



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the VA Eastern
Colorado Health Care
System in Aurora



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Figure 1. VA Eastern Colorado Health Care System in Aurora.
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 VA Eastern Colorado Health Care System and multiple outpatient clinics in Colorado. 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 looked 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 response¹
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 VA Eastern Colorado Health Care System during the week of November 30, 2020. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this healthcare system and other Veterans Health

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](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)."

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

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued seven recommendations to the 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, Associate Director for Patient Care Services, Associate Director, and Assistant Director.² Organizational communications and accountability were managed through a committee reporting structure, with Executive Leadership Board oversight of several working groups. Leaders monitored patient safety and care through the Quality Safety Values Executive Council, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the executive leadership team had worked together for over one year. However, several executive leaders had served in their positions for more than two years. The Associate Director for Patient Care Services, who was assigned in 2017, was the most tenured leader but had been detailed to another position since March 2020. The Director, who was assigned in 2019, was the newest member of the executive leadership team.

The OIG reviewed employee satisfaction and patient experience survey results. The OIG found opportunities for the Director, acting Associate Director for Patient Care Services, and Associate Director to reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing).³ The scores also indicated that the Director and acting Associate Director for Patient Care Services could improve perceptions of respect, and the Director has an opportunity to minimize perceptions of discrimination in the workplace. Patient experience survey data indicated satisfaction with the inpatient care provided. However, the data revealed opportunities for improvement in patient-centered medical home and specialty care.

² At the time of the inspection, the healthcare system had one Assistant Director (North) and was recruiting for a second assistant director position. The second Assistant Director (South) was appointed on January 17, 2021.

³ “2019 VA All Employee Survey (AES): Questions by Organizational Health Framework,” VA Workforce Surveys Portal, VHA Support Service Center, accessed July 29, 2021, <http://aes.vssc.med.va.gov/Pages/Default.aspx>. (This is an internal website not publicly accessible.)

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.⁴

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with “measures on healthcare quality, employee satisfaction, access to care, and efficiency.” Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.⁵

In individual interviews, the executive leaders 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. The executive leaders were also generally knowledgeable, within their scope of responsibilities, about performance opportunities highlighted by SAIL and community living center SAIL models.

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.⁶

Quality, Safety, and Value

The OIG found the healthcare system complied with requirements for committee oversight of quality, safety, and value functions; designation of the Systems Redesign and Improvement Coordinator; tracking of performance improvement capability and projects; staff education on performance improvement principles and techniques; completion of protected peer reviews; assignment and duties of the Chief of Surgery; and the Surgical Work Group’s tracking and review of surgical program metrics. However, the OIG identified deficiencies with the Systems Redesign and Improvement Coordinator’s participation on the facility’s quality management committee and required member attendance at Surgical Work Group meetings.

⁴ 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.”

⁵ “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.)

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

Medication Management

The healthcare system addressed many of the indicators of expected performance, including the availability of staff to receive remdesivir shipments, staff determination that patients met criteria for receiving remdesivir prior to administration, and completion of required testing prior to remdesivir administration. However, the OIG found deficiencies with the use of the proper name for medication orders and provision of patient/caregiver education.

Mental Health

The healthcare system generally complied with requirements related to suicide prevention screening within the emergency department. However, the OIG identified a deficiency with mandatory training completion by staff responsible for suicide safety plan development.

Care Coordination

The OIG observed general compliance with requirements for the completion of the *Inter-Facility Transfer Form* or facility-defined equivalent by the appropriate provider(s) and communication between nurses at sending and receiving facilities.⁷ However, the OIG identified deficiencies with the establishment of a facility policy for inter-facility transfers, monitoring and evaluation of inter-facility transfers, and transmission of patients' active medication lists to receiving facilities.

High-Risk Processes

The healthcare system complied with many of the requirements for the management of disruptive and violent behavior. However, the OIG noted that some employees had not completed the required prevention and management of disruptive behavior training.

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued seven recommendations for improvement to the System Director, Chief of Staff, and Associate Director for Patient Care Services. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for system leaders to use these recommendations as a road map to help

⁷ 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.

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.

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 59–60, and the responses within the body of the report for the full text of the directors’ comments.) The OIG considers recommendations 1, 2, and 3 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Purpose and Scope

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

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

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

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

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response⁵
3. Quality, safety, and value (QSV)
4. Registered nurse credentialing

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](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 (coronavirus disease) is an infectious disease caused by the “severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).”

5. Medication management (targeting remdesivir use)
6. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
7. Care coordination (spotlighting inter-facility transfers)
8. High-risk processes (examining the management of disruptive and violent behavior)

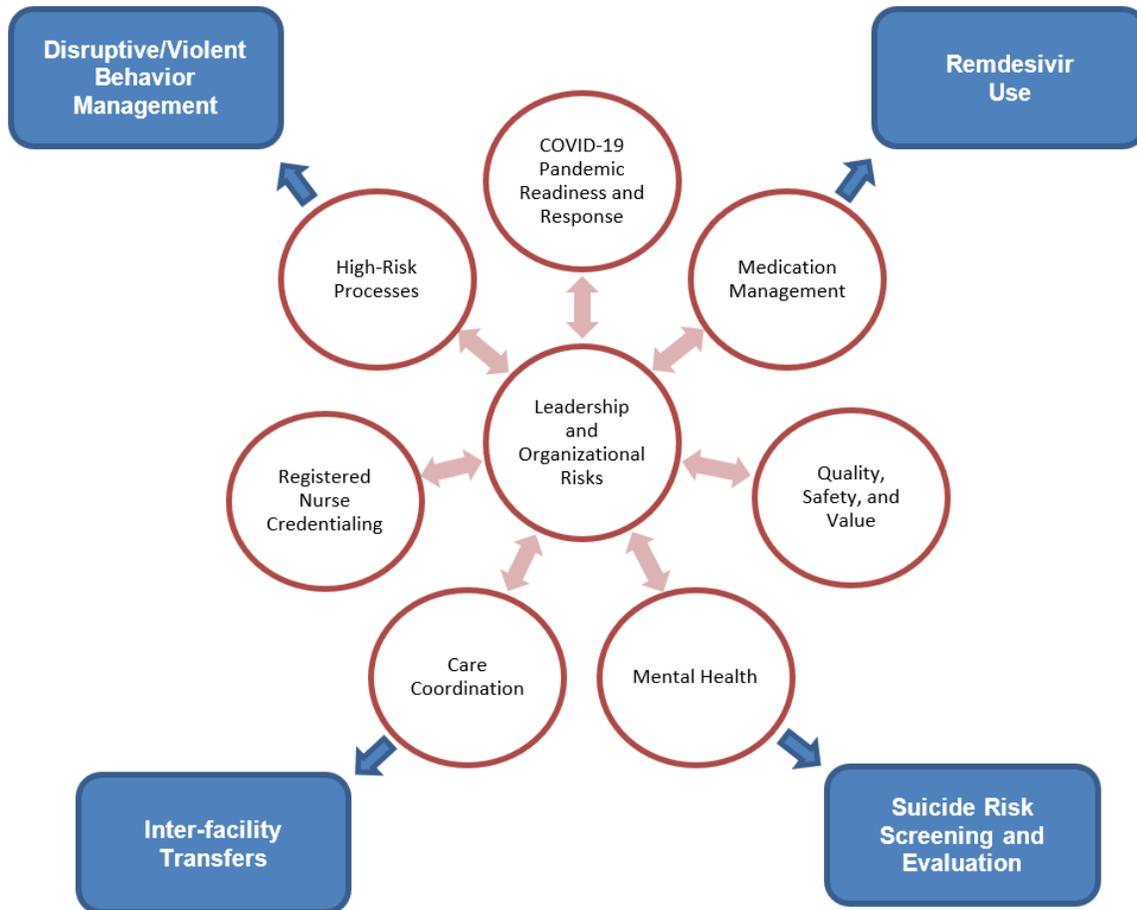


Figure 2. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.

Source: VA OIG.

