT	(436GK) Glendive, MT	(436GL) Cut Bank, MT	(436GM) Lewistown, MT	(436GN) Billings Spring Creek Lane, MT (Dr. Joseph Medicine Crow)	(436HC) Havre, MT (Merril Lundman)	(436QA) Hamilton, MT	(436QB) Plentywood, MT
OCT-FY20	3.9	3.4	3.7	1.1	6.7	5.0	4.0	2.2	11.0	1.2	3.1	3.6	0.8	12.2	9.4	4.1	0.4
NOV-FY20	4.2	5.4	2.5	0.9	5.8	4.2	5.8	4.3	n/a	5.0	5.1	2.6	5.7	13.8	17.6	3.1	0.7
DEC-FY20	4.2	4.2	1.9	3.1	4.2	3.1	3.6	4.6	n/a	3.4	2.3	3.4	5.6	9.5	11.3	4.6	1.6
JAN-FY20	4.8	4.4	1.3	4.6	6.1	2.5	2.4	2.9	n/a	2.0	3.3	4.5	6.6	6.6	11.7	4.1	1.1
FEB-FY20	4.3	3.5	0.8	2.5	4.3	2.3	4.6	1.6	0.0	1.9	1.2	0.7	5.2	6.4	11.2	4.8	0.0
MAR-FY20	3.9	3.0	1.1	1.2	1.9	1.9	3.3	1.3	n/a	0.1	1.8	1.4	8.7	7.7	6.0	5.1	1.8
APR-FY20	1.9	4.1	0.2	1.7	1.2	1.4	0.3	1.7	n/a	0.1	4.5	0.8	0.1	5.2	4.3	2.9	0.0
MAY-FY20	2.1	2.4	0.4	3.3	0.8	0.5	5.6	1.1	n/a	1.4	0.0	2.5	0.7	4.7	3.8	1.7	6.8
JUN-FY20	3.7	8.2	6.2	5.2	3.4	3.1	10.8	2.3	0.0	3.9	17.2	1.2	4.0	7.5	5.4	3.4	9.6
JUL-FY20	5.1	11.3	3.1	8.8	3.4	5.7	10.8	2.7	6.0	5.2	44.8	1.2	3.9	6.5	6.8	4.1	6.7
AUG-FY20	5.0	6.5	2.6	6.9	3.7	2.8	7.0	1.1	n/a	6.5	13.9	1.4	5.8	7.1	10.4	4.0	6.7
SEP-FY20	4.9	8.0	0.8	2.8	2.4	3.6	4.6	1.5	1.6	1.3	0.6	1.0	1.6	8.1	7.6	4.0	3.5

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.

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." The absence of reported data is indicated by "n/a."

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

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

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

Source: VHA Support Service Center.

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

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 22, 2021

From: Director, VA Rocky Mountain Network (10N19)

Subj: Comprehensive Healthcare Inspection of the Montana VA Health Care System in Fort Harrison

To: Director, Office of Healthcare Inspections (54CH01)

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

1. I have reviewed the findings, recommendations, and action plan of the Montana VA Health Care System. I am in agreement with the above.

(Original signed by:)

Ralph Gigliotti

Network Director, VISN 19

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: June 10, 2021

From: Director, Montana VA Health Care System (436/00)

Subj: Comprehensive Healthcare Inspection of the Montana VA Health Care System in Fort Harrison

To: Director, VA Rocky Mountain Network (10N19)

1. On behalf of the Montana VA Health Care System, I want to express my appreciation to the Office of Inspector General (OIG) Office of Healthcare Inspections for the Comprehensive Healthcare Inspection review of the Montana VA Health Care System, conducted November 30 – December 4, 2020.

2. The attached documents provide comment to the reported findings and outlines the actions taken by the staff of the Montana VA Health Care System in response to the OIG recommendations.

(Original signed by:)

Judy Hayman, Ph.D.

Executive Director, Montana VA Health Care System

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