



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the VA Maine
Healthcare System in
Augusta



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Figure 1. VA Maine Healthcare System in Augusta.

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

Abbreviations

| | |
|----------|---|
| ADPNS | Associate Director for Patient and Nursing Services |
| CHIP | Comprehensive Healthcare Inspection Program |
| CLC | community living center |
| COVID-19 | coronavirus disease |
| FY | fiscal year |
| OIG | Office of Inspector General |
| OBR | Order of Behavioral Restriction |
| QSV | quality, safety, and value |
| RN | registered nurse |
| SAIL | Strategic Analytics for Improvement and Learning |
| 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 Maine Healthcare System, which includes multiple outpatient clinics in Maine. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

1. COVID-19 pandemic readiness and response¹
2. Quality, safety, and value
3. Registered nurse credentialing
4. Medication management (targeting remdesivir use)²
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 Maine Healthcare System during the week of January 25, 2021. 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

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)."

² The OIG's review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the VA Maine Healthcare System because staff did not administer remdesivir during the review period.

report may help this healthcare system and other Veterans Health 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 11 recommendations to the System Director, Chief of Staff, and Associate Director for Patient and Nursing 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 and Nursing Services, Associate Director for Business Operations, and Associate Director for Facility Operations. Organizational communications and accountability were managed through a committee reporting structure, with Executive Committee of the Governing Body oversight of several working groups. 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.

When the OIG conducted this inspection, the healthcare system's leaders had worked together for eight months. The Director and two other executive leaders had served in their positions for over one year. The Chief of Staff and Associate Director for Facility Operations, assigned in 2020, were the newest leaders.

During an interview with the OIG, the Director indicated the fiscal year 2020 budget increase helped the healthcare system acquire needed equipment and supplies, support system operations, and finance capital investments. However, leaders also described various hiring and recruitment challenges and the strategies taken to address them.

Specific employee satisfaction survey data revealed that the system's averages for selected leadership, workplace, and workgroup relationship questions were similar to or higher than the VHA averages. The OIG noted the same trend for the executive leaders. Patient experience survey scores generally reflected higher care ratings than the VHA averages. However, survey results highlighted opportunities to improve experiences for female veterans related to courtesy from doctors while hospitalized and availability of routine specialty care appointments when needed.

The OIG’s review of accreditation findings, sentinel events, and disclosures of adverse patient events did not identify any substantial organizational risk factors.³

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with “measures on healthcare quality, employee satisfaction, access to care, and efficiency.” Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.⁴

In individual interviews, the executive leaders were able to speak in depth about actions taken during the previous 12 months to maintain or improve employee satisfaction and patient experiences. The executive leaders were also knowledgeable within their scope of responsibilities about VHA data and system-level factors contributing to poor performance on specific system and Community Living Center SAIL measures and should continue to take actions to improve performance.⁵

COVID-19 Pandemic Readiness and Response

The OIG will report 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.

Quality, Safety, and Value

The healthcare system complied with requirements for a committee responsible for quality, safety, and value oversight functions. However, the OIG identified opportunities for improvement with the Systems Redesign and Improvement Program, Peer Review Committee, and Surgical Work Group.

Care Coordination

Generally, the healthcare system met expectations for the transmission of the patient’s active medication list to the receiving facility. However, the OIG found deficiencies with the current

³ 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.”

⁴ “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.)

⁵ VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers*, June 1, 2017. Community living centers, previously known as nursing home care units, provide a skilled nursing environment and a variety of interdisciplinary programs for persons needing short- and long-stay services.

inter-facility transfer policy, patient transfer monitoring and evaluation, VA *Inter-Facility Transfer Form* or equivalent note completion by an appropriate provider, and nurse-to-nurse communication between sending and receiving facilities. In addition, the OIG noted noncompliance with the transmission of patients' advance directives to receiving facilities.

High-Risk Processes

The healthcare system met many of the key processes for the management of disruptive and violent behavior. However, the OIG noted concerns with a required representative attending Disruptive Behavior Committee meetings, patient notification of an Order of Behavioral Restriction, and staff training.

Conclusion

The OIG conducted a detailed inspection across seven key areas (two administrative and five clinical) and subsequently issued 11 recommendations for improvement to the System Director, Chief of Staff, and Associate Director for Patient and Nursing Services. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for system leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues and other less-critical findings that may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 60–61, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendation 4 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Maine Healthcare 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
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)

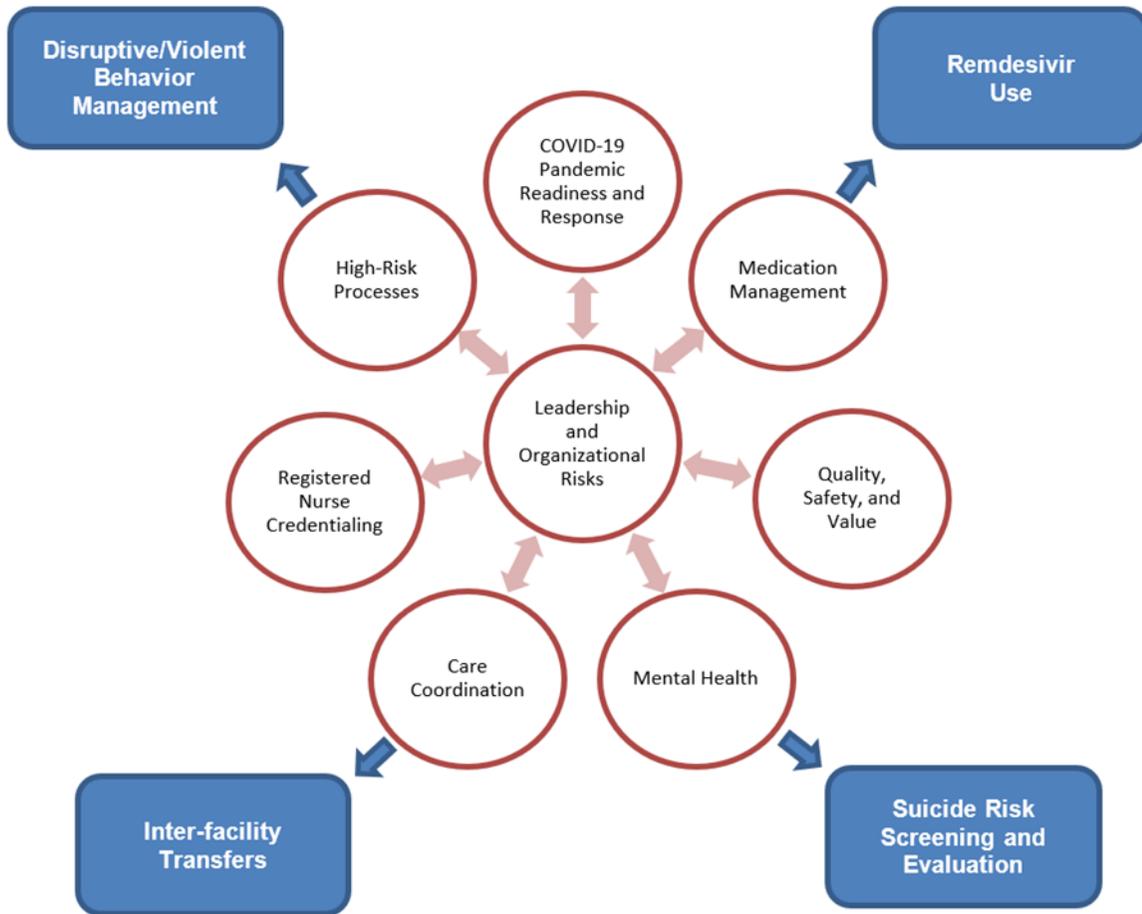


Figure 2. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.