Methodology

The VA Eastern Colorado Health Care System includes multiple outpatient clinics located in Colorado. 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 4, 2017, through December 4, 2020, the last day of the unannounced multiday evaluation.⁷ During the virtual site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline management team for further review.

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 had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and two Assistant Directors. The Chief of Staff and 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.

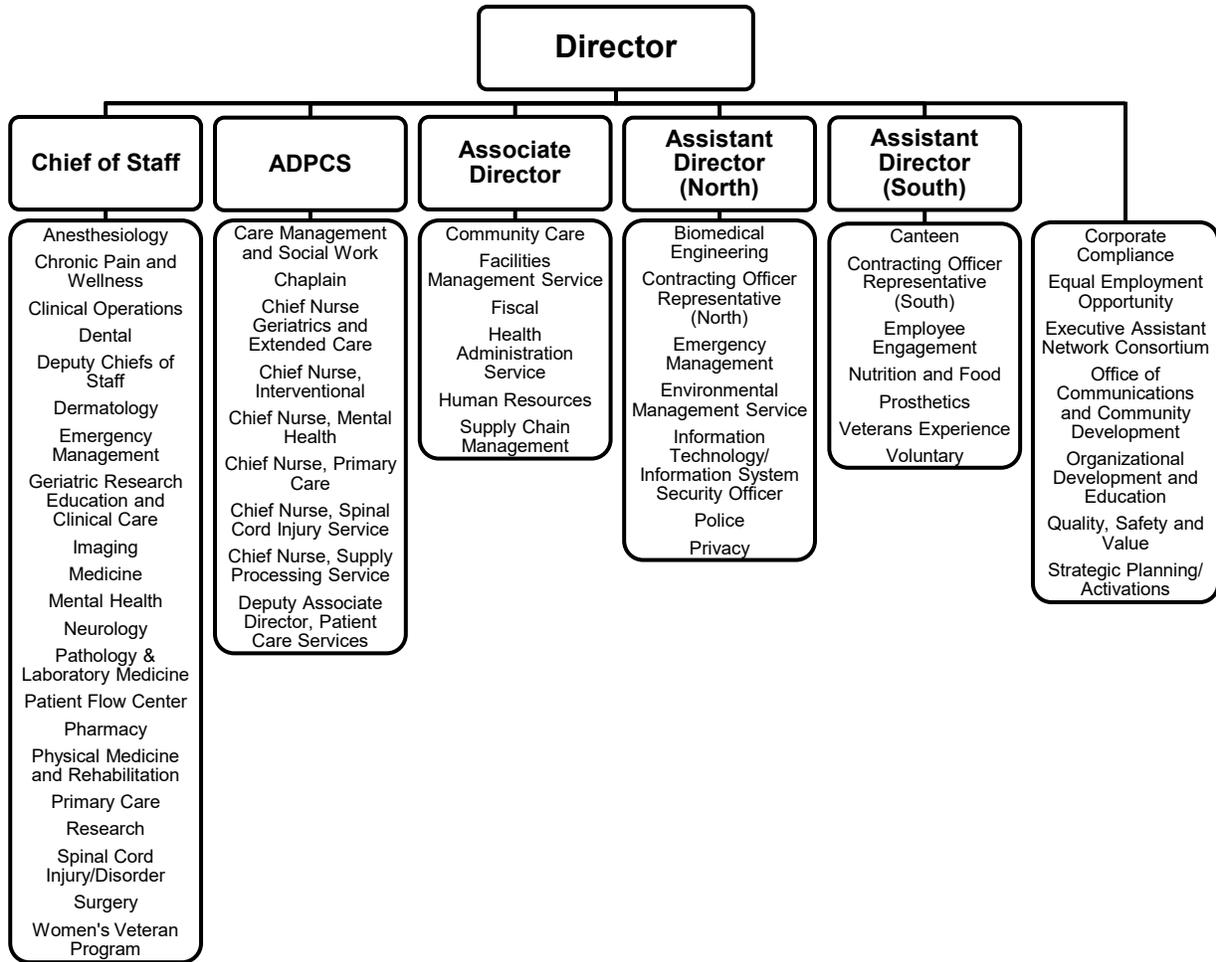


Figure 3. Healthcare system organizational chart.

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

At the time of the OIG inspection, the executive leadership team had worked together for over one year. However, several executive leaders had served in their positions for more than two years. The permanent ADPCS had been detailed to another position since March 2020, and acting staff had covered the position since that time. Additionally, the healthcare system was recruiting for a second assistant director position. The position was new and had not been filled (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
System Director	September 15, 2019
Chief of Staff	July 7, 2019
Associate Director for Patient Care Services	March 19, 2017
Associate Director	January 7, 2018
Assistant Director (North)	September 30, 2018
Assistant Director (South)	—*

Source: VA Eastern Colorado Health Care System acting Human Resources Officer (received November 30, 2020) and Supervisory Human Resources Specialist (received February 4, 2021).

**The Assistant Director (South) was assigned on January 17, 2021, after the OIG inspection.*

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

The executive leaders were knowledgeable within their scope of responsibilities regarding VHA data and/or system-level factors contributing to poor performance on specific Strategic Analytics for Improvement and Learning (SAIL) measures. During individual interviews, the executive leaders 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 Operations, Healthcare Delivery, Quality Safety Values Executive, and Organizational Health Councils. These leaders monitored patient safety and care through the Quality Safety Values Executive Council, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Leadership Board (see figure 4).



Figure 4. Healthcare system committee reporting structure.

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

Budget and Operations

The healthcare system’s FY 2020 annual medical care budget of \$1,051,597,311 increased by approximately 23 percent compared to the previous year’s budget of \$852,759,415.¹² When asked about the effect of this change on the healthcare system’s operations, the Director indicated the medical care budget was adequate and provided needed resources, including those related to the COVID-19 pandemic.

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.¹³ Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of the clinical and nonclinical VHA occupations with the largest staffing

¹² VHA Support Service Center.

¹³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

shortages within each medical facility.¹⁴ In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.¹⁵

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*.¹⁶ The Director and Chief of Staff spoke of strategies implemented to address clinical and nonclinical occupational shortages. The strategies included operating in conjunction with university affiliates, providing care in the community, and hiring part-time staff.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Medical Officer	1. Mail and File
2. Neurology	2. Supply Clerical and Technician
3. Anesthesiology	3. Custodial Worker
4. Cardiology–Interventional	4. Human Resources Management
5. Vascular Surgery	5. Records and Information Management

Source: VA OIG.

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.¹⁷ 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

¹⁴ 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.

¹⁵ VA OIG, *Critical Deficiencies at the Washington DC VA Medical Center*, Report No. 17-02644-130, March 7, 2018.

¹⁶ VA OIG, *OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages, Fiscal Year 2020*.

¹⁷ “AES Survey History,” VA Workforce Surveys Portal, VHA Support Service Center, accessed May 3, 2021, http://aes.vssc.med.va.gov/Documents/04_AES_History_Concepts.pdf. (This is an internal website not publicly accessible.)

September 30, 2019.¹⁸ Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA’s All Employee Survey. The OIG found the healthcare system average for the selected survey leadership questions was lower than the VHA average.¹⁹ The scores reflect employee attitudes toward the Associate Director and Assistant Director (North). They do not reflect attitudes toward the other leaders, who assumed their roles after VHA administered the 2019 All Employee Survey.

Scores for the Chief of Staff, Associate Director, and Assistant Director were similar to or higher than VHA and healthcare system averages. Scores for the Director and ADPCS were similar to or lower than VHA and healthcare system averages. The acting ADPCS reported that the healthcare system’s culture began changing when the system hired the current Director. The acting ADPCS said leadership was more visible, nursing leaders held open question and answer sessions, and meetings and daily communications helped build professional relationships. The Director also reported starting a book club for all levels of leadership. The first three books focused on ownership and accountability. In individual interviews, all executive leaders spoke of the need for communication, education, and support for staff.

During leadership and staff interviews focusing on the effect of COVID-19 on the system, multiple staff members commended the Assistant Director on leading the health system’s response to the pandemic.

