



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the VA Salt
Lake City Health Care
System in Utah



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Figure 1. *VA Salt Lake City Health Care System in Utah.*

Source: <https://vaww.va.gov/directory/guide/> (accessed January 7, 2021).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
COVID-19	coronavirus disease
ED	emergency department
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
UCC	urgent care center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Salt Lake City Health Care System, which includes outpatient clinics in Idaho, Nevada, and Utah. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

1. COVID-19 pandemic readiness and 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 Salt Lake City Health Care System during the week of December 7, 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 six recommendations to the Director, Chief of Staff, and Associate Director for Patient Care Services. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

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

When the team conducted this inspection, the Chief of Staff and Director had served in their roles since 2012 and 2017, respectively. However, the remaining three executive leaders had recently assumed their positions within the past 10 months, with the least tenured leader joining the team in October 2020; thus, the executive team as a whole had only worked together for two months.

The OIG noted a budget increase of 22 percent in FY 2020; according to the Director, most of the additional funds supported Care in the Community and the hiring of additional employees to provide services to an increased number of veterans seeking care at the system.

Specific survey data revealed employees' general satisfaction with leadership, the workplace, and the maintenance of an environment where staff felt respected and discrimination was not tolerated. Selected patient experience survey scores highlighted opportunities to improve female veterans' experiences in the inpatient and specialty care settings.

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

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

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

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

The executive leaders were generally knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to specific poorly performing quality and efficiency measures. In individual interviews, the executive leaders were able to speak in depth about actions taken to maintain or improve organizational performance, employee satisfaction, or patient experiences during the previous 12 months.

COVID-19 Pandemic Readiness and Response

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

Medication Management

The OIG found the healthcare system addressed many of the indicators of expected performance, including the availability of staff to receive medication shipments, proper naming of medication orders, provision of required tests prior to administration of remdesivir, and reporting of adverse events to the Food and Drug Administration. However, the OIG identified opportunities for improvement with the provision of required patient/caregiver education.

Mental Health

The healthcare system complied with requirements related to suicide prevention screening within emergency departments and urgent care centers. However, the OIG noted opportunities for improvement with the completion of staff training.

Care Coordination

Generally, the healthcare system met expectations for an inter-facility transfer policy. However, the OIG identified deficiencies with monitoring and evaluation of inter-facility transfers, completion of the required *Inter-Facility Transfer Form*, transmission of active medication lists to receiving facilities, and communication between nurses at sending and receiving facilities.⁵

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

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

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

High-Risk Processes

The healthcare system met many of the requirements for the management of disruptive and violent behavior. However, the OIG noted opportunities for improvement with the completion of 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 six 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 healthcare system. The intent is for healthcare system leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues and other less-critical findings that may eventually interfere with the delivery of quality health care.

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 F and G, pages 54–55, and the responses within the body of the report for the full text of the directors’ comments.) 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 Salt Lake City 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, (October 14, 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)

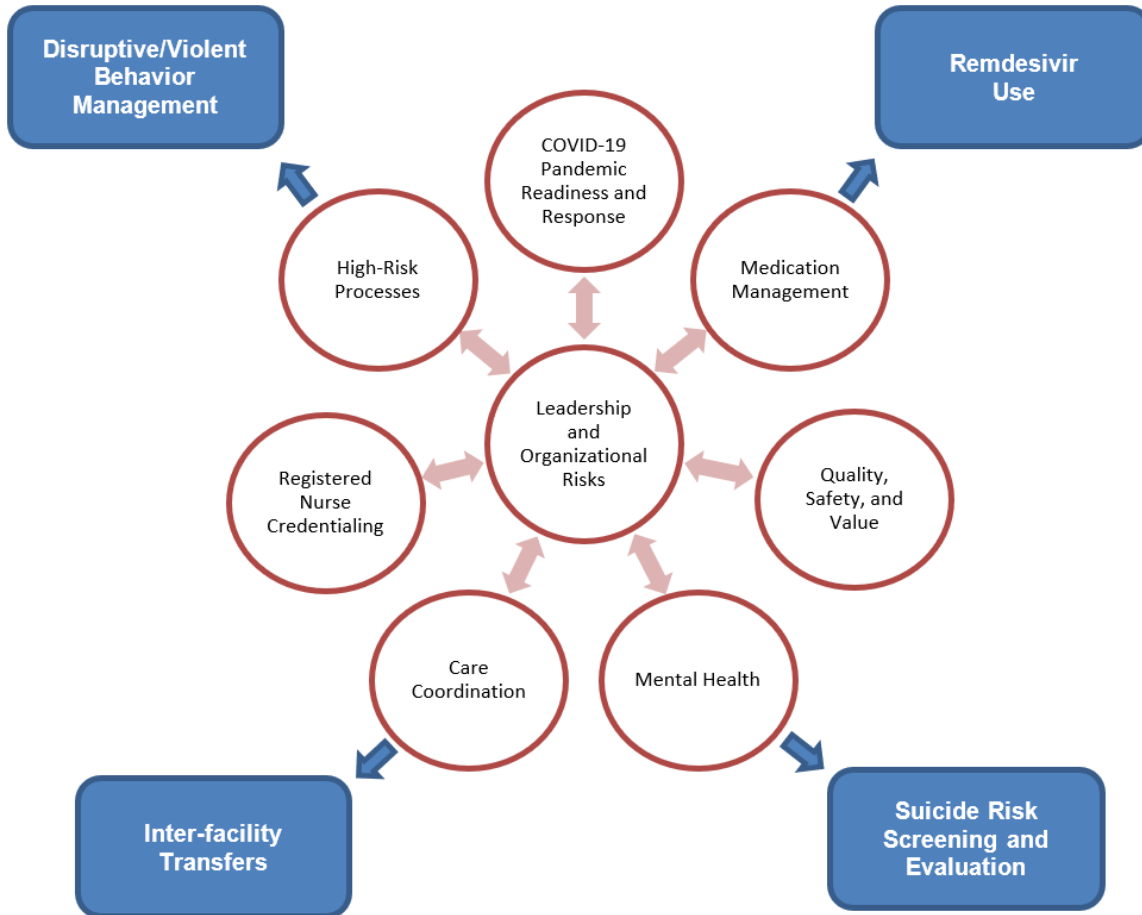


Figure 2. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.

Source: VA OIG.

Methodology

The VA Salt Lake City Health Care System includes multiple outpatient clinics in Idaho, Nevada, and Utah. 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 December 10, 2016, through December 11, 2020, the last day of the unannounced multiday evaluation.⁷ During the virtual review, the OIG did not receive any complaints beyond the scope of the inspection.