Source: VA OIG.

⁶ The OIG’s review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the VA Maine Healthcare System because staff did not administer remdesivir during the review period.

Methodology

The VA Maine Healthcare System includes multiple outpatient clinics in Maine. 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.⁷ The team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection examined operations from June 30, 2018, through January 29, 2021, the last day of the unannounced multiday evaluation.⁸ During the virtual site visit, the OIG did not receive any complaints beyond the scope of the inspection.

The OIG will report 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.

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 Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that system leaders developed based on the reasons for noncompliance.

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

⁷ The OIG did not review VHA's internal survey results and instead focused on OIG inspections and external surveys that affect facility accreditation status.

⁸ The range represents the time period from the prior CHIP site visit to the completion of the unannounced, multiday virtual CHIP visit in January 2021.

⁹ Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

Leadership and Organizational Risks

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

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the healthcare system response
8. VHA performance data (healthcare system)
9. VHA performance data (community living center (CLC))¹¹

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this healthcare system's reported organizational structure. The healthcare system had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient and Nursing Services (ADPNS), Associate Director for Business Operations, and Associate Director for Facility Operations. The Chief of Staff and ADPNS oversaw patient care, which required managing service directors and chiefs of programs and practices.

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

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

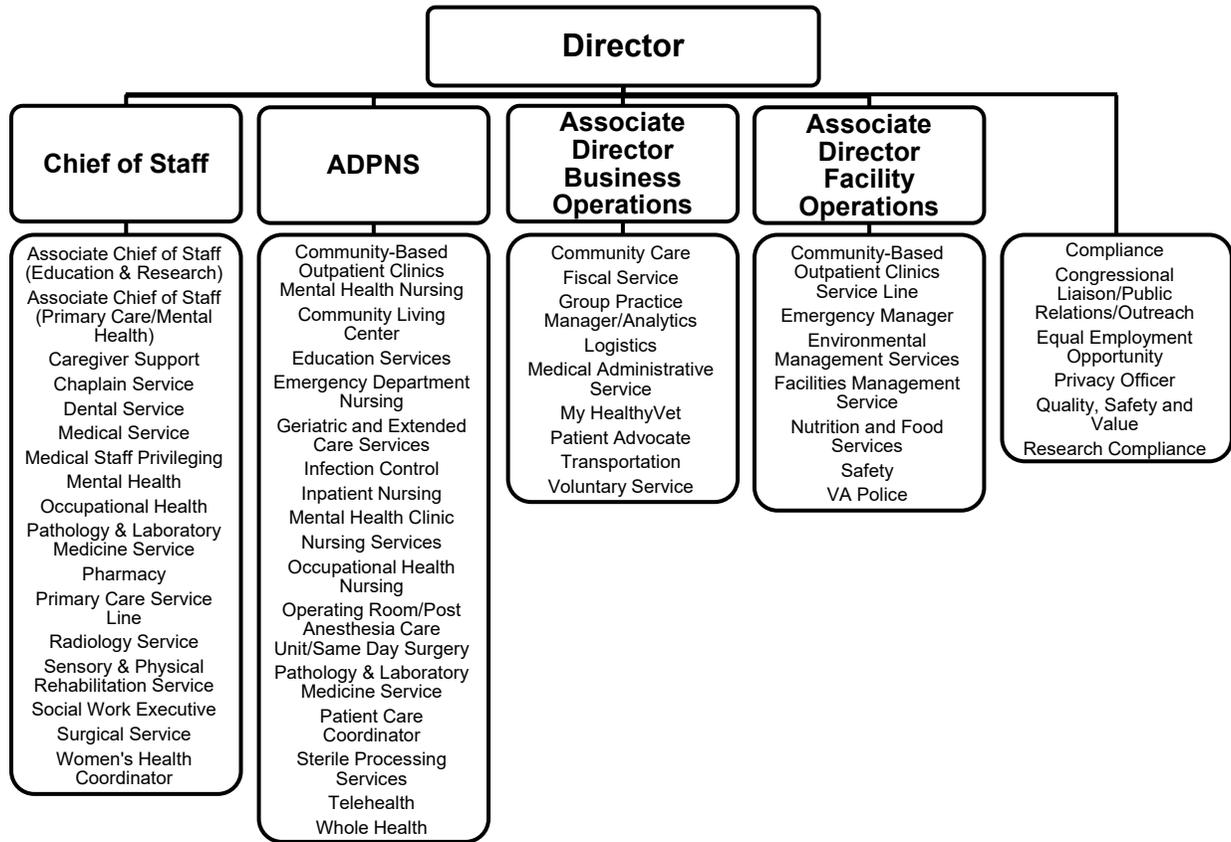


Figure 3. Healthcare system organizational chart.

Source: VA Maine Healthcare System (received January 25, 2021).

At the time of the OIG inspection, the executive leadership team appeared stable and had worked together for eight months. The Director had served for over one year, and two other leaders had been in their positions for over two years. The previous Quality, Safety and Value Chief served as acting Associate Director for Facility Operations beginning in September 2019 before being permanently assigned in March 2020. The Chief of Staff was the newest member of the leadership team (see table 1).

Table 1. Executive Leader Assignments

| Leadership Position | Assignment Date |
|--|-----------------|
| System Director | April 14, 2019 |
| Chief of Staff | May 10, 2020 |
| ADPNS | August 1, 2010 |
| Associate Director for Business Operations | August 5, 2018 |
| Associate Director for Facility Operations | March 29, 2020 |

Source: VA Maine Healthcare System’s Senior Strategic Business Partner (received January 25, 2021).

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

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific system Strategic Analytics for Improvement and Learning (SAIL) and CLC 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. These are discussed in greater detail below.

The Director served as the chairperson of the Executive Committee of the Governing Body, which has the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Committee of the Governing Body oversaw various working groups, such as the Resource Management, Clinical Executive, and Nursing Executive Boards.

System 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 Committee of the Governing Body (see figure 4).