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: <i>Servant Leader Index Composite.*</i>	0–100 where higher scores are more favorable	72.6	70.8	66.3	85.9	66.1	77.5	93.0

¹⁸ 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.

¹⁹ The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.4	3.1	3.1	3.3	3.2	3.5	4.2
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.4	3.6	3.7	3.4	3.7	4.2
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.3	3.5	3.5	3.1	3.7	4.4

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

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.²⁰ The healthcare system average for the selected survey questions was similar to the VHA average. Although the leaders' scores for two of the three questions were similar to or better than those for VHA and the healthcare system, opportunities appear to exist for the Director, acting ADPCS, and Associate Director to reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing). The Associate Director reported meeting or speaking with staff every day and expecting to see a positive change in the next All Employee Survey results.

²⁰ 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 leaders described efforts to speak with front line staff and the importance of collaboration with each other. The Chief of Staff reported that when taking on projects, nursing and administrative leaders are involved so that collaboration occurs, and staff work together.

During the virtual review, the OIG attended the daily system-wide huddle call in which system leaders and key staff reviewed COVID-19 and healthcare operations data and discussed plans for the day. Specific items addressed during the huddle included a state veteran home update, veterans at high risk for suicide, number of staff testing positive or pending results for COVID-19, staffing levels, assistance needed, community COVID-19 status, hospital census, ventilators in use, quality reports on adverse events, and overdue items. Additionally, two individuals were recognized by their peers for actions that positively affected patients.

In this 30-minute meeting, system leaders and staff discussed or touched on topics necessary for daily operations and coordinated a system-wide response to the rapidly changing COVID-19 situation. The Director listened and intervened to offer advice and praise to staff. The huddle appeared to be an environment where staff spoke freely and asked for assistance if needed. The staff were engaged and demonstrated a “we can do this together” attitude.

**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>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.7	4.0	4.2	4.3	4.7	–*

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>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).</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.7	3.6	3.7	3.8	3.7	3.8	4.2
All Employee Survey: <i>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)?</i>	0 (Never)–6 (Every Day)	1.4	1.6	1.8	1.3	1.7	1.7	1.4

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

*Data were not available for this selected survey question.

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.²¹

The Director reported being involved in the VA’s “Stand Up to Stop Harassment Now!” campaign.²² To demonstrate commitment to a culture of safety, the Chief of Staff described sharing the stop harassment message with all medical staff and following up with individuals as

²¹ “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.

²² Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*.

needed. Additionally, the Associate Director spoke of setting expectations for staff on how to treat each other and take action when an issue was identified.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA’s All Employee Survey responses. Healthcare system averages were similar to the VHA averages. Overall, leaders appeared to be maintaining an environment where staff feel respected and safe and discrimination is not tolerated. However, the Director and acting ADPCS have an opportunity to improve perceptions of respect. Additionally, the Director should minimize perceptions of discrimination in the workplace.

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: <i>People treat each other with respect in my workgroup.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	3.5	4.2	3.4	4.0	4.2
All Employee Survey: <i>Discrimination is not tolerated at my workplace.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	4.0	4.0	3.8	4.3	4.0	4.0	4.8
Employee Survey: <i>Members in my workgroup are able to bring up problems and tough issues.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.7	3.5	4.2	3.7	4.2	4.6

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.²³ Patient experience survey data indicated satisfaction with the inpatient care provided. However, the data highlighted opportunities for improvement in patient-centered medical home and specialty care. The Director commented that patient experience survey data were negatively influenced by construction delays and expenses.

**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): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	69.6	74.2
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of “Very satisfied” and “Satisfied” responses.	82.8	76.3
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of “Very satisfied” and “Satisfied” responses.	84.9	81.9

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.²⁴ For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

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

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

The OIG reviewed selected responses to several additional relevant questions that reflect patients’ experiences by gender, including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys (see tables 7–9). Patient experience survey data indicated general satisfaction with the inpatient care provided. However, male veterans appeared less satisfied with outpatient care than VHA averages.

The executive leaders spoke of multiple reasons for the lower outpatient experience scores. These reasons included a geographically diverse area, multiple sites and programs for care, and patient confusion regarding where to go for care. Additionally, the Associate Director noted that while patients can schedule and cancel primary care appointments through the call center, they do not have this option for patient-centered medical home and specialty care. The Associate Director indicated that this may negatively affect patient experiences.

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
<i>Would you recommend this hospital to your friends and family?</i>	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.9	73.4	83.0
<i>During this hospital stay, how often did doctors treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	85.5	82.6	100.0
<i>During this hospital stay, how often did nurses treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	82.9	88.4	100.0

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 373–379 male and 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
<i>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?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.6	44.7	47.4	50.9
<i>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?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	60.0	53.2	49.8	57.3
<i>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?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.1	69.6	70.0	77.6

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 539–1,473 male and 52–132 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
<i>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?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.8	46.2	39.3	42.4
<i>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?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.7	54.0	48.3	56.0
<i>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?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.1	74.2	72.9

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

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

The healthcare system averages are based on 572–1,782 male and 47 or 121 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.²⁵ Table 10 summarizes the relevant system inspections most recently performed by the OIG and The Joint

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

Commission (TJC).²⁶ At the time of the OIG review, the system had closed all recommendations for improvement issued since the previous Clinical Assessment Program site visit conducted in February 2017.

The OIG team noted the system’s current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.²⁷ Additional results included the Long Term Care Institute’s inspection of the system’s CLC.²⁸

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (<i>Clinical Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado, Report No. 16-00546-388, September 29, 2017</i>)	February 2017	27	0
OIG (<i>Quality and Coordination of a Patient’s Care at the VA Eastern Colorado Health Care System, Denver, Colorado, Report No. 18-01455-108, April 11, 2019</i>)	March 2018	8	0
TJC Hospital Accreditation	August 2018	65	0
TJC Behavioral Health Care Accreditation		12	0
TJC Home Care Accreditation		9	0

Source: OIG and TJC (inspection/survey results received from the Quality Management Specialist-Regulatory Compliance Coordinator on November 30, 2020).

²⁶ VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. TJC provides an “internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care.” TJC “has been accrediting VA medical facilities for over 35 years.” Compliance with TJC standards “facilitates risk reduction and performance improvement.”

²⁷ VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs*, May 9, 2017. The Commission on Accreditation of Rehabilitation Facilities “provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies.” VHA’s commitment “is supported through a system-wide, long-term joint collaboration with CARF [Commission on Accreditation of Rehabilitation Facilities] to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.” “About the College of American Pathologists,” College of American Pathologists, accessed February 20, 2019, <https://www.cap.org/about-the-cap>. According to the College of American Pathologists, for 75 years it has “fostered excellence in laboratories and advanced the practice of pathology and laboratory science.” Additionally, as stated in VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

²⁸ “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.”

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

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

Table 11 lists the reported patient safety events from February 27, 2017 (the prior OIG Clinical Assessment Program site visit), to November 30, 2020.²⁹

Table 11. Summary of Selected Organizational Risk Factors (February 27, 2017, to November 30, 2020)

Factor	Number of Occurrences
Sentinel Events	2
Institutional Disclosures	11
Large-Scale Disclosures	0

Source: VA Eastern Colorado Health Care System’s Patient Safety Managers on November 30, 2020.

The Director spoke knowledgeably about serious adverse event reporting. The Director indicated that staff report adverse events during daily huddles. Additionally, the Director stated that institutional disclosure determinations were made in consultation with the Chief of Staff and Quality, Safety and Value team.

²⁹ It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The VA Eastern Colorado Health Care System is a high complexity (1a) affiliated system as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient “death, permanent harm, or severe temporary harm and intervention required to sustain life.” Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an “administrative disclosure”) as “a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.” Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as “notifications”) as “a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.”