The 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 the 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)

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 Assistant Director. 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.

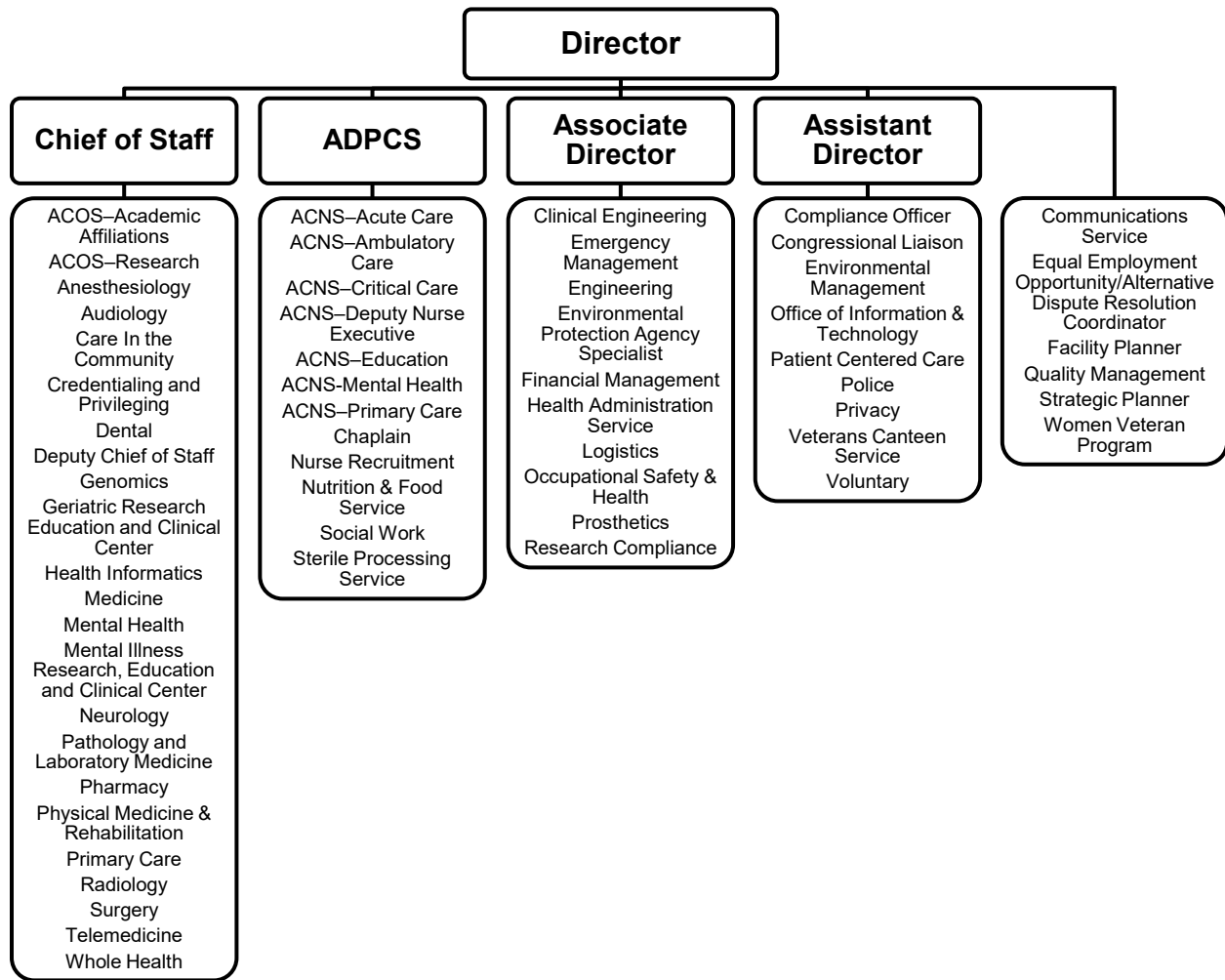


Figure 3. VA Salt Lake City Health Care System organizational chart.

Source: VA Salt Lake City Health Care System (received December 8, 2020).

ACNS = Associate Chief Nursing Service.

ACOS = Associate Chief of Staff.

At the time of the inspection, the Chief of Staff and Director had served in their roles since 2012 and 2017, respectively. However, the remaining three executive leaders had recently assumed their positions within the past 10 months, with the least tenured leader joining the team in October 2020; thus, the executive team as a whole had only worked together for two months (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	June 11, 2017
Chief of Staff	January 15, 2012
Associate Director for Patient Care Services	February 16, 2020
Associate Director	July 5, 2020
Assistant Director	October 11, 2020

Source: VA Salt Lake City Health Care System's Strategic Business Partner (received December 7, 2020).

To help assess the healthcare system executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, 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 generally knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific Strategic Analytics for Improvement and Learning (SAIL) measures. In individual interviews, the executive leadership team members 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. Details from these interviews are discussed in greater detail below.