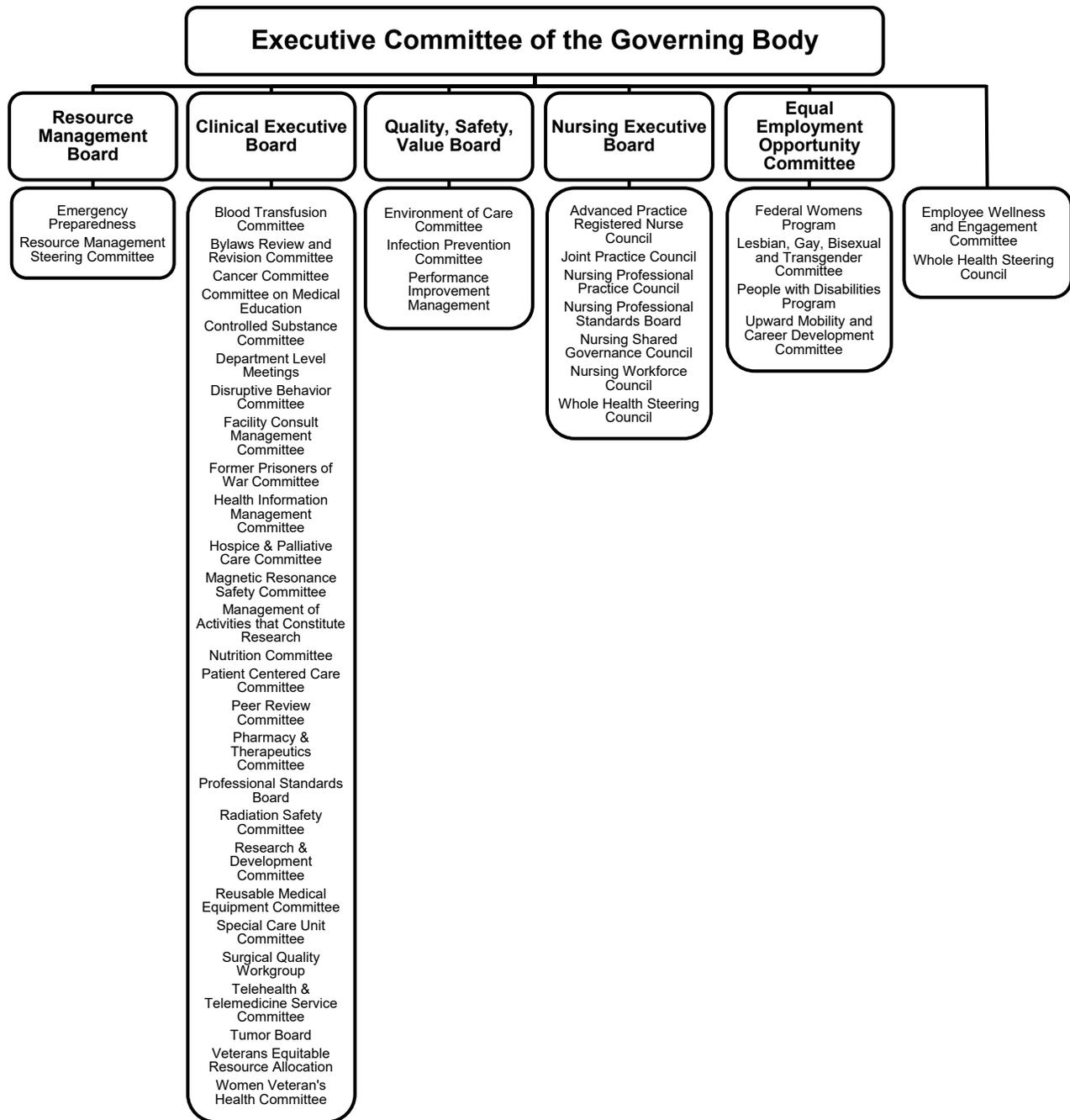


Figure 4. Healthcare system committee reporting structure.
 Source: VA Maine Healthcare System (received January 25, 2021).

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of \$469,667,457 increased by approximately 16.7 percent compared to the previous year's budget of \$402,479,721.¹² When asked about the effect of this change on the healthcare system's operations, the Director indicated that the additional funds helped acquire needed equipment and supplies, supported system operations, and financed capital investments, such as upgrading and renovating Sterile Processing Services.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.¹³ Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.¹⁴ In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.¹⁵

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.¹⁶ The executive leaders reported that while the top clinical and nonclinical shortages listed in table 2 remain a priority, the healthcare system was experiencing ongoing recruitment and retention challenges with mental health providers, medical support assistants, Environmental Management Service employees, and Nutrition and Food Service workers. To address mental health provider recruitment challenges, the Chief of Staff cited developing a nurse practitioner mental health residency program to supplement staffing for these positions. The ADPNS reported implementing several strategies to address the nursing shortage. These strategies included hiring several critical care and medical-surgical nurses as well as a dedicated nurse recruiter to support ongoing recruitment and retention efforts. The Associate Director for Facility Operations reported working with VISN 1 to raise the salary for engineers and offered incentives such as overtime pay. The executive team explained that because information

¹² VHA Support Service Center.

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

¹⁴ VA Choice and Quality Employment Act of 2017, Pub. L. No. 115-46 (2017); VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*, Report No. 20-01249-259, September 23, 2020.

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

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

technology staff report to the VISN, addressing the shortage was beyond the system leaders’ purview.

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

| Top Clinical Staffing Shortages | Top Nonclinical Staffing Shortages |
|--|--------------------------------------|
| 1. Registered Nurse (RN) Staff–Inpatient CLC | 1. General Engineering |
| 2. RN Staff–Inpatient Mental Health | 2. Information Technology Management |
| 3. RN Staff–Inpatient | 3. – |
| 4. RN Staff–Critical Care | 4. – |
| 5. RN Staff–Outpatient Mental Health | 5. – |

Source: VA OIG.

Employee Satisfaction

The All Employee Survey “is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential.”¹⁷ Since 2001, the instrument has been refined several times in response to VA leaders’ inquiries on VA culture and organizational health.¹⁸ Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA’s All Employee Survey from October 1, 2019, through September 30, 2020.¹⁹ Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA’s All Employee Survey. The OIG found the healthcare system average for the selected survey leadership questions was similar to or higher than the VHA average and noted the same trend for the executive leaders.²⁰ The OIG found that survey scores for the Director were notably higher than those for VHA, the healthcare system, and other members of the leadership team.²¹

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

¹⁸ “AES Survey History.”

¹⁹ Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPNS, and Associate Directors for Facility and Business Operations.

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

²¹ The 2020 All Employee Survey results are not entirely reflective of employee satisfaction with the current Chief of Staff, who assumed the role a few months before the survey was administered.

Table 3. Survey Results on Employee Attitudes toward Healthcare System Leaders (October 1, 2019, through September 30, 2020)

| Questions/ Survey Items | Scoring | VHA Average | Health- care System Average | Director Average | Chief of Staff Average | ADPNS Average | Assoc. Director for Business Operations Average | Assoc. Director for Facility Operations Average |
|--|--|----------------|--------------------------------------|---------------------|------------------------------|------------------|--|---|
| All Employee Survey: <i>Servant Leader Index Composite.*</i> | 0–100 where higher scores are more favorable | 73.5 | 76.0 | 97.9 | 77.4 | 85.4 | 84.2 | 93.9 |
| 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 | 3.5 | 4.9 | 3.7 | 4.4 | 3.6 | 4.6 |
| 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 | 5.0 | 3.9 | 4.4 | 3.9 | 4.8 |
| All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i> | 1 (Strongly Disagree)–5 (Strongly Agree) | 3.7 | 3.8 | 5.0 | 3.8 | 4.4 | 3.8 | 4.6 |

Source: VA All Employee Survey (accessed December 21, 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.²² The healthcare system average for the selected survey questions was similar to or better than the VHA average. Scores for the executive leaders were generally better than those for VHA and the healthcare system.