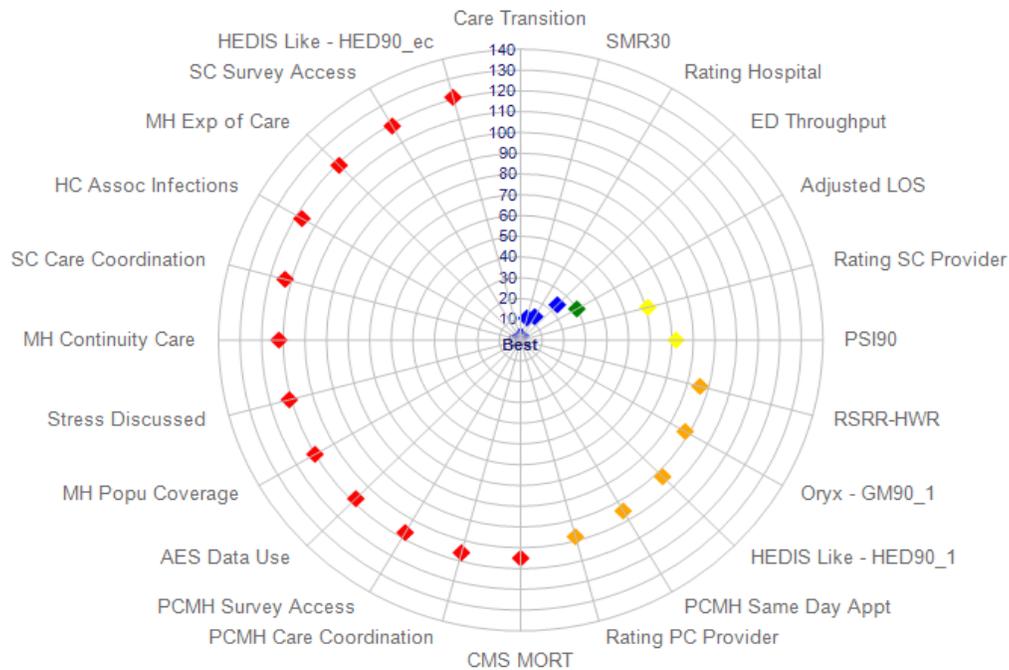
Veterans Health Administration Performance Data for the Healthcare System

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 satisfaction, access to care, and efficiency.” Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.³⁰

Figure 5 illustrates the 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 healthcare system’s performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of care transition, emergency department (ED) throughput, and adjusted length of stay (LOS)). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, rating (of) primary care (PC) provider, mental health (MH) continuity (of) care, and health care (HC) associated (assoc) infections).³¹

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

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



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

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

Source: VHA Support Service Center.

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

Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to “summarize and compare performance of CLCs in the VA.” The model “leverages much of the same data” used in the Centers for Medicare & Medicaid Services’ (CMS) *Nursing Home Compare* and provides a single resource “to review quality measures and health inspection results.”³²

Figures 6 illustrates the healthcare system’s CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. Figure 6 displays the CLC metrics with high performance (blue data points) in the first quintile (for example, in the areas of high risk pressure

³² Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, July 23, 2020. “In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several “star” ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes.”

ulcer (PU)—long-stay (LS), and physical restraints (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, ability to move independently worsened (LS), urinary tract infections (UTI) (LS), and falls with major injury (LS)).³³

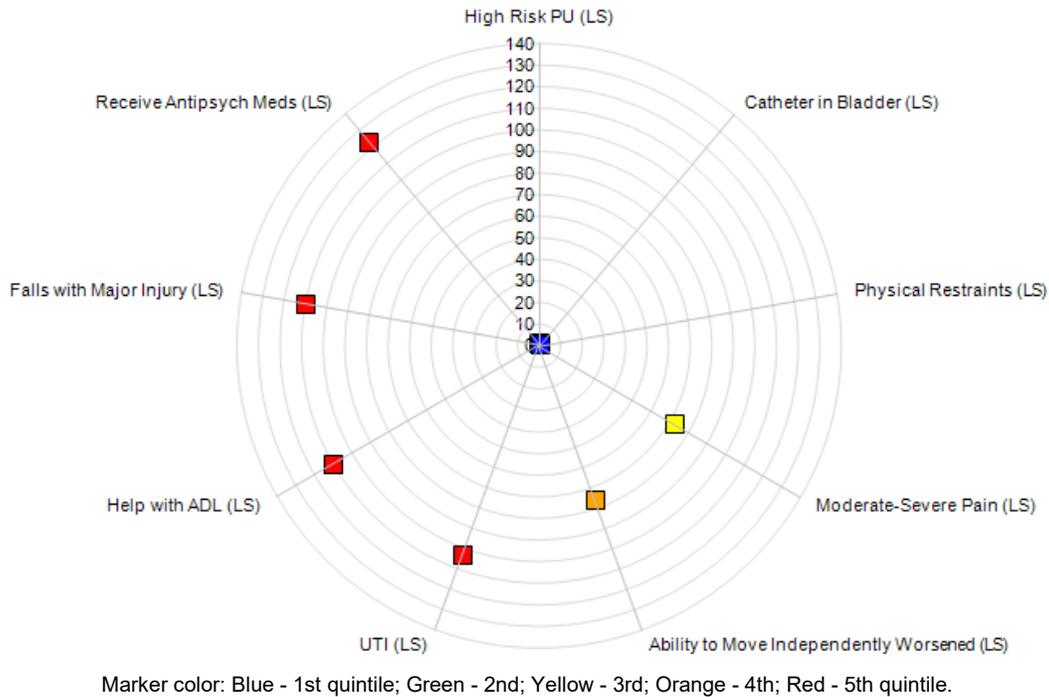


Figure 6. Pueblo CLC quality measure rankings, FY 2020 quarter 3 (as of June 30, 2020).

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 executive leadership team had worked together for over one year. However, several executive leaders had served in their positions for more than two years. The ADPCS, who was assigned in 2017, was the most tenured leader but had been detailed to another position since March 2020. The Director, who was assigned in 2019, was the newest member of the executive leadership team.

In individual interviews, the executive leaders 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.

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

The Director and Chief of Staff spoke of interim strategies implemented to address clinical and nonclinical occupational shortages. The Director and Chief of Staff also spoke of working in conjunction with university affiliates, providing care in the community, and hiring part-time staff.

All Employee Survey scores highlighted opportunities for the Director, acting ADPCS, and Associate Director to reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing). The scores also indicated that the Director and acting ADPCS could improve employee perceptions of respect, and the Director had an opportunity to minimize perceptions of discrimination in the workplace.

Patient experience survey data indicated that patients appeared satisfied with the inpatient care provided. However, the data highlighted opportunities for improvement in patient-centered medical home and specialty care.

The leaders spoke of engaging with employees and patients and working to sustain and improve employee and patient satisfaction. The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes. The OIG's review of the system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. The executive leaders were generally knowledgeable, within their scope of responsibilities, about performance opportunities highlighted by SAIL and CLC SAIL models.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the “alarming levels of spread and severity” of COVID-19, the World Health Organization declared a pandemic.³⁴ VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.³⁵

During this time, VA continued providing care to veterans and engaged its fourth mission, the “provision of hospital care and medical services during certain disasters and emergencies” to persons “who otherwise do not have VA eligibility for such care and services.”³⁶ “In effect, VHA facilities provide a safety net for the nation’s hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans.”³⁷

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

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

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

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

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

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

³⁷ VA OIG, *OIG Inspection of Veterans Health Administration’s COVID-19 Screening Processes and Pandemic Readiness, March 19–24, 2020*, Report No. 20-02221-120, March 26, 2020.

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.³⁹ To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.⁴⁰ Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."⁴¹

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

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

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

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

³⁹ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

⁴⁰ VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

⁴¹ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

⁴² VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

Next, the OIG assessed the healthcare system's processes for conducting protected peer reviews of clinical care.⁴³ Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."⁴⁴ Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.⁴⁵ The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit⁴⁶
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews⁴⁷
- 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; (2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select

⁴³ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a "critical review of care, performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. In the context of protected peer reviews, "protected" refers to the designation of review as a confidential quality management activity under 38 U.S.C. § 5705 as "a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for improving the quality of medical care or the utilization of health-care resources in VA facilities."

⁴⁴ VHA Directive 1190.

⁴⁵ VHA Directive 1190.

⁴⁶ VHA Directive 1190.

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

specialty programs.”⁴⁸ The healthcare system’s performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (registered nurse)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events⁴⁹

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

Quality, Safety, and Value Findings and Recommendations

The OIG found the healthcare system complied with requirements for committee oversight of QSV functions, designation of the Systems Redesign and Improvement Coordinator, tracking of performance improvement capability and projects, staff education on performance improvement principles and techniques, completion of protected peer reviews, assignment and duties of the Chief of Surgery, and the Surgical Work Group’s tracking and review of surgical program metrics. However, the OIG identified deficiencies with the Systems Redesign and Improvement Coordinator’s participation on the quality management committee and required member attendance at Surgical Work Group meetings.

VHA requires the Systems Redesign and Improvement Coordinator to participate on the facility quality management committee and the VISN Systems Redesign Review Advisory Group to review program data and information.⁵¹ The OIG reviewed the Quality Safety Values Executive Council’s (this healthcare system’s quality management committee) charter and nine months of meeting minutes from November 2019 through October 2020. The OIG found that the Systems Redesign and Improvement Coordinator was not a Quality Safety Values Executive Council member and did not participate in meetings during the reviewed time period. The lack of participation could hinder leadership oversight and result in missed opportunities to identify

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

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

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

⁵¹ VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

improvement needs. The Chief of QSV reported that efforts began in September 2020 to implement systems redesign and improvement reporting to the Quality Safety Values Executive Council; however, the Systems Redesign and Improvement Coordinator had not yet commenced reporting to the council due to competing priorities.

Recommendation 1

1. The System Director evaluates and determines reasons for noncompliance and ensures that the Systems Redesign and Improvement Coordinator participates on the Quality Safety Values Executive Council.⁵²

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: System Redesign (SRD) Section Chief or designee such as the Deputy System Redesign Section Chief was added to the QSVEC [Quality Safety Values Executive Council] meetings as well as the QSVEC reporting schedule. QSVEC is a quarterly meeting, right after the CHIP, the SRD Section Chief agreed to report to QSVEC rather than Strategic Planning Committee. SRD Section Chief was immediately placed on the QSVEC reporting schedule. The first SRD presentation was at the Feb 21 meeting. SRD reported in both February and May and is scheduled to report in August.

The numerator is attendance of the System Redesign Section Chief or designee such as the Deputy System Redesign Section Chief at QSVEC meetings for 6 consecutive months or 2 consecutive quarters. SRD attended and presented in Feb and May.

The denominator is the number of QSVEC meetings. 2

The Director, via QSVEC attendance rosters, monitored the QSVEC attendance for compliance.

VHA requires that the facility's Surgical Work Group meets monthly and have a membership that includes, but is not limited to, the Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager.⁵³ The OIG found that the Chief of Staff did not attend 5 of 11 meetings, based on review of Surgical Work Group attendance records for December 2019 through October 2020. Inconsistent attendance by the Chief of Staff could result in the absence of the authority and expertise required to identify challenges, create a plan, and implement actions to

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

⁵³ VHA Directive 1102.01(1), *National Surgery Office*, April 24, 2019, amended May 22, 2019. At the VA Eastern Colorado Health Care System, the Surgical Work Group reports to the Operative and Other Invasive Procedures Committee.

optimize surgical program outcomes. The Chief of Staff cited competing priorities as the reason why the requirement was not met.

Recommendation 2

2. The System Director evaluates and determines any additional reasons for noncompliance and ensures that the Chief of Staff regularly attends Surgical Work Group meetings.⁵⁴

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: Chief of Staff or designee such as Deputy Chief of Staff had attended all the Surgical Work Group (SWG) meetings for Nov/Dec 2020 through May 2021 and will continue to attend. The denominator is the number of SWG meetings held which was six.

The Director, via SWG which falls under Operative and Other Invasive Procedures Committee that falls under Healthcare Delivery Council, monitored the SWG attendance for compliance.

⁵⁴ The OIG reviewed evidence sufficient to demonstrate that healthcare system staff completed improvement actions, and therefore, closed the recommendation before publication of the report.

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.”⁵⁵ 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.”⁵⁶

VA requires all RNs to hold at least one active, unencumbered license.⁵⁷ 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.⁵⁸ 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.⁵⁹ 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.⁶⁰

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 51 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 credentialing files for 30 of the 51 RNs to determine whether healthcare system staff completed primary source verification prior to the appointment.

⁵⁵ VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012.

⁵⁶ VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

⁵⁷ 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.”

⁵⁸ 38 U.S.C. § 7402.

⁵⁹ VHA Directive 2012-030.

⁶⁰ VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

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

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-19.⁶¹ 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.⁶²

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.⁶³ 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.⁶⁴

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."⁶⁵ The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.⁶⁶

To determine whether VHA facilities complied with requirements related to the administration of remdesivir, the OIG interviewed key employees and managers and reviewed electronic health records of 15 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

⁶¹ 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.

⁶² Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*.

⁶³ Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*, May 8, 2020.

⁶⁴ 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*.

⁶⁵ 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.

⁶⁶ 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)⁶⁷
 - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)⁶⁸
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG found the healthcare system addressed many of the indicators of expected performance, including the availability of staff to receive medication shipments, staff determination that patients met criteria for receiving the medication prior to administration, and completion of required testing prior to remdesivir administration. However, the OIG found deficiencies with the use of the proper name for medication orders and provision of patient/caregiver education.

Under the Remdesivir Emergency Use Authorization, VA Pharmacy Benefits Management Services required that patient orders for remdesivir be entered into the electronic health record as “INV-REMDESIVIR.”⁶⁹ Entries starting with “INV” identify the medication as investigational on local and national reports.⁷⁰ The OIG found that all 15 patients orders for remdesivir lacked the required medication title. Failure to appropriately label the medication could have resulted in inadequate safeguards for authorized use or prevented the tracking of patients receiving remdesivir. The Associate Chief of Pharmacy confirmed that the system did not use the required naming convention for the emergency use of remdesivir because there was already an approved facility-based remdesivir research study using the “INV” naming convention; to ensure patient safety and accuracy in dispensing, the “INV” naming convention was only being used for research study purposes. The Quality Assurance Pharmacy Program Manager reported not being aware of the required medication title.

⁶⁷ “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.”

⁶⁸ “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.

⁶⁹ VHA Handbook 1108.04, *Investigational Drugs and Supplies*, February 29, 2012; VA Pharmacy Benefits Management Services, *Remdesivir Emergency Use Authorization (EUA) Requirements*, May 2020.

⁷⁰ VHA Handbook 1108.04.

Additionally, under the same 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 prior to administration, provide the option to refuse the medication, and advise patients or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.⁷¹ Of the 15 patients who received remdesivir, the OIG determined that clinical staff did not

- provide the “Fact Sheet for Patients and Parents/Caregivers” to 87 percent of patients or caregivers before administering remdesivir,
- inform 40 percent of patients or caregivers that remdesivir was not an FDA-approved medication,
- inform 33 percent of patients or caregivers of the option to refuse remdesivir,
- inform 47 percent of patients or caregivers of the significant known and potential risks and benefits of remdesivir, and
- advise 40 percent of patients or caregivers of alternatives to receiving remdesivir prior to administration.

This could have resulted in patients or caregivers lacking the information needed to make a fully-informed decision to receive the medication. The Chief of Hospital Medicine reported that residents failed to document the information provided to patients or caregivers. The Chief of Infectious Diseases also reported that some providers documented “as per EUA” in progress notes and believed that met the requirements.

Given the FDA’s approval of remdesivir for use in adult patients hospitalized with COVID-19, the OIG made no recommendations related to Emergency Use Authorization requirements.⁷²

⁷¹ VA Pharmacy Benefits Management Services, *Remdesivir Emergency Use Authorization (EUA) Requirements*, May 2020.

⁷² Food and Drug Administration, “FDA News Release: FDA Approves 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 2019.⁷³ 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 2018.⁷⁴ However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.⁷⁵

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 completion of the Comprehensive Suicide Risk Assessment when screening is positive.⁷⁶ 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.⁷⁷ 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;

⁷³ “Preventing Suicide,” Centers for Disease Control and Prevention, accessed December 9, 2020, <https://www.cdc.gov/violenceprevention/suicide/fastfact.html>.

⁷⁴ Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, November 2020.

⁷⁵ Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*.

⁷⁶ Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Suicide Risk Screening and Assessment Requirements*, May 23, 2018.

⁷⁷ 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 47 randomly selected patients who were seen in the emergency department from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

The OIG found the healthcare system had generally complied with staff initiation and completion of the Columbia-Suicide Severity Rating Scale and suicide safety plans. However, the OIG identified a deficiency with mandatory training completion by staff who develop suicide safety plans.

VA requires that appropriately-credentialed staff complete suicide safety plans with patients after “the staff member has documented training via the TMS [Training Management System] course (VA-36232 Suicide Safety Plan Training Recording).”⁷⁸ The OIG reviewed the training records for 26 staff responsible for suicide safety plan development and found that all lacked evidence that staff completed the mandatory training. Lack of training could prevent staff from providing optimal treatment to veterans who are at risk for suicide. The Suicide Prevention/Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment Coordinator described nationally mandated trainings as being typically supported by formal directives/policies, which are communicated through the education system and contain parameters specifying a time frame, completion tracking, and if the training was one time or annual. The Suicide Prevention Program Manager reported that because this training was not communicated through the formal process, it was not identified as needed, and therefore, not assigned to staff members.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures staff complete suicide safety plan training prior to developing suicide safety plans.⁷⁹

⁷⁸ VA Suicide Prevention Safety Plan and Suicide Behavior and Overdose Report (SBOR) Templates, Staff Specific Guidance, April 17, 2019. (This document was updated on June 18, 2020. The two documents contain similar language related to training requirements.)

⁷⁹ The OIG reviewed evidence sufficient to demonstrate that healthcare system staff completed improvement actions, and therefore, closed the recommendation before publication of the report.

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: 453 of 453 total staff completing suicide safety plans have received the TMS course VA-36232 Suicide Safety Plan Training and completed training as of June 30, 2021, including new employees onboarded since [the] OIG CHIP visit. New employees in job roles requiring the TMS course VA-36232 Suicide Safety Plan will be assigned upon hire and the suicide prevention coordinator will continue to monitor for continued compliance.

The numerator is all staff required to have suicide safety plan training who have completed suicide safety plan training.

The denominator is all staff required to have suicide safety plan training.

The Director, via Regulatory Compliance Work Group which reports to Performance Improvement Committee that falls under QSVEC, has monitored for a period of 6 consecutive months or 2 consecutive quarters with 100% compliance for current and newly onboarded employees.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.⁸⁰

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.⁸¹

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

The OIG observed general compliance with requirements for the completion of the *Inter-Facility Transfer Form* or facility-defined equivalent by the appropriate provider(s) and communication between nurses at sending and receiving facilities. However, the OIG identified deficiencies with the establishment of a facility policy for inter-facility transfers, monitoring and evaluation of inter-facility transfers, and transmission of patients’ active medication lists to receiving facilities.

⁸⁰ VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

⁸¹ 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 System Director or designee to ensure that a written policy is in place for “the safe, appropriate, orderly, and timely transfer of patients.”⁸² The Chief of QSV reported that the system did not have a policy for inter-facility patient transfers. Failure to maintain a current inter-facility transfer policy could result in lack of coordination between facilities to provide seamless care for patients through the transfer process. The Chief of QSV reported that the previous Patient Access Center supervisor began establishing a transfer policy in 2019, but it was not completed prior to vacating the position. As of December 1, 2020, leaders reported that a draft policy was created and were seeking input from all stakeholders.

Recommendation 4

4. The System Director evaluates and determines reasons for noncompliance and makes certain that a written policy is in place to ensure the safe, appropriate, orderly, and timely transfer of patients.

Healthcare system concurred.

Target date for completion: August 31, 2021

Healthcare system response: The Patient Access Center Chief/Lead PUMA [Provider Utilization Management Advisor] has drafted an updated policy to ensure safe, appropriate, orderly, and timely transfer of patients. Once the policy is finalized, Service Chiefs will be educated on the requirements of the facility policy. Each Service Chief will then be expected to educate their employees on the policy and requirements and report back to Patient Access Center Chief/Lead PUMA on education status.

The Director, via QSV policy process (which includes training on new policies and managers’ responsibilities in communicating), will monitor until the finalized policy is approved.

VHA also requires the Chief of Staff and ADPCS to ensure that “all transfers are monitored and evaluated as part of VHA’s Quality Management Program.”⁸³ The OIG reviewed Performance Improvement Committee meeting minutes from November 2019 through October 2020 and did not find evidence that staff monitored and evaluated patient transfers. Failure to monitor patient transfer data could prevent identification of system-level deficiencies that jeopardize the health of vulnerable patients. The Nurse Manager Patient Flow Center reported not being aware of the requirement until recently.

Lack of evidence that healthcare system staff monitor and evaluate inter-facility transfers is a repeat finding from the *Clinical Assessment Program Review of the VA Eastern Colorado Health*

⁸² VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

⁸³ VHA Directive 1094.

Care System, Denver, Colorado report. The report was closed on May 28, 2020. However, the OIG found continued issues that warranted a repeat recommendation.⁸⁴

Recommendation 5

5. The System Director evaluates and determines additional reasons for noncompliance and ensures that all patient transfers are monitored and evaluated as part of Veterans Health Administration's Quality Management Program.

Healthcare system concurred.

Target date for completion: October 31, 2021

Healthcare system response: A process is being developed & implemented to ensure appropriate oversight by Patient Access Center to monitor & evaluate all patient transfers as part of VHA's Quality Management Program. The Patient Access Center Director or designee will review all inter-facility transfers by reviewing the patient EHRs for the VA Form 10-2649A templated note and to validate the templated note was completely filled in and complete medical record sent with patient. Lack of documentation on the VA Form 10-2649A templated note that the complete medical record was sent indicates non-compliance. The inter-facility compliance & non-compliance data is reported to Performance Improvement Committee at least quarterly.

The numerator is number of inter-facility transfers that are compliant with evaluation and monitoring as part of VHA's Quality Management Program per quarter.

The denominator is the total number of inter-facility transfers per quarter.

The Director, via Performance Improvement Committee which falls under QSVEC, will monitor the completion of all inter-facility transfer reviews by Patient Flow Center to a 90% compliance goal until 6 consecutive months or 2 consecutive quarters of inter-facility transfer data is achieved.

Additionally, VHA requires the Chief of Staff and ADPCS to ensure that staff send all pertinent medical records with the patient during inter-facility transfers. This includes an active patient medication list and advance directive, when applicable.⁸⁵ The OIG estimated that 89 percent of electronic health records lacked evidence that staff sent an active medication list to the receiving facility.⁸⁶ Further, the OIG found that for the 15 patients who had an advanced directive, staff did not send a copy to the receiving facility. This could result in suboptimal treatment decisions that

⁸⁴ VA OIG, *Clinical Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado*, Report No. 16-00546-388, September 29, 2017.

⁸⁵ VHA Directive 1094.

⁸⁶ The OIG estimated that 95 percent of the time, the true compliance rate is between 2.2 and 20.4 percent, which is statistically significantly below the 90 percent benchmark.

compromise patient safety. The Chief of the Emergency Department attested that the Health Administration Service staff are tasked with creating a packet of documentation to include an active medication list and copy of advance directive, if applicable. The Chief reported that the packet is to be sent with the patient when transferred. However, there was no evidence to support this process. Due to the low number of patients identified for the advance directive requirement, the OIG made no recommendation.

Recommendation 6

6. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine the reasons for noncompliance and ensure that staff send pertinent medical records, including an active patient medication list, to the receiving facility during inter-facility transfers.

Healthcare system concurred.

Target date for completion: December 31, 2021

Healthcare system response: The Patient Access Center reviews all inter-facility transfers to ensure that complete medical records, to include an active patient medication list are sent with patients in accordance with VHA Directive 1094 and facility policy. Audits of inter-facility transfers consist of reviewing the patient EHR for the VA Form 10-2649A templated note and to validate the templated note was completely filled in and complete medical record sent with patient. Lack of documentation on the VA Form 10-2649A templated note that the complete medical record was sent indicates non-compliance.

The numerator is number of inter-facility transfers indicating non-compliance.

The denominator is total inter-facility transfers.

The Director, via Performance Improvement Committee which falls under QSV Executive Council, will monitor minutes indicating information present for at least 90% compliance quarterly for a period of 6 consecutive months or 2 consecutive quarters.

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.”⁸⁷ 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.”⁸⁸ 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 team⁸⁹
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings⁹⁰
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction⁹¹
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants⁹²

⁸⁷ VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

⁸⁸ VHA Directive 2012-026.

⁸⁹ 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.”

⁹⁰ 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.”

⁹¹ 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.”

⁹² 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.⁹³ Additionally, VHA requires that employee threat assessment team members complete the appropriate team-specific training.⁹⁴ 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 healthcare system complied with many of the requirements for the management of disruptive and violent behavior. However, the OIG noted that required prevention and management of disruptive behavior training had not been completed by all employees.

VHA requires employees to complete prevention and management of disruptive behavior training based on the risk level assigned to their work areas.⁹⁵ The OIG found that 27 percent of employees did not complete the required trainings based on the risk level for their work. This could result in lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Chair of the Disruptive Behavior Committee and the Clinical Educator reported that parts 2 and 3 of the training are face-to-face and were delayed as a result of the pandemic.⁹⁶

Recommendation 7

7. The System Director evaluates and determines any additional reasons for noncompliance and ensures employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work area.⁹⁷

⁹³ DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

⁹⁴ DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

⁹⁵ DUSHOM Memorandum, *Update to Prevention Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

⁹⁶ The Disruptive Behavior Committee reports to the Workplace Violence Prevention Oversight Committee.

⁹⁷ 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: March 1, 2022

Healthcare system response: ECHCS [Eastern Colorado Health Care System] offers training opportunities adequate to meet the required prevention and management of disruptive behavior training. The training is based on the risk level assigned to their work area. By completing the training, employees garner the needed education and training to enhance awareness, preparedness, and precautions when responding to disruptive behavior. All staff requiring prevention and management of disruptive behavior training are assigned initial training in TMS. Those who require Part 2, low or moderate, and Part 3, are required to self-register in TMS for virtual or in-person training. The Prevention and Management of Disruptive Behavior Training Coordinator, who falls under Organizational Development & Education reporting structure, will develop a process to communicate, on at least a monthly basis, with supervisors when employees need to schedule the training or have not completed the prevention and management of disruptive behavior training, part 2 and part 3.

The numerator is the number of employees having completed prevention and management of disruptive behavior training based on the risk level assigned to their work area.

The denominator is the number of employees requiring prevention and management of disruptive behavior training based on the risk level assigned to their work area.

The Director, via the Regulatory Compliance Subcommittee (reports to Performance Improvement Committee), will monitor for compliance with 90% of employees compliant with completion of the required prevention and management of disruptive behavior training based on the risk level assigned to their work area for 6 consecutive months or 2 consecutive quarters.

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 seven 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 seven 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 System Director, Chief of Staff, and Associate Director for Patient Care Services. The intent is for these leaders to use the 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	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
COVID-19 Pandemic Readiness and Response	<ul style="list-style-type: none"> • Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback 	<p>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.</p>	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • The Systems Redesign and Improvement Coordinator participates on the Quality Safety Values Executive Council. • The Chief of Staff regularly attends Surgical Work Group meetings.
RN Credentialing	<ul style="list-style-type: none"> • RN licensure requirements • Primary source verification 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Medication Management: Remdesivir Use in VHA	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	<ul style="list-style-type: none"> • Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements 	<ul style="list-style-type: none"> • Staff complete suicide safety plan training prior to developing suicide safety plans. 	<ul style="list-style-type: none"> • None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Staff send pertinent medical records, including an active patient medication list, to the receiving facility during inter-facility transfers. 	<ul style="list-style-type: none"> • A written policy is in place to ensure the safe, appropriate, orderly, and timely transfer of patients. • Patient transfers are monitored and evaluated.
High-Risk Processes: Management of Disruptive and Violent Behavior	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work area.

Appendix B: Healthcare System Profile

The table below provides general background information for this high complexity (1a) affiliated healthcare system reporting to VISN 19.¹

**Table B.1. Profile for VA Eastern Colorado Health Care System (554)
(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	\$786,889,107	\$852,759,415	\$1,051,597,311
Number of:			
• Unique patients	94,592	96,088	96,259
• Outpatient visits	1,023,067	1,068,816	978,808
• Unique employees§	2,766	3,050	3,128
Type and number of operating beds:			
• Community living center	40	30	30
• Domiciliary	59	59	37
• Medicine	58	58	58
• Mental health	30	30	30
• Rehabilitation medicine	8	8	8
• Spinal cord	30	20	20
• Surgery	22	22	22
Average daily census:			
• Community living center	29	30	26
• Domiciliary	49	46	28
• Medicine	43	45	40
• Mental health	30	27	19
• Rehabilitation medicine	6	7	4

¹ An affiliated healthcare system is associated with a medical residency program. VHA medical centers are classified according to a facility complexity model; a designation of “1a” indicates a facility with “high volume, high risk patients, most complex clinical programs, and large research and teaching programs.”

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019	Healthcare System Data FY 2020‡
• Spinal Cord	–	4	12
• Surgery	15	18	16

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).

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
Aurora, CO	554GB	8,865	1,652	Dermatology	–	Nutrition Pharmacy
Golden, CO	554GC	15,268	12,028	Dermatology Nephrology Neurology Poly-Trauma Rehab physician Spinal cord injury	EMG Radiology	Nutrition 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.

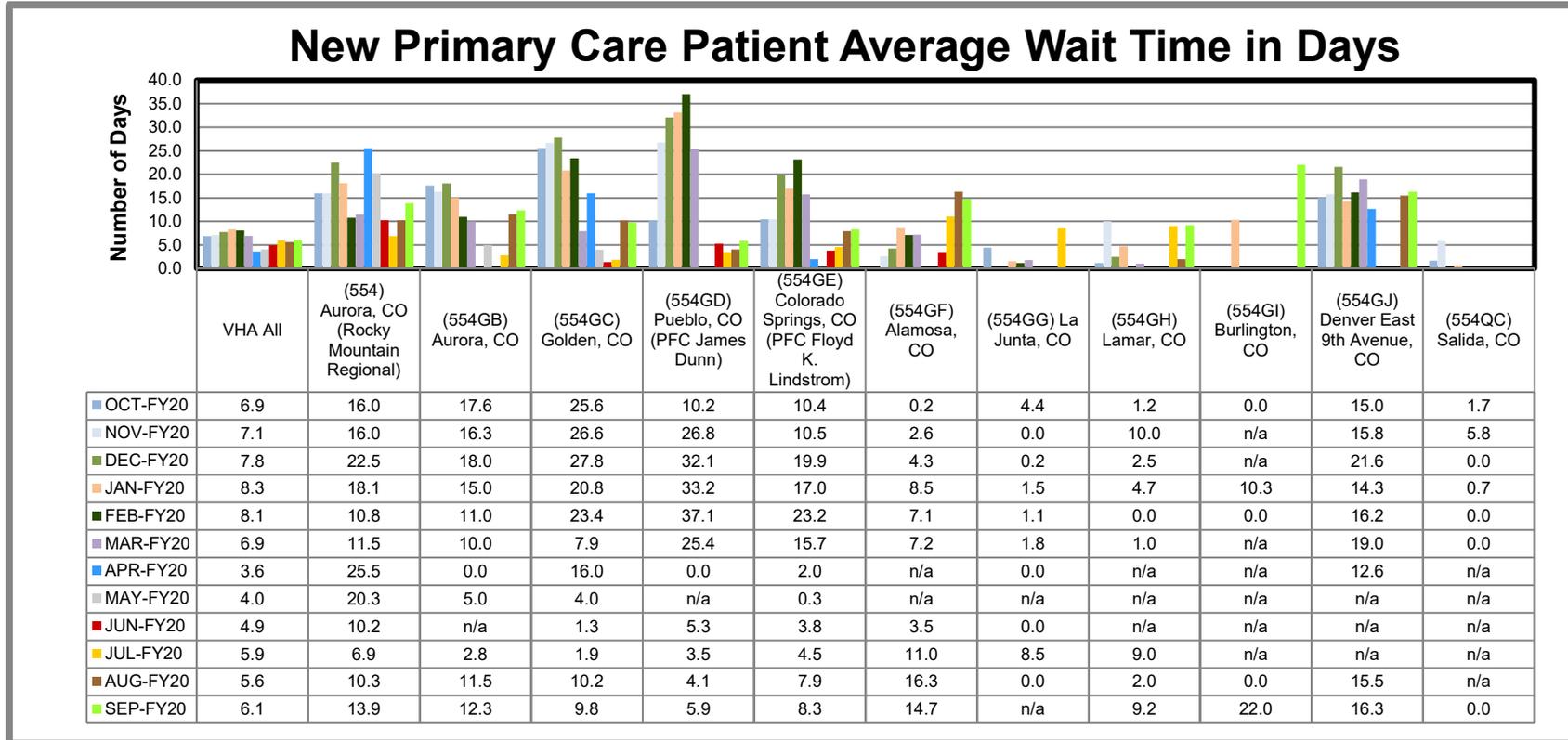
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Pueblo, CO	554GD	11,729	10,865	Dermatology Endocrinology Gastroenterology General surgery Nephrology Podiatry	Radiology	Dental Nutrition Pharmacy Weight management
Colorado Springs, CO	554GE	39,646	24,109	Anesthesia Dermatology Endocrinology Eye Gastroenterology General surgery GYN Nephrology Orthopedics Podiatry Poly-Trauma Urology Vascular	Laboratory & Pathology Radiology	Dental Nutrition Pharmacy Social work Weight management
Alamosa, CO	554GF	2,203	842	Anesthesia Dermatology Endocrinology General surgery Nephrology	–	Pharmacy Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
La Junta, CO	554GG	1,777	960	Anesthesia Dermatology Endocrinology Gastroenterology Nephrology	–	Pharmacy Weight management
Lamar, CO	554GH	1,021	234	Dermatology Endocrinology Gastroenterology Nephrology	–	Pharmacy
Burlington, CO	554GI	795	134	Dermatology Endocrinology Nephrology	–	Pharmacy
Denver, CO	554GJ	6,750	872	–	–	Pharmacy
Denver, CO	554QA	1	4	–	–	–
Salida, CO	554QC	460	233	Dermatology	–	Pharmacy

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

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

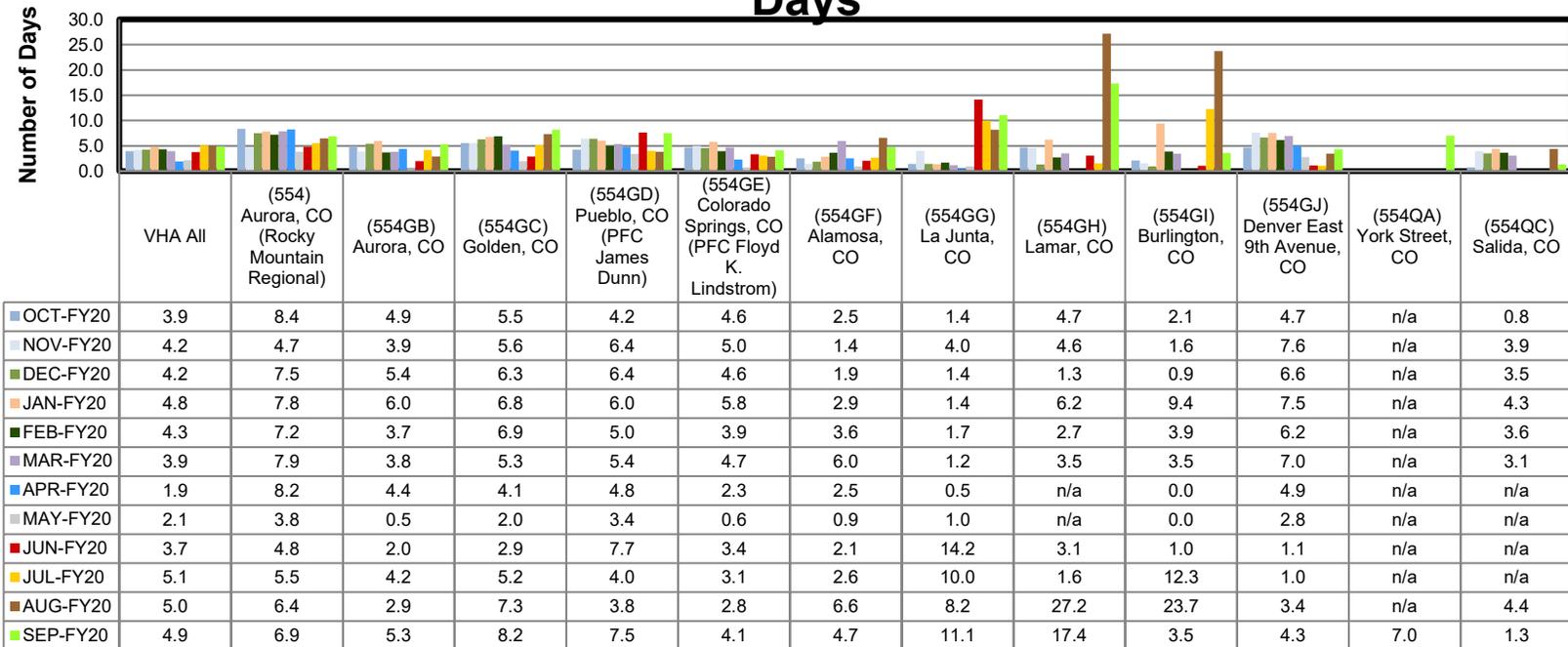
Appendix D: Patient Aligned Care Team Compass Metrics



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 Pueblo community-based outpatient clinic. The OIG omitted (554A5) Denver, CO, (554QA) York, Street, CO, (554QB) Jewell, CO, as no data were reported. Data Definition: “The average number of calendar days between a New Patient’s Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL)), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.” Prior to FY 2015, this metric was calculated using the earliest possible create date. The absence of reported data is indicated by “n/a.”

Established Primary Care Patient Average Wait Time in Days



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 Pueblo community-based outpatient clinic. The OIG omitted (554A5) Denver, CO, (554QB) Jewell, CO, as no data were reported.

Data Definition: “The average number of calendar days between an Established Patient’s Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.” 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: July 13, 2021

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

Subj: Comprehensive Healthcare Inspection of the VA Eastern Health Care System in Denver

To: Director, Office of Healthcare Inspections (54CH03)

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

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

(Original signed by:)

Ralph G. Gigliotti, FACHE

VISN 19 Network Director

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: July 1, 2021

From: Director, VA Eastern Colorado Healthcare System (ECHCS) (554/00)

Subj: Comprehensive Healthcare Inspection of the VA Eastern Colorado Health Care System in Denver

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

1. We are submitting written comments in response to the Comprehensive Healthcare Inspection completed the week of November 30, 2020, at the VA Eastern Colorado Health Care System (ECHCS).
2. In reviewing the draft report, the facility has addressed all identified deficiencies and has either already resolved and/or a plan to resolve all remaining non-compliant areas cited in the report. I concur with all the remaining findings, recommendations, and submitted action plans

(Original signed by:)

Michael T. Kilmer

Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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