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

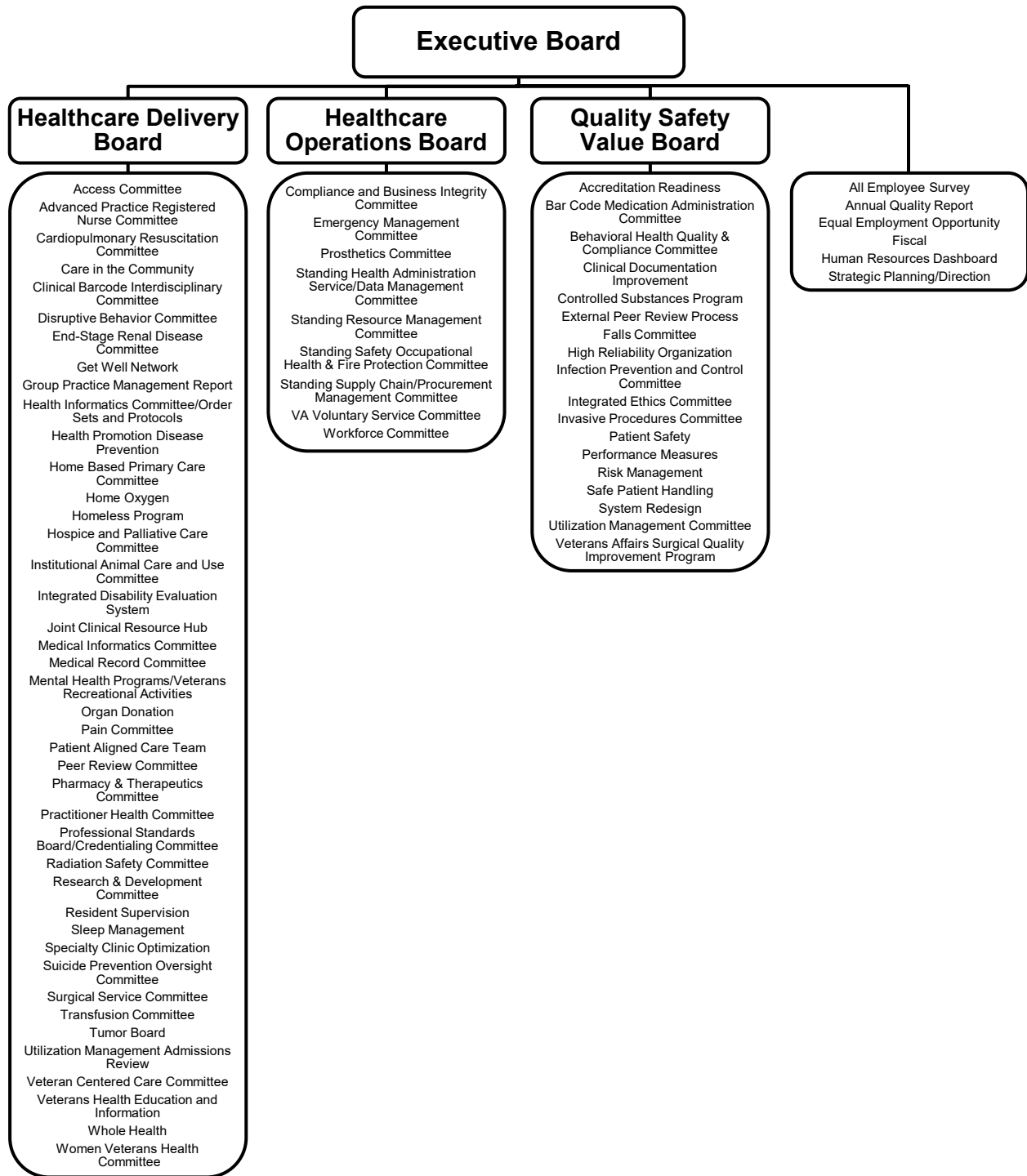


Figure 4. Healthcare system committee reporting structure.

Source: VA Salt Lake City Health Care System (received February 11, 2021).

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of \$759,878,707 increased by 22 percent compared to the previous year's budget of \$622,812,877.¹¹ When asked about the effect of this change on the healthcare system's operations, the Director indicated that most of the additional funds supported Care in the Community and the hiring of additional employees to provide services to an increased number of veterans seeking care at the system.

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.¹² Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.¹³ In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.¹⁴

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*.¹⁵ Executive leaders discussed strategies used to address the primary care physician shortage. These strategies included hiring advanced practice registered nurses and physician assistants.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Medical Officer	1. Food Service Worker
2. Psychiatry	2. Police
3. Primary Care	3. General Engineering
4. Nurse	4. Custodial Worker
5. Nephrology	5. Medical Support Assistance

Source: VA OIG.

¹¹ VHA Support Service Center.

¹² Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

¹³ 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.

¹⁴ VA OIG, *Critical Deficiencies at the Washington DC VA Medical Center*, Report No. 17-02644-130, March 7, 2018.

¹⁵ VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.

Employee Satisfaction

The All Employee Survey “is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential.” Since 2001, the instrument has been refined several times in response to VA leaders’ inquiries on VA culture and organizational health.¹⁶ Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA’s All Employee Survey from October 1, 2018, through September 30, 2019.¹⁷ 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 averages for the selected survey leadership questions were higher than the VHA averages.¹⁸ The OIG noted the same trend for the Director, Chief of Staff, ADPCS, and Associate Director; however, the Assistant Director scores were similar to or lower than VHA and the healthcare system. The 2019 All Employee Survey results are not reflective of employee satisfaction with the current ADPCS, Associate Director, and Assistant Director, who assumed their roles after the survey was administered.

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	76.6	80.6	95.0	77.0	78.3	69.7

¹⁶ “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.)

¹⁷ 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.

¹⁸ 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	3.6	4.0	4.6	4.0	4.0	3.5
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	3.8	4.4	4.8	4.3	4.2	3.6
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	3.8	4.2	4.8	4.3	4.2	3.6

Source: VA All Employee Survey (accessed November 4, 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.¹⁹ The healthcare system averages for the selected survey questions were similar to the VHA averages. Scores for the Director, Chief of Staff, ADPCS, and Associate Director were consistently better than those for VHA and the healthcare system. Scores for the Assistant Director were similar to the VHA averages. Again, the 2019 All Employee Survey results are not reflective of employee satisfaction with the current ADPCS, Associate Director, and Assistant Director, who assumed their roles after the survey was administered.

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

**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	3.9	4.2	4.9	4.7	4.0	3.9
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	3.8	4.1	4.5	4.3	4.3	3.6
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	1.5	1.0	1.1	0.8	0.8	1.4

Source: VA All Employee Survey (accessed November 4, 2020).

VHA leaders have articulated that the agency “is committed to a harassment-free healthcare environment.” To this end, leaders initiated the “End Harassment” and “Stand Up to Stop Harassment Now!” campaigns to help create a culture of safety where staff and patients feel secure and respected.²⁰

The Director reported starting the “See Something, Say Something” submission portal. The portal encompasses the three pillars of a High Reliability Organization—leadership commitment, culture of safety, and process improvement. Staff access the portal through a desktop icon or the healthcare system’s intranet page and may use the portal to voice concerns and share ideas. The executive leaders fully support using the submission portal and intend to use it for years to come.

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

**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	4.0	3.9	4.9	4.3	4.4	4.1
All Employee Survey: <i>Discrimination is not tolerated at my workplace.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	4.0	4.2	4.5	4.9	4.4	4.2	4.4

²⁰ “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.

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>Members in my workgroup are able to bring up problems and tough issues.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.9	4.1	4.9	4.3	4.3	3.6

Source: VA All Employee Survey (accessed November 4, 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.²¹ For this healthcare system, the patient satisfaction survey results reflected higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

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

Questions	Scoring	VHA Average	Health- care System Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	69.6	74.0

²¹ Ratings are based on responses by patients who received care at this healthcare system.

Questions	Scoring	VHA Average	Health-care System Average
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	85.7
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	86.2

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 4, 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 2048.²² For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients’ experiences by gender, including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys (see tables 7–9). The results for male respondents were generally similar to or more favorable than the corresponding VHA averages. Survey responses also indicated that the healthcare system’s doctors and nurses had opportunities to deliver care with more courtesy and respect to female veterans. Additionally, many female veterans receiving care at the healthcare system felt that their patient-centered medical home provider was the best provider possible, but the OIG noted opportunities to improve female veterans’ access to routine patient-centered as well as urgent specialty care appointments.