**Table 4. Survey Results on Employee Attitudes toward the Workplace
(October 1, 2019, through September 30, 2020)**

| Questions/ Survey Items | Scoring | VHA Average | Health- care System Average | Director Average | Chief of Staff Average | ADPNS Average | Assoc. Director for Business Operations Average | Assoc. Director for Facility Operations 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 | 4.8 | 4.0 | 4.0 | 4.2 | 5.0 |
| 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 | 4.6 | 3.8 | 4.3 | 4.3 | 4.3 |

²² Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPNS, and Associate Directors for Business and Facility Operations.

| Questions/ Survey Items | Scoring | VHA Average | Health- care System Average | Director Average | Chief of Staff Average | ADPNS Average | Assoc. Director for Business Operations Average | Assoc. Director for Facility Operations Average |
|--|-----------------------------|----------------|--------------------------------------|---------------------|------------------------------|------------------|--|---|
| 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 | 1.2 | 1.1 | 1.6 | 0.9 | 1.6 | 0.8 |

Source: VA All Employee Survey (accessed December 21, 2020).

VHA leaders have articulated that the agency “is committed to a harassment-free health care environment.”²³ 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.²⁴

The Director expressed commitment to a harassment-free environment and reported actions taken to create a culture of safety. These actions included allowing the Equal Employment Opportunity Committee to shift focus and become the Diversity and Inclusion Committee, developing action plans to protect whistleblowers, and meeting with resolution management personnel to discuss implicit bias and generational diversity.²⁵

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA’s All Employee Survey responses. The healthcare system and executive leadership team 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.

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

²⁴ “Stand Up to Stop Harassment Now!”

²⁵ Merriam Webster, *Definition of Implicit Bias*, accessed June 29, 2021, <https://www.merriam-webster.com/dictionary/implicit%20bias>. Implicit bias refers to “a bias or prejudice that is present but not consciously held or recognized.”

Table 5. Survey Results on Employee Attitudes toward Workgroup Relationships (October 1, 2019, through September 30, 2020)

| Questions/ Survey Items | Scoring | VHA Average | Health- care System Average | Director Average | Chief of Staff Average | ADPNS Average | Assoc. Director for Business Operations Average | Assoc. Director for Facility Operations Average |
|--|--|----------------|--------------------------------------|---------------------|------------------------------|------------------|---|---|
| All Employee Survey: <i>People treat each other with respect in my workgroup.</i> | 1 (Strongly Disagree)– 5 (Strongly Agree) | 3.9 | 4.0 | 4.7 | 4.0 | 4.7 | 4.5 | 5.0 |
| All Employee Survey: <i>Discrimination is not tolerated at my workplace.</i> | 1 (Strongly Disagree)– 5 (Strongly Agree) | 4.0 | 4.3 | 4.7 | 4.3 | 4.5 | 4.6 | 4.9 |
| 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 | 4.8 | 3.9 | 4.4 | 4.4 | 4.7 |

Source: VA All Employee Survey (accessed December 21, 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 September 30, 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 VA Maine Healthcare System.²⁶ For this system, the overall patient satisfaction survey results reflected higher care ratings than the VHA averages. Patients appeared satisfied with the care provided.

²⁶ Ratings are based on responses by patients who received care at this healthcare system.

**Table 6. Survey Results on Patient Experience
(October 1, 2019, through September 30, 2020)**

| Questions | Scoring | VHA Average | Healthcare System Average |
|---|--|-------------|---------------------------|
| Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i> | The response average is the percent of “Definitely Yes” responses. | 69.5 | 77.4 |
| 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. | 82.5 | 87.9 |
| 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. | 84.8 | 89.4 |

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 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 2048.²⁷ 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 OIG noted opportunities to improve experiences for female veterans related to courtesy from doctors while hospitalized and availability of routine specialty care appointments when needed. Despite these scores, both male and female veterans would recommend the hospital to family and friends. Patient-centered medical home and specialty care provider scores were more favorable than corresponding VHA averages.

²⁷ “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 September 30, 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 | 64.5 | 77.4 | 76.2 |
| <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 | 84.8 | 90.6 | 76.9 |
| <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 | 83.3 | 91.3 | 95.5 |

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 20, 2020).

**The VHA averages are based on 48,907–49,521 male and 2,395–2,423 female respondents, depending on the question.*

†The healthcare system averages are based on 380–388 male and 14–15 female respondents, depending on the question.

Table 8. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2019, through September 30, 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). | 51.3 | 44.0 | 53.5 | 44.8 |
| <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). | 59.5 | 53.0 | 64.3 | 61.6 |
| <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). | 74.0 | 68.9 | 74.7 | 77.7 |

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 20, 2020).

*The VHA averages are based on 74,278–223,617 male and 6,158–13,836 female respondents, depending on the question.

†The healthcare system averages are based on 732–2,159 male and 48–108 female respondents, depending on the question.

Table 9. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2019, through September 30, 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). | 50.5 | 47.3 | 64.8 | 53.2 |
| <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). | 57.4 | 54.3 | 65.5 | 44.1 |
| <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 | 72.2 | 79.1 | 83.2 |

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 20, 2020).

*The VHA averages are based on 63,661–187,441 male and 3,777–10,616 female respondents, depending on the question.

†The healthcare system averages are based on 437–1,218 male and 22–66 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspection and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.²⁸

The healthcare system had not undergone a survey by The Joint Commission since the prior CHIP site visit. Table 10 summarizes the relevant system inspection most recently performed by

²⁸ “Profile Definitions and Methodology: Joint Commission Accreditation,” *American Hospital Directory*, accessed December 12, 2020, https://www.ahd.com/definitions/prof_accred.html. “The Joint Commission conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.”

the OIG. At the time of the OIG review, the system had closed all recommendations for improvement issued since the previous CHIP site visit conducted in June 2018. The OIG team also noted results from the Long Term Care Institute’s inspection of the system’s CLC.²⁹

Table 10. Office of Inspector General Inspection

| Accreditation or Inspecting Agency | Date of Visit | Number of Recommendations Issued | Number of Recommendations Remaining Open |
|--|---------------|----------------------------------|--|
| OIG (<i>Comprehensive Healthcare Inspection Program Review of the VA Maine Healthcare System, Augusta, Maine</i> , Report No. 18-01152-14, November 28, 2018) | June 2018 | 7 | 0 |

Source: OIG.

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

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

Table 11 lists the reported patient safety events from June 30, 2018 (the prior OIG CHIP site visit), through January 24, 2021.³⁰

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

³⁰ It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The VA Maine Health Care System is a medium complexity (2) 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.”

Table 11. Summary of Selected Organizational Risk Factors (June 30, 2018, through January 24, 2021)

| Factor | Number of Occurrences |
|---------------------------|-----------------------|
| Sentinel Events | 5 |
| Institutional Disclosures | 2 |
| Large-Scale Disclosures | 0 |

Source: VA Maine Healthcare System’s Risk Manager (received January 25, 2021).