²² “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.

**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	74.0	74.8
<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	85.7	58.2
<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	88.9	58.1

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 4, 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 338–341 male and 13 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	53.7	66.1
<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	65.8	52.9
<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	77.8	76.8

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 4, 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 546–1,631 male and 41–96 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	56.7	39.4
<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	61.4	54.5
<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	78.8	68.1

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 4, 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 390–1,143 male and 13–67 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.²³ Table 10 summarizes the relevant system inspections most recently performed by the OIG and The Joint

²³ “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).²⁴ At the time of the OIG review, the system had closed all recommendations for improvement issued since the previous Clinical Assessment Program site visit in December 2016.

The OIG team also noted the system’s current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.²⁵

Table 10. Office of Inspector General Inspection/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 Salt Lake City Health Care System, Salt Lake City, Utah</i> , Report No. 16-00572-179, March 31, 2017)	December 2016	20	0
TJC Hospital Accreditation	February 2019	42	0
TJC Behavioral Health Care Accreditation		5	0
TJC Home Care Accreditation		8	0

Source: OIG and TJC (inspection/survey results received from the Chief of Quality Management on December 8, 2020).

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

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

²⁴ 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.”

²⁵ 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.

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 December 10, 2016 (the prior OIG Clinical Assessment Program site visit), through December 7, 2020.²⁶

**Table 11. Summary of Selected
Organizational Risk Factors
(December 10, 2016, through December 7, 2020)**

Factor	Number of Occurrences
Sentinel Events	17
Institutional Disclosures	11
Large-Scale Disclosures	0

Source: VA Salt Lake City Health Care System's Patient Safety and Risk Managers (received December 7, 2020).

The Director reported dedicating as much time as needed for quality activities, considering quality and safety as the system's top priority, and participating in discussions when institutional disclosures were warranted. In addition, the Director reported that the "morning report," the daily meeting to review organizational priorities and establish situational awareness, began with discussions on safety and incident reports. The OIG's review of the system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors.

²⁶ 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 Salt Lake City 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 Health Care System

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with “measures on healthcare quality, employee satisfaction, access to care, and efficiency.” Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.²⁷

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 VA Salt Lake City Health Care System’s performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of adjusted length of stay (LOS), rating (of) specialty care (SC) provider, care transition, and stress discussed). Metrics in the fourth and fifth quintiles (denoted in orange and red, respectively) are those that need improvement (for example, in the areas of mental health (MH) population (popu) coverage, health care (HC) associated (assoc) infections, and acute care 30-day standardized mortality ratio (SMR30)).²⁸

²⁷ “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.)

²⁸ For information on the acronyms in the SAIL metrics, please see appendix E.

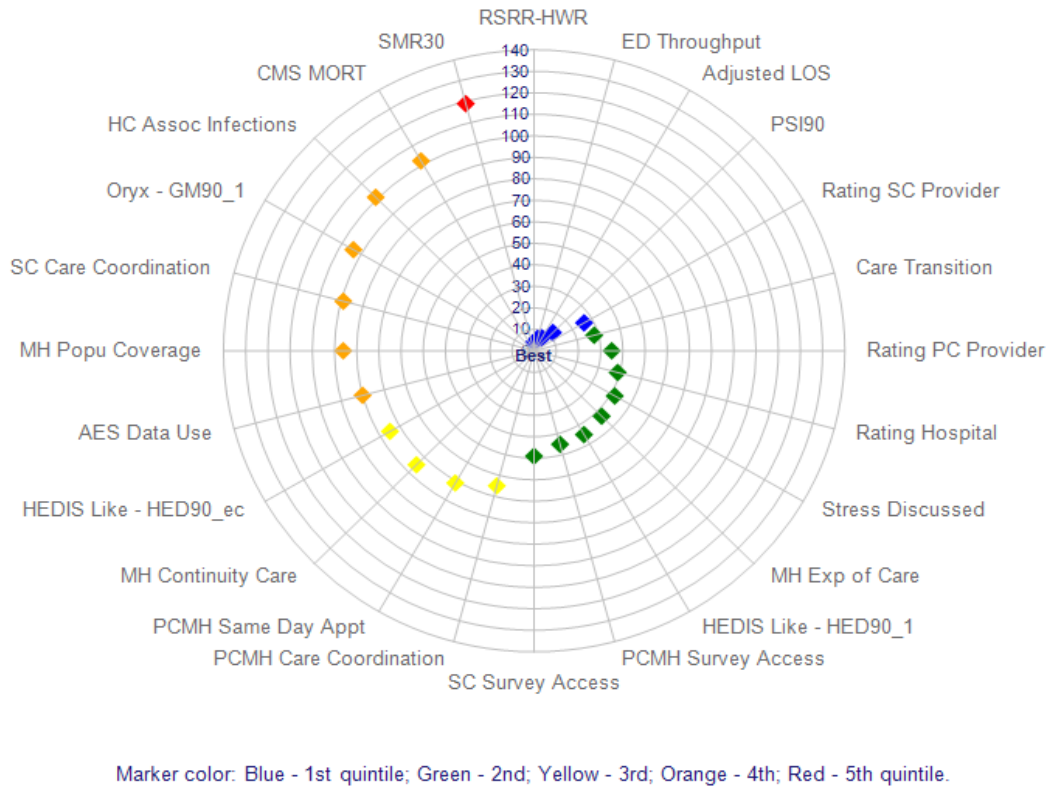


Figure 5. System quality of care and efficiency metric rankings, FY 2020 quarter 3 (as of June 30, 2020).

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

At the time of the inspection, the Chief of Staff and Director had served in their roles since 2012 and 2017, respectively. However, the remaining three executive leaders had recently assumed their positions within the past 10 months, with the least tenured leader joining the team in October 2020; thus, the executive team as a whole had only worked together for two months. The healthcare system managed organizational communications and accountability through a committee reporting structure, with the Executive Board overseeing various working groups. Leaders monitored patient safety and care through the Quality Safety Value Board, which tracked and trended quality of care and patient outcomes.

Selected employee satisfaction survey responses demonstrated satisfaction with most of the executive leaders and the workplace, and maintenance of an environment where staff felt respected and discrimination was not tolerated. Patient experience survey data implied satisfaction with the care provided. However, the OIG found that some inpatient and outpatient survey results for female respondents were less favorable than corresponding VHA averages.

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 selected VHA data used by the SAIL model. Additionally, they were able to speak in depth about actions taken to maintain or improve organizational performance, employee satisfaction, or patient experiences during the previous 12 months.

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.²⁹ VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.³⁰

During this time, VA continued providing 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.”³¹ “In effect, VHA facilities provide a safety net for the nation’s hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans.”³²

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

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

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.³³

²⁹ “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>.

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

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

³² VA OIG, *OIG Inspection of Veterans Health Administration’s COVID-19 Screening Processes and Pandemic Readiness, March 19–24, 2020*, Report No. 20-02221-120, March 26, 2020.

³³ VA OIG, *Comprehensive Healthcare Inspection of Facilities’ COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19*, Report No. 21-01699-175, July 7, 2021.

Quality, Safety, and Value

VHA’s goal is to serve as the nation’s leader in delivering high quality, safe, reliable, and veteran-centered care.³⁴ To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.³⁵ Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare “favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency.”³⁶

To determine whether VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the 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.”³⁷ 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

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

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

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

³⁷ VHA Directive 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.³⁸ 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.”³⁹ Peer reviews are “intended to promote confidential and non-punitive” processes that consistently contribute to quality management efforts at the individual provider level.⁴⁰ 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 unit⁴¹
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews⁴²
- 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

³⁸ 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.”

³⁹ VHA Directive 1190.

⁴⁰ VHA Directive 1190.

⁴¹ VHA Directive 1190.

⁴² 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.”⁴³ 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 events⁴⁴

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.⁴⁵

Quality, Safety, and Value Findings and Recommendations

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

⁴³ “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.)

⁴⁴ VHA Directive 1102.01(1), *National Surgery Office*, April 24, 2019, amended May 22, 2019.

⁴⁵ For CHIP visits, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

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.”⁴⁶ 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.”⁴⁷

VA requires all RNs to hold at least one active, unencumbered license.⁴⁸ 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.⁴⁹ 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.⁵⁰ 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.⁵¹

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 43 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 43 RNs to determine whether healthcare system staff completed primary source verification prior to the appointment.

⁴⁶ VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012.

⁴⁷ VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

⁴⁸ 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.”

⁴⁹ 38 U.S.C. § 7402.

⁵⁰ VHA Directive 2012-030.

⁵¹ VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

Generally, the healthcare system met the above requirements. Therefore, 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-19.⁵² 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.⁵³

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.⁵⁴ 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.⁵⁵

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."⁵⁶ The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.⁵⁷

To determine whether VHA facilities complied with requirements related to the administration of remdesivir, the OIG interviewed key employees and managers and reviewed the electronic health records of 46 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

⁵² 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.

⁵³ Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*.

⁵⁴ Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*, May 8, 2020.

⁵⁵ 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*.

⁵⁶ 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.

⁵⁷ 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)⁵⁸
 - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)⁵⁹
- 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, proper naming of medication orders, provision of required tests prior to administration of remdesivir, and reporting of adverse events to the FDA. However, the OIG identified deficiencies with patient/caregiver education.

Under the Emergency Use Authorization, the FDA 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; and advise them of known risks, benefits, and alternatives prior to administration.⁶⁰ For the 46 electronic health records reviewed, the OIG determined that 86 percent did not contain evidence that patients and/or caregivers were informed of the known and potential risks and benefits of remdesivir and 91 percent did not contain evidence that individuals were informed of alternatives prior to receiving remdesivir. This could have resulted in the patient and/or caregiver not being fully aware of the significant known and potential medication risks. An Infectious Disease Clinical Pharmacist stated that providers believed the “Infectious Diseases E-Consult Note” for the RDV [remdesivir] template met documentation requirements.

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

⁵⁸ “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.”

⁵⁹ “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.

⁶⁰ Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*.

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.⁶¹ The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.⁶² However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.⁶³

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

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

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

To determine whether VHA facilities complied with selected requirements for suicide risk screening and evaluation within EDs and UCCs, the OIG inspection team interviewed key employees and reviewed

- relevant documents;

⁶¹ “Preventing Suicide,” Centers for Disease Control and Prevention, accessed December 9, 2020, <https://www.cdc.gov/violenceprevention/suicide/fastfact.html>.

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

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

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

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

- the electronic health records of 45 randomly selected patients who were seen in the ED/UCC from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

The healthcare system complied with requirements related to suicide prevention screening within EDs and UCCs. However, staff responsible for suicide safety plan development had not consistently completed the required training.

VHA requires staff to complete suicide safety plan training prior to developing suicide prevention safety plans.⁶⁶ The OIG found that 6 of 11 staff responsible for suicide prevention safety plan development had not completed the mandatory training. Lack of staff training may lead to inadequate safety planning with patients who are at risk for suicide. The Suicide Prevention Coordinator and a Talent Management System Coordinator reported not being aware of the suicide safety plan training requirement.

Recommendation 1

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

⁶⁶ 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.

Healthcare system concurred.

Target date for completion: August 31, 2021

Healthcare system response: The Chief of Staff evaluated reasons for noncompliance and ensures that the staff responsible for suicide prevention safety plan development will have mandatory training completed. The Suicide Prevention Coordinator and Talent Management System Coordinator will work in conjunction to ensure suicide safety plan training requirements are completed. A TMS [Talent Management System] deficiency report will be run monthly and reviewed at the Suicide Prevention Committee to ensure compliance. Any deficiencies will be reported to the employee's direct supervisor for completion. As of June 21, 2021, there are 5 staff (99.1%) who are deficient in completing the TMS #36262 – Suicide Safety Planning Training. There are 593 staff would have been assigned the TMS #36262 – Suicide Safety Planning Training course.

Responsibility: The Chief of Mental Health will ensure staff responsible for suicide prevention safety plan development will have safety plan training completed timely at 95% compliance for 6 consecutive months or 2 consecutive quarters and report the results to the Suicide Prevention Committee.

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.⁶⁷

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 must use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.⁶⁸

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 50 patients who were transferred from the healthcare system due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The healthcare system complied with requirements for a facility policy addressing inter-facility transfers. However, the OIG identified deficiencies with monitoring and evaluation of inter-facility transfers, completion of the required *Inter-Facility Transfer Form*, transmission of active medication lists to receiving facilities, and communication between nurses at sending and receiving facilities.

⁶⁷ VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

⁶⁸ 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 that “all transfers are monitored and evaluated as part of VHA’s Quality Management Program.”⁶⁹ The Chief Nurse, Acute Care reported that inter-facility transfer data were not collected in FY 2020. This could have prevented potential improvements to the healthcare system’s inter-facility transfer processes. The Chief Nurse, Acute Care stated that monitoring of the transfer process was overlooked.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that inter-facility transfers are monitored and evaluated.

Healthcare system concurred.

Target date for completion: September 30, 2021

Healthcare system response: The Chief Nurse of Acute Care and the Chief of the Emergency Department collect and analyze data each month for all transfers. Opportunities for improvement and noncompliance are reported to the Patient Flow Committee quarterly. An action plan will be developed for any noted deficiencies in inter-facility transfers.

Responsibility: The Chief Nurse of Acute Care and the Chief of the Emergency Department will ensure inter-facility transfers are in compliance in accordance with VHA Directive 1094 – Inter-Facility Transfer Policy and develop an action plan for any deficiencies. VA Salt Lake City Health Care System will have 90% compliance for 6 consecutive months or 2 consecutive quarters and report the results to the Patient Flow Committee.

VHA requires appropriately-privileged providers to complete the *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record prior to an inter-facility patient transfer.⁷⁰ The OIG estimated that 89 percent of patient inter-facility transfer forms were not completed or cosigned by appropriately-privileged providers.⁷¹ This could have resulted in the unsafe transfer of patients, the inability to monitor and evaluate transfer data, and an incomplete medical record. The Chief of Emergency Medicine acknowledged noncompliance and explained that the healthcare system’s process requires review and revision.

⁶⁹ VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

⁷⁰ VHA Directive 1094.

⁷¹ The OIG estimated that 95 percent of the time, the true compliance rate is between 2.3 and 21.4 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 3

3. The Chief of Staff determines the reasons for noncompliance and ensures that appropriately-privileged providers complete or cosign the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note prior to inter-facility patient transfers.

Healthcare system concurred.

Target date for completion: August 31, 2021

Healthcare system response: On December 22, 2020, VA Salt Lake City modified the VA Form 10-2649A note template to include a co-signer which must be signed by the referring provider. All VA Form 10-2649A are reviewed to ensure proper completion, data is tracked on a monthly basis, and analyzed for compliance and opportunities to improve patient care. Data is reported to the Patient Flow Committee quarterly.

Responsibility: The Chief Nurse of Acute Care and the Chief of the Emergency Department will ensure that an appropriately privileged transferring provider completed or cosigned the VA Inter-Facility Transfer Form prior to inter-facility patient transfer and develop an action plan for any deficiencies. VA Salt Lake City Health Care System will have 90% compliance for 6 consecutive months or 2 consecutive quarters and report the results to the Patient Flow Committee.

VHA requires transferring physicians to send “all pertinent medical records available, including an active medication list” to receiving facilities during inter-facility patient transfers.⁷² The OIG estimated that physicians did not send an active medication list to the receiving facility for 23 percent of inter-facility patient transfers.⁷³ This could have resulted in suboptimal treatment decisions that compromised patient safety. The Chief of Emergency Medicine acknowledged noncompliance and expressed that transferring physicians provided medication lists to the receiving facilities but failed to communicate this in the electronic health record.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that transferring physicians send active medication lists to receiving facilities during inter-facility transfers.

⁷² VHA Directive 1094.

⁷³ The OIG estimated that 95 percent of the time, the true compliance rate is between 64.3 and 89.1 percent, which is statistically significantly below the 90 percent benchmark.

Healthcare system concurred.

Target date for completion: August 31, 2021

Healthcare system response: VA Salt Lake City Health Care System contacts the receiving facility and faxes discharge summary note, which contains a current medication list. The current medication list is also included on 10-2649A that is transferred as a hard copy with the patient. All VA Form 10-2649A are reviewed to ensure proper completion of a current medication list, data is tracked on a monthly basis, and analyzed for compliance and opportunities to improve patient care. Data is reported to the Patient Flow Committee quarterly.

Responsibility: The Chief Nurse of Acute Care and the Chief of the Emergency Department will ensure that an active medication list is present on the 10-2649A VA Inter-Facility Transfer Form prior to inter-facility patient transfer and develop an action plan for any deficiencies. VA Salt Lake City Health Care System will have 90% compliance for 6 consecutive months or 2 consecutive quarters and report the results to the Patient Flow Committee.

VHA states that “the accepting physician, or designee, must speak directly with the referring physician, or designee, regarding the care of the patient. A nurse-to-nurse contact for a patient report is also essential. These verbal communications need to allow for questions and answers from both transferring and receiving facilities.”⁷⁴ The OIG did not find evidence of nurse-to-nurse communication in an estimated 64 percent of inter-facility transfers.⁷⁵ This could have resulted in staff at the receiving facility lacking the information needed to care for patients. The Chief of Emergency Medicine acknowledged noncompliance and reported that nurse-to-nurse discussions were completed but not documented.

Recommendation 5

5. The Associate Director of Patient Care Services determines the reasons for noncompliance and ensures nurse-to-nurse communication occurs between sending and receiving facilities.

⁷⁴ VHA Directive 1094.

⁷⁵ The OIG estimated that 95 percent of the time, the true compliance rate is between 22.7 and 51.1 percent, which is statistically significantly below the 90 percent benchmark.

Healthcare system concurred.

Target date for completion: October 31, 2021

Healthcare system response: VA Salt Lake City Health Care System updated our nursing transfer note to reflect a nurse-to-nurse report on December 22, 2020. The Associate Director of Patient Care Services (ADPCS) will ensure nurse-to-nurse contact occurs between sending and receiving facilities. Data is reported to the Patient Flow Committee quarterly.

Responsibility: The Chief Nurse of Acute Care and the Chief of the Emergency Department will ensure that a nurse-to-nurse report is documented prior to an inter-facility patient transfer and develop an action plan for any deficiencies. VA Salt Lake City Health Care System will have 90% compliance for 6 consecutive months or 2 consecutive quarters and report the results to the Patient Flow Committee.

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.”⁷⁶ 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.”⁷⁷ 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 team⁷⁸
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings⁷⁹
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction⁸⁰
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants⁸¹

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

⁷⁶ VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

⁷⁷ VHA Directive 2012-026.

⁷⁸ 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.”

⁷⁹ 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.”

⁸⁰ 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.”

⁸¹ 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.”

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 must complete parts 1, 2, and 3 of the training.⁸² VHA also requires that employee threat assessment team members complete the appropriate team-specific training.⁸³ The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The OIG determined that the healthcare system complied with many of the requirements for the management of disruptive and violent behavior. However, the OIG found deficiencies with the completion of required training.

VHA requires that staff are assigned prevention and management of disruptive behavior part 1 training at hire and additional levels of training based on the Workplace Behavioral Risk Assessment.⁸⁴ The OIG found that 12 of 30 selected staff did not complete the required part 1 training. This could have resulted in lack of awareness, preparedness, and precautions when responding to disruptive behavior. A Prevention and Management of Disruptive Behavior Coordinator stated that the COVID-19 pandemic potentially affected supervisors' ability to ensure completion of required training for these employees who were hired within the nine months prior to the inspection.

Recommendation 6

6. The System Director evaluates and determines any additional reasons for noncompliance and ensures that staff complete the required prevention and management of disruptive behavior training.

⁸² DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMD) Training Assignments*, February 24, 2020.

⁸³ DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018.

⁸⁴ DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMD) Training Assignment*.

Healthcare system concurred.

Target date for completion: August 31, 2021

Healthcare system response: The education department reviewed staff learning plans for correct assignment of PMDB [prevention and management of disruptive behavior] and corrected any errors. All classes for new employees will be scheduled in New Employee Orientation (NEO) with emails sent out to managers to inform dates the new employee is to attend these classes.

The Chief of Education and Talent Management System Coordinator will work in conjunction to ensure PMDB training requirements are completed. A TMS deficiency report will be run monthly and reviewed at Disruptive Behavior Committee to ensure compliance. Any deficiencies will be reported to the employee's direct supervisor for completion. They will further notify the Senior Leadership Team of staff who fail to comply with training requirements. Enforcement of these requirements will include suspension of access to the computer system until compliant. As of June 21, 2021, there are 17 staff who are deficient in completing the PMDB training out of 2888 staff assigned.

Responsibility: The Chief of Education will ensure that PMDB training completed timely at 95% compliance for 6 consecutive months or 2 consecutive quarters and report the results to the Disruptive Behavior Committee.

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 six recommendations on systemic issues that may adversely affect patients. While the OIG's recommendations are not 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 six OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, and ADPCS. The intent is for 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) 	<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 Staff feedback 	The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<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"> • None
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 mandatory suicide safety plan training prior to developing suicide prevention 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"> • Appropriately-privileged providers complete or cosign the <i>VA Inter-Facility Transfer Form</i> or a facility-defined equivalent note prior to inter-facility patient transfers. • Transferring physicians send active medication lists to receiving facilities during inter-facility transfers. • Nurse-to-nurse communication occurs between sending and receiving facilities. 	<ul style="list-style-type: none"> • Inter-facility 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"> • Staff complete the required prevention and management of disruptive behavior training.

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 Salt Lake City Health Care System (660)
(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	\$567,525,509	\$622,812,877	\$759,878,707
Number of:			
• Unique patients	65,271	66,898	67,780
• Outpatient visits	708,553	685,498	631,303
• Unique employees§	2,267	2,428	2,432
Type and number of operating beds:			
• Domiciliary	15	15	15
• Medicine	47	45	45
• Mental health	30	30	30
• Rehabilitation medicine	5	3	3
• Surgery	31	21	21
Average daily census:			
• Domiciliary	14	13	11
• Medicine	33	33	29
• Mental health	20	24	22
• Rehabilitation medicine	3	3	3

¹ “Facility Complexity Model,” VHA Office of Productivity, Efficiency & Staffing (OPES), accessed August 20, 2021, <http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx>. (This is an internal website not publicly accessible.) 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‡
• Surgery	12	12	8

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
Pocatello, ID	660GA	4,681	1,904	Cardiology Dermatology Gastroenterology Nephrology	EKG Laboratory & Pathology	Nutrition Pharmacy Weight management
South Ogden, UT	660GB	7,615	647	Anesthesia Cardiology Gastroenterology Podiatry	EKG Laboratory & Pathology	Nutrition Pharmacy Social work Weight management
Roosevelt, UT	660GD	1,069	107	Cardiology Gastroenterology	Laboratory & Pathology	–

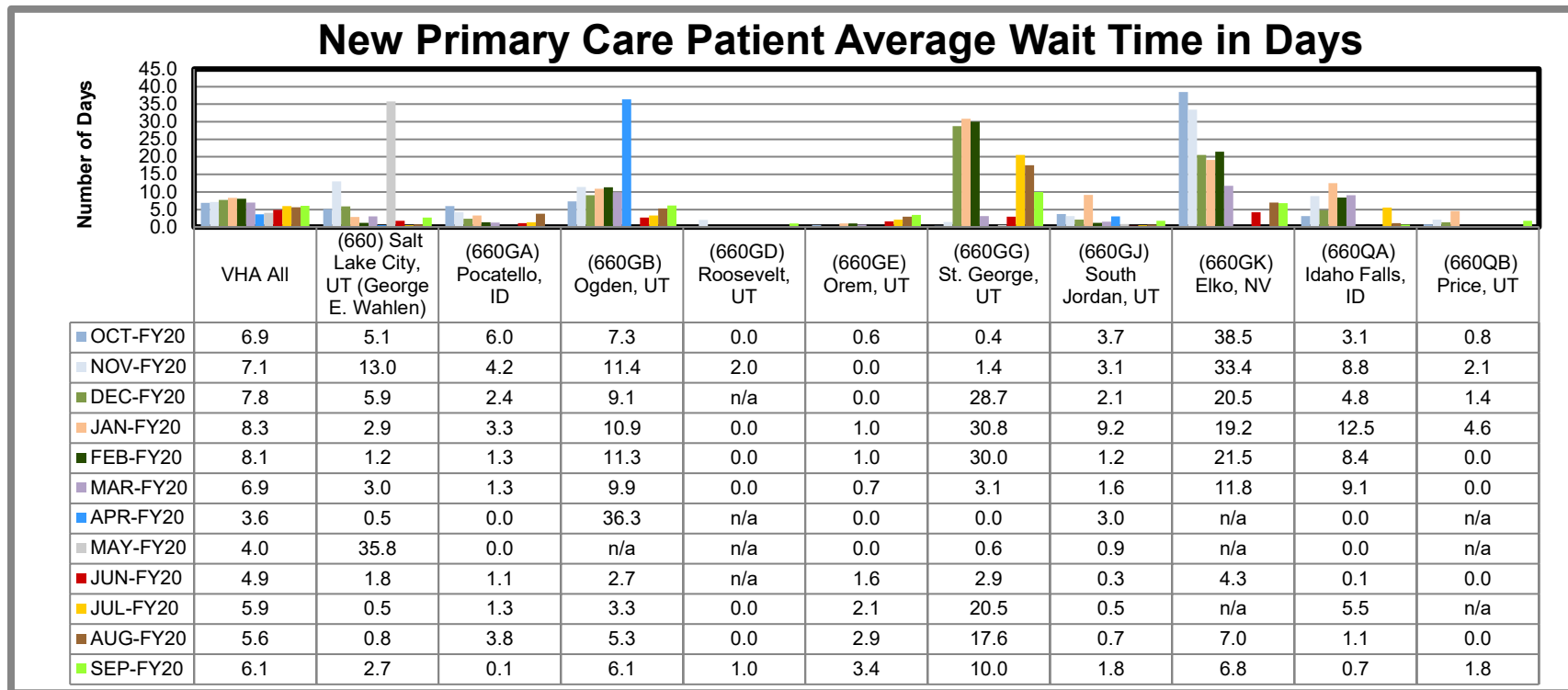
¹ The OIG omitted (660QD) North Logan, UT as no workload/encounters or services were reported. VHA Directive 1230(4), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended June 17, 2021. An encounter is a “professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.” Specialty care services refer to non-primary care and non-mental health services provided by a physician.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Orem, UT	660GE	3,067	2,617	Cardiology Gastroenterology	EKG Laboratory & Pathology	Nutrition Pharmacy Weight management
St. George, UT	660GG	7,538	1,181	Cardiology Dermatology Gastroenterology Nephrology	EKG Laboratory & Pathology	Nutrition Pharmacy Weight management
South Jordan, UT	660GJ	8,923	876	–	EKG Laboratory & Pathology	Nutrition Pharmacy Weight management
Elko, NV	660GK	1,127	127	Gastroenterology	EKG Laboratory & Pathology	Nutrition
Idaho Falls, ID	660QA	4,561	833	Anesthesia Cardiology Dermatology Gastroenterology	EKG Laboratory & Pathology	Nutrition Pharmacy Weight management
Price, UT	660QB	709	116	Gastroenterology	EKG Laboratory & Pathology	Nutrition Pharmacy Weight management
South Ogden, UT	660QC	–	2,981	–	–	–

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

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

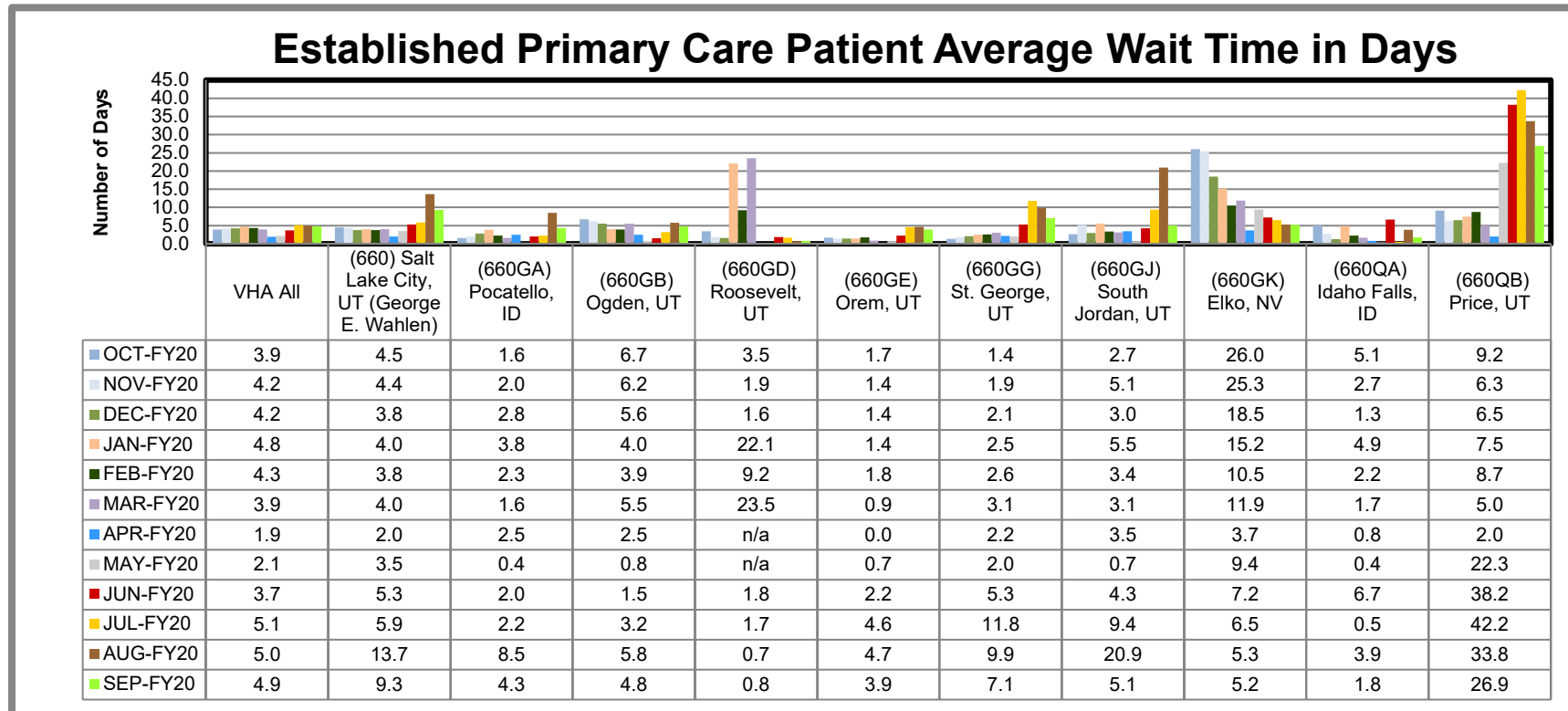
Appendix D: Patient Aligned Care Team Compass Metrics



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 Ogden and Elko community-based outpatient clinics. The OIG omitted (660QC) South Ogden, UT and (660QD) North Logan, UT 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."



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 Price Community Based Outpatient Clinic. The OIG omitted (660QC) South Ogden, UT and (660QD), North Logan, UT 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: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 30, 2021

From: Director, Rocky Mountain Network (10N19)

Subj: Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah

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

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

I have reviewed the findings within the Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah. I agree with the findings of the review.

(Original signed by:)

Ralph T. Gigliotti, FACHE

Director, VA Rocky Mountain Network

Appendix G: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: June 29, 2021

From: Director, VA Salt Lake City Health Care System (660/00)

Subj: Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah

To: Ralph T. Gigliotti, Director, Rocky Mountain Network (10N19)

I have reviewed the findings within the Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah. I agree with the findings of the review.

The plan of corrective actions and target dates have been established.

(Original signed by:)

Shella Stovall, MNA, RN

Director, VA Salt Lake City Healthcare System

OIG Contact and Staff Acknowledgments

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