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

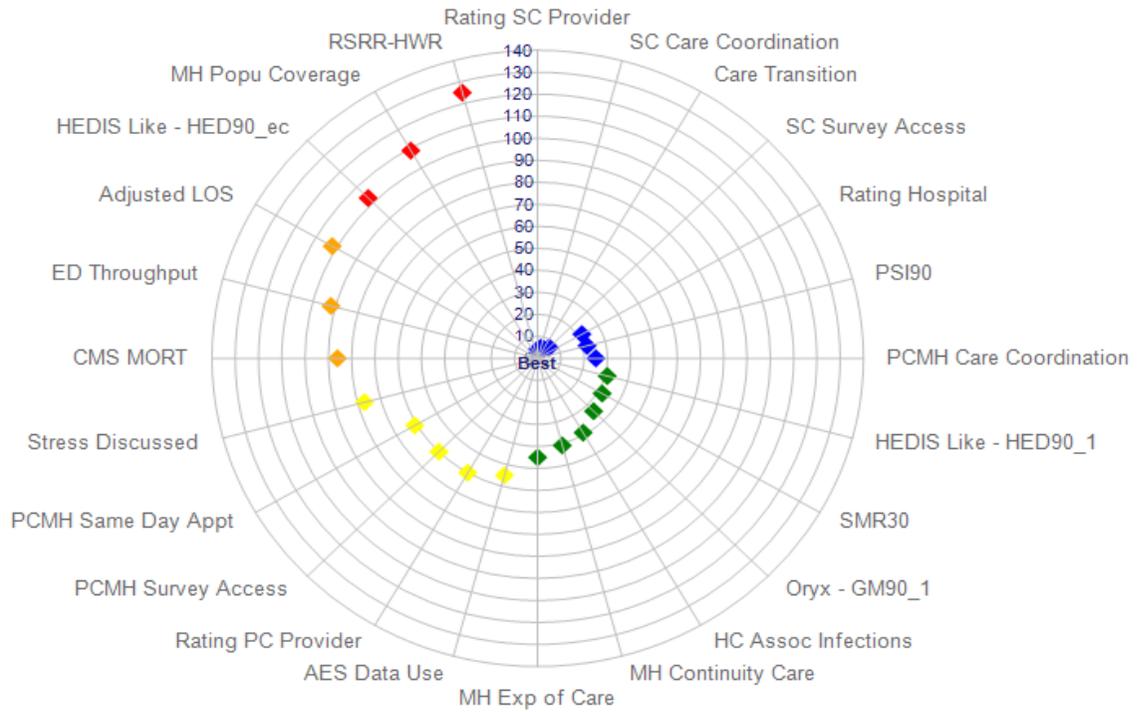
Veterans Health Administration Performance Data for the Healthcare System

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with “measures on healthcare quality, employee satisfaction, access to care, and efficiency.” Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.³¹

Figure 5 illustrates the healthcare system’s quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2020. Figure 5 shows the 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 specialty care (SC) care coordination, care transition, and health care (HC) associated (assoc) infections). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, emergency department (ED) throughput, adjusted length of stay (LOS), and mental health (MH) population (popu) coverage).³²

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

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



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

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

Source: VHA Support Service Center.

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

Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to “summarize and compare performance of CLCs in the VA.”³³ The model “leverages much of the same data” used in the Centers for Medicare & Medicaid Services’ (CMS) *Nursing Home Compare* and provides a single resource “to review quality measures and health inspection results.”³⁴

³³ Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC): A tool to examine Quality Using Internal VA Benchmarks*, July 16, 2021. “In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several “star” ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality, making meaningful distinctions between high and low performing nursing homes.”

³⁴ Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC): A tool to examine Quality Using Internal VA Benchmarks*.

Figure 6 illustrates the healthcare system’s CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. Figure 6 displays the system’s CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of physical restraints–long-stay (LS), high risk pressure ulcers (PU) (LS), and urinary tract infections (UTI) (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, help with activities of daily living (ADL) (LS), catheter in bladder (LS), moderate-severe pain (LS), and falls with major injury (LS)).³⁵ Various opportunities exist for executive leaders to take action to improve CLC quality measures.

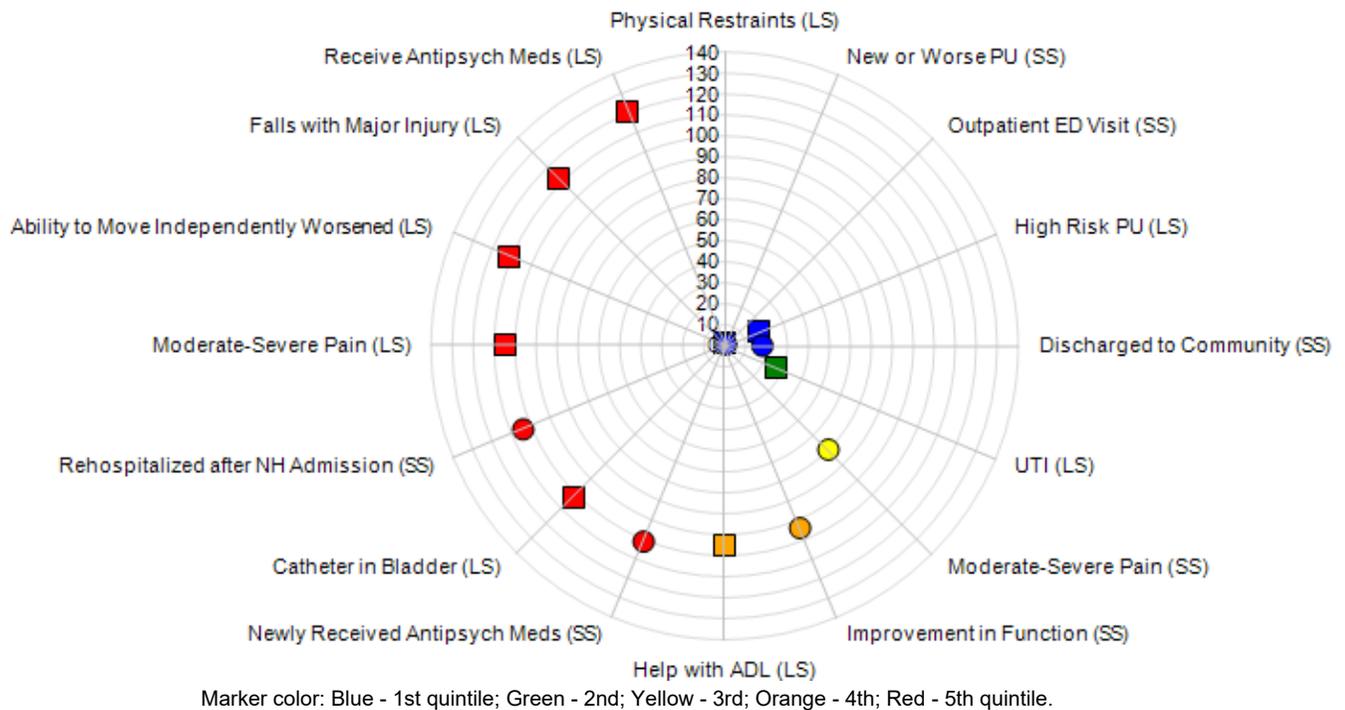


Figure 6. VA Maine Healthcare System CLC quality measure rankings for FY 2020 quarter 3 (as of June 30, 2020).

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

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

The healthcare system’s executive leadership team appeared stable, given that all positions were permanently assigned at the time of the OIG virtual review. The system managed organizational communications and accountability through a committee reporting structure with the Executive Committee of the Governing Body overseeing several working groups, including the Resource

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

Management, Clinical Executive, and Nursing Executive Boards. Leaders monitored patient safety and care through the Quality, Safety, Value Board, which tracked and trended quality of care and patient outcomes.

During an interview with the OIG, the Director indicated the FY 2020 budget increase helped the healthcare system acquire needed equipment and supplies, support system operations, and finance capital investments. To address the clinical nursing shortages, leaders hired several critical care and medical-surgical nurses as well as a dedicated nurse recruiter to support ongoing recruitment and retention efforts.

Employee satisfaction survey responses revealed satisfaction with leaders and a workplace where staff felt respected and discrimination was not tolerated. Patient experience survey data indicated overall patient satisfaction and generally reflected higher care ratings than the VHA averages. However, survey results highlighted opportunities to improve satisfaction for female veterans being treated with courtesy by doctors in the inpatient setting and securing outpatient specialty care appointments for routine care when needed.

The OIG's review of the healthcare system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. The executive leaders were able to speak in depth about actions taken during the previous 12 months to maintain or improve employee satisfaction and patient experiences. The leadership team was generally knowledgeable within their scope of responsibility about system and CLC SAIL measures and should continue to take actions to improve performance.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the “alarming levels of spread and severity” of COVID-19, the World Health Organization declared a pandemic.³⁶ 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.³⁷

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.”³⁸ “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.”³⁹

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
- CLC patient care and operations

The OIG also surveyed healthcare system staff to solicit their feedback and potentially identify any problematic trends and/or issues that may require follow-up.

The OIG will report 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.

³⁶ “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>.

³⁷ VHA, Office of Emergency Management, *COVID-19 Response Plan*, March 23, 2020.

³⁸ 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.”

³⁹ 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.

Quality, Safety, and Value

VHA’s goal is to serve as the nation’s leader in delivering high quality, safe, reliable, and veteran-centered care.⁴⁰ To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.⁴¹ Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare “favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency.”⁴²

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

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

The OIG reviewers also assessed the healthcare system’s processes for its Systems Redesign and Improvement Program, which support “VHA’s transformation journey to become a High Reliability Organization.”⁴³ 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.”⁴⁴ The OIG team examined various requirements related to systems redesign and improvement:

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

⁴⁰ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

⁴¹ VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

⁴² Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

⁴³ VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

⁴⁴ VHA Directive 1026.01.

Next, the OIG assessed the healthcare system's processes for conducting protected peer reviews of clinical care.⁴⁵ 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."⁴⁶ Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.⁴⁷ 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 unit⁴⁸
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews⁴⁹
- 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."⁵⁰ 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

⁴⁵ 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."

⁴⁶ VHA Directive 1190.

⁴⁷ VHA Directive 1190.

⁴⁸ VHA Directive 1190.

⁴⁹ VHA Directive 1190. A peer review is assigned a Level 3 when "most experienced and competent clinicians would have managed the case differently."

⁵⁰ "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.)

specialty programs.”⁵¹ 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 events⁵²

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.⁵³

Quality, Safety, and Value Findings and Recommendations

The healthcare system complied with requirements for a committee responsible for QSV oversight functions. However, the OIG identified opportunities for improvement with the Systems Redesign and Improvement Program, Peer Review Committee, and Surgical Work Group.

VHA requires facility directors to assign a systems redesign and improvement coordinator to participate on the “Facility Quality Management Committee to review: improvement needs, data, business rules, and to ensure that key improvement, quality, safety, and value functions are discussed and integrated on a regular basis.”⁵⁴ The OIG received Quality, Safety, Value Board meeting minutes for February through October 2020 and noted that the Systems Redesign Analyst-Program Manager was either excused from or attended all quarterly meetings.⁵⁵ However, there was no evidence that the board discussed systems redesign projects in the meetings. This may have resulted in inadequate oversight and prioritization of continuous improvement projects. The Chief, Quality Management acknowledged recent awareness of the requirement and attributed the noncompliance to a lack of a permanent systems redesign and improvement coordinator.

⁵¹ “NSO Reporting, Resources, & Tools.”

⁵² VHA Directive 1102.01(1), *National Surgery Office*, April 24, 2019, amended May 22, 2019.

⁵³ For CHIP visits, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

⁵⁴ VHA Directive 1026.01.

⁵⁵ The Systems Redesign Analyst-Program Manager previously served as the acting Systems Redesign and Improvement Coordinator and was a standing member of the QSV Board.

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures the acting Systems Redesign and Improvement Coordinator participates on the Quality, Safety, Value Board to review program data and information.

Healthcare system concurred.

Target date for completion: December 31, 2021

Healthcare system response: The System Director reviewed and evaluated additional reasons for noncompliance. Starting in February 2021, the System Director added Systems Redesign Project reviews as a standing agenda item at the Quality, Safety and Value (QSV) Board meetings. The System Director will monitor the attendance of the Acting System Redesign Coordinator and the presentation of System Redesign projects until 90% compliance with attendance is demonstrated for six consecutive months. The facility is in the interview phase of hiring a full-time system redesign coordinator. Evidence of compliance will be documented in the QSV Board minutes.

VHA requires the Peer Review Committee to submit quarterly summaries of peer review data for review by an executive-level medical committee (locally known as the Clinical Executive Board).⁵⁶ The OIG found that from December 2019 through November 2020, the Peer Review Committee did not submit quarterly summary reports to the Clinical Executive Board. Failure to submit summary reports may prevent the Clinical Executive Board from identifying clinical practice trends, determining the need for further action, and monitoring the effectiveness of quality improvement initiatives. The Risk Manager reported that the process of forwarding the quarterly summary reports to the Clinical Executive Board was inadvertently discontinued when an acting Chief, Quality Management was appointed in August 2019.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain the Peer Review Committee submits quarterly summaries of peer review data for review by the Clinical Executive Board.

⁵⁶ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

Healthcare system concurred.

Target date for completion: October 31, 2021

Healthcare system response: The Chief of Staff have previously reviewed and evaluated additional reasons for non-compliance. As of December 2020, Peer Review quarterly summaries are reviewed as a standing agenda item at Clinical Executive Board meetings. The Chief of Quality Management will monitor the Peer Review Committee (PRC) submission of quarterly summaries until a 90% compliance rate is demonstrated for four consecutive quarters. Evidence of compliance will be demonstrated with the PRC quarterly summaries and evidence PRC summaries were reviewed in the Clinical Executive Board Minutes.

VHA requires medical facility directors to ensure that facilities have a surgical work group that meets monthly; this work group must be chaired by the Chief of Surgery and include the Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.⁵⁷ Based on available meeting minutes from December 2019 through November 2020, the Surgical Work Group did not meet for two of nine monthly meetings. In addition, the OIG noted that the Chief of Staff did not attend any of the meetings.⁵⁸ The lack of monthly meetings and healthcare system leader's involvement resulted in the review of surgery program activities without the perspectives of key staff. The Chief, Surgical Service attributed the noncompliance to conflicting priorities and scheduling issues. The Chief of Staff reported being unaware of the attendance requirement.⁵⁹

Recommendation 3

3. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that the Surgical Work Group meets monthly and the Chief of Staff attends the meetings.

⁵⁷ VHA Directive 1102.01(1), *National Surgery Office*, April 24, 2019, amended May 22, 2019.

⁵⁸ The Surgical Work Group suspended meetings from March to May 2020 due to the COVID-19 pandemic; therefore, there were nine required meetings during the review period. The workgroup did not meet in December 2019 and September 2020.

⁵⁹ The current Chief of Staff was appointed in May 2020.

Healthcare system concurred.

Target date for completion: August 31, 2021

Healthcare system response: The System Director has previously reviewed and evaluated additional reasons for noncompliance. As of February 2021, the Chief of Staff was added as a regular attendee to Surgical Workgroup, and meetings are scheduled to occur monthly. The Chief of Quality Management will monitor the frequency of meetings and Chief of Staff or Designee attendance until a 90% compliance rate is demonstrated for six consecutive months. Evidence of compliance will be demonstrated in Surgical Work Group minutes.

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.”⁶⁰ 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.”⁶¹

VA requires all RNs to hold at least one active, unencumbered license.⁶² 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.⁶³ 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.⁶⁴ 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.⁶⁵

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 44 RNs hired from January 1 through December 21, 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 44 RNs to determine whether healthcare system staff completed primary source verification prior to the appointment.

⁶⁰ VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012.

⁶¹ VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

⁶² 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.”

⁶³ 38 U.S.C. § 7402.

⁶⁴ VHA Directive 2012-030.

⁶⁵ VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

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

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 2019.⁶⁶ 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 2018.⁶⁷ However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.⁶⁸

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.⁶⁹ The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.⁷⁰ The healthcare system was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

⁶⁶ “Preventing Suicide,” Centers for Disease Control and Prevention, accessed December 9, 2020, <https://www.cdc.gov/violenceprevention/suicide/fastfact.html>.

⁶⁷ Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, November 2020.

⁶⁸ Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*.

⁶⁹ Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Suicide Risk Screening and Assessment Requirements*, May 23, 2018; Department of Veterans Affairs, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Minimum Requirements by Setting*, December 18, 2019.

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

Mental Health Findings and Recommendations

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

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.⁷¹

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.”⁷² Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.⁷³

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 45 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 generally met expectations for the transmission of the patient’s active medication list to the receiving facility. However, the OIG found noncompliance with the requirements for a current inter-facility transfer policy, patient transfer monitoring and evaluation, VA *Inter-Facility Transfer Form* or equivalent note completion by an appropriate provider, and nurse-to-nurse communication between sending and receiving facilities. In

⁷¹ VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

⁷² VHA Directive 1094.

⁷³ 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.

addition, the OIG noted an improvement opportunity with the transmission of patients' advance directives to receiving facilities.

VHA requires the System Director to ensure “that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients.”⁷⁴ The OIG found that the healthcare system had an inter-facility transfer policy with a scheduled review date of January 2019; however, at the time of the OIG virtual review in January 2021, the policy had not been reviewed. Failure to maintain a current inter-facility transfer policy could result in lack of coordination between facilities to provide seamless care for patients through the transfer process. The Deputy ADPNS and Whole Health Program Manager, Bed Management Service reported that the prior Chief of Staff was notified but did not review the policy, and the current Chief of Staff was not aware of the review date.

Recommendation 4

4. The System Director evaluates and determines any additional reasons for noncompliance and maintains a current policy to ensure the safe, appropriate, orderly, and timely transfer of patients.⁷⁵

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The System Director had previously reviewed and evaluated additional reasons for noncompliance. The facility published a current Interfacility Transfer Policy on August 3, 2021. We would like to request closure of this recommendation prior to publication based on supporting evidence provided to the OIG.

VHA requires the Chief of Staff and ADPNS to ensure that “[a]ll transfers are monitored and evaluated as part of VHA’s Quality Management Program.”⁷⁶ The Chief, Quality Management informed the OIG that the healthcare system did not monitor and evaluate patient transfers. Failure to monitor and evaluate patient transfers could hinder the healthcare system’s ongoing performance improvement activities. The Chief, Quality Management reported that the prior acting Chief, Quality Management was unaware of the requirement and stated that the new Interfacility Transfer Committee will be chartered to monitor and evaluate patient transfers.⁷⁷

⁷⁴ VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

⁷⁵ The OIG reviewed evidence sufficient to demonstrate that the system had completed improvement actions, and therefore, closed the recommendation before publication of the report.

⁷⁶ VHA Directive 1094.

⁷⁷ In March 2021, the system chartered the Interfacility Transfer Committee to review appropriateness of all patient transfers. The system’s governance structure in figure 4 does not include this newly formed committee.

Recommendation 5

5. The Chief of Staff and Associate Director for Patient and Nursing Services evaluate and determine any additional reasons for noncompliance and make certain the Interfacility Transfer Committee monitors and evaluates patient transfers.

Healthcare system concurred.

Target date for completion: December 31, 2021

Healthcare system response: The Chief of Staff and Associate Director for Patient and Nursing Services reviewed and evaluated additional reasons for noncompliance. As of March 2021, the facility convened an Interfacility Transfer Committee to monitor interfacility transfers. The committee name was subsequently changed to Facility Flow Committee and charged with monitoring patient flow metrics and reporting out to the Quality, Safety and Value Board. The chair of the Facility Flow Committee will be responsible for monitoring and evaluating patient transfers. Evidence of compliance will be demonstrated by six consecutive months of 90% or greater compliance in the Facility Flow Committee meeting minutes. The Chair of the Facility Flow Committee will provide meeting minutes to the Quality, Safety and Value Board for six consecutive months.

VHA requires the Chief of Staff and ADPNS to ensure “documentation of the patient’s (or legally-responsible person acting on the patient’s behalf) informed consent” prior to transfer.⁷⁸ The OIG estimated that 49 percent of electronic health records reviewed did not include evidence of patients’ or legally-responsible persons’ informed consent.⁷⁹ Lack of informed consent could result in patients not fully understanding the risks and benefits of transfer. The Whole Health Program Manager, Bed Management Service and Co-Medical Director, Emergency Department reported that providers believed they met the intent of the requirement by completing informed consents for unstable patient transfers. However, they were unaware that informed consent is required for all inter-facility transfers.

Recommendation 6

6. The Chief of Staff and Associate Director for Patient and Nursing Services evaluate and determine any additional reasons for noncompliance and make certain that providers document patients’ informed consent prior to inter-facility transfers.

⁷⁸ VHA Directive 1094.

⁷⁹ The OIG estimated that 95 percent of the time, the true compliance rate is between 36.4 and 65.9 percent, which is statistically significantly below the 90 percent benchmark.

Healthcare system concurred.

Target date for completion: February 28, 2022

Healthcare system response: The Chief of Staff and Associate Director for Patient and Nursing Services reviewed and evaluated additional reasons for noncompliance. The chair of the Facility Flow Committee will be responsible to monitor monthly audits of all interfacility transfers to evaluate for provider completion of informed consent until 90% compliance has been achieved for six consecutive months. Evidence of compliance will be documented in the Facility Flow Committee minutes and reported monthly to the Quality, Safety, and Value Board with the audits included.

VHA requires the Chief of Staff and ADPNS to ensure that appropriately privileged providers complete the *VA Inter-Facility Transfer Form* or an equivalent note prior to patient transfers. VHA also requires providers to approve and co-sign documentation when transfer-related decisions are made by a designee.⁸⁰ Based on the electronic health records reviewed, the OIG estimated that an appropriately privileged provider did not complete or co-sign the *VA Inter-Facility Transfer Form* or an equivalent note for 22 percent of patient transfers.⁸¹ These deficiencies could result in the unsafe transfer of patients. The Co-Medical Director, Emergency Department reported that physician assistants completed the *VA Inter-Facility Transfer Form* and were unaware that transfers require prior approval and signature of an appropriately privileged provider.

Recommendation 7

7. The Chief of Staff and Associate Director for Patient and Nursing Services evaluate and determine any additional reasons for noncompliance and ensure that appropriately privileged providers complete or co-sign the *VA Inter-Facility Transfer Form* or equivalent note prior to patient transfers.

⁸⁰ VHA Directive 1094.

⁸¹ The OIG estimated that 95 percent of the time, the true compliance rate is between 65.1 and 89.1 percent, which is statistically significantly below the 90 percent benchmark.

Healthcare system concurred.

Target date for completion: February 28, 2022

Healthcare system response: The Chief of Staff and Associate Director for Patient and Nursing Services reviewed and evaluated additional reasons for noncompliance. The chair of the Facility Flow Committee will be responsible to monitor monthly audits of inter-facility transfer documentation to ensure providers complete or co-sign the VA *Inter-Facility Transfer Form* until 90% compliance has been achieved for six consecutive months. Evidence of compliance will be documented in the Facility Flow Committee minutes and reported monthly to the Quality, Safety, and Value Board with the audits included.

VHA states that nurse-to-nurse communication during the inter-facility transfer process is essential and allows for questions and answers from staff at both sending and receiving facilities.⁸² The OIG estimated that 22 percent of patient transfers did not include nurse-to-nurse communication.⁸³ This could result in receiving staff having insufficient information needed to care for patients. The Whole Health Program Manager, Bed Management Service, and the Deputy ADPNS attributed the noncompliance to nursing staff's inattention to detail.

Recommendation 8

8. The Chief of Staff and Associate Director for Patient and Nursing Services evaluate and determine any additional reasons for noncompliance and make certain that nurse-to-nurse communication between the sending and receiving facility occurs during the inter-facility transfer process.

Healthcare system concurred.

Target date for completion: February 28, 2022

Healthcare system response: The Chief of Staff and Associate Director for Patient and Nursing Services reviewed and evaluated additional reasons for noncompliance. The chair of the Facility Flow Committee will monitor monthly audits of inter-facility transfer documentation to ensure nurse-to-nurse communication between sending and receiving facilities are properly documented until 90% compliance has been achieved for six consecutive months. Evidence of compliance will be documented in the Facility Flow Committee minutes and reported monthly to the Quality, Safety, and Value Board with the audits included.

⁸² VHA Directive 1094.

⁸³ The OIG estimated that 95 percent of the time, the true compliance rate is between 65.2 and 89.1 percent, which is statistically significantly below the 90 percent benchmark.

VHA requires the Chief of Staff and the ADPNS to ensure “all pertinent medical records available, including an active patient medication list and any medications given to the patient prior to transfer [be sent] with the patient, including documentation of the patient’s advance directive made prior to transfer, if any.”⁸⁴ The OIG determined that all 23 applicable electronic health records lacked evidence that staff sent the advance directive to the receiving facility. As a result, there was no assurance that receiving facility staff could determine patient preferences regarding future health care decisions at transfer. The Whole Health Program Manager, Bed Management Service reported that staff were unaware of how to access copies of the advance directives, and as a result, the directives were not documented on the transfer form or sent to the receiving facility. Due to the small number of patients identified for the advance directive requirement, the OIG made no recommendation.

⁸⁴ VHA Directive 1094.

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.”⁸⁵ 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.”⁸⁶ 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 team⁸⁷
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings⁸⁸
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction (OBR)⁸⁹
- Patient notification of an OBR
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants⁹⁰

⁸⁵ VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

⁸⁶ VHA Directive 2012-026.

⁸⁷ 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.”

⁸⁸ 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.”

⁸⁹ 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.”

⁹⁰ DUSHOM Memorandum, *Workplace Behavioral Risk Assessment (WBRA)*, October 19, 2012. The Workplace Behavioral Risk Assessment is a “data-driven process that evaluates the unique constellation of factors that affect workplace safety. It enables facilities to make informed, supportable decisions regarding the level of PMDB [Prevention and Management of Disruptive Behavior] training needed to sustain a culture of safety in the workplace.”

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.⁹¹ VHA also requires that employee threat assessment team members complete the appropriate team-specific training.⁹² 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 found that the healthcare system met many of the requirements for the management of disruptive and violent behavior. However, the OIG noted concerns with a required representative attending Disruptive Behavior Committee meetings, patient notification of an OBR, and staff training.

VHA requires the Chief of Staff and Nurse Executive (ADPNS) to establish a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; a patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and the Union Safety Committee.⁹³ The OIG reviewed Disruptive Behavior Committee meeting minutes from December 2019 through November 2020 and found that the Prevention and Management of Disruptive Behavior Program representative did not attend 4 of 12 (33 percent) meetings. This could result in a lack of knowledge and expertise when assessing patients' disruptive behavior. The Prevention and Management of Disruptive Behavior Coordinator attributed the lack of attendance to unplanned leave and inaccurate recording of excused absences in meeting minutes.

Recommendation 9

9. The Chief of Staff and Associate Director for Patient and Nursing Services evaluate and determine any additional reasons for noncompliance and ensure all required representatives attend Disruptive Behavior Committee meetings.

⁹¹ DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

⁹² DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

⁹³ VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.

Healthcare system concurred.

Target date for completion: August 31, 2021

Healthcare system response: The Chief of Staff and Associate Director for Patient and Nursing Services had previously reviewed and evaluated additional reasons for noncompliance. As of October 2020, the Disruptive Behavior Committee reviewed attendance requirements with the membership. The chair of the Disruptive Behavior Committee will be responsible for monitoring compliance with required representative attendance until 90% compliance has been achieved for six consecutive months. Compliance will be documented in the Disruptive Behavior Committee meeting minutes.

VHA requires the Disruptive Behavior Committee to document patient notification of OBRs, with information regarding the patient's right to appeal the order and the appeal process, in the Disruptive Behavior Reporting System.⁹⁴ The OIG did not find evidence of patient notification in the Disruptive Behavior Reporting System for three of nine OBRs issued from December 2019 through November 2020. Additionally, two OBRs reflected patient notification in the system; however, the Disruptive Behavior Committee Co-Chair did not provide evidence of the notification letters. For the remaining four OBRs, the notification did not include information regarding patients' right to appeal the order. Failure to notify patients of OBR placements could result in the issuance of orders without patients' knowledge and denial of their right to appeal. The Disruptive Behavior Committee Co-Chairs attributed the missed documentation to lack of oversight and reported unawareness of the requirement to inform patients of their right to appeal.

Recommendation 10

10. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain the Disruptive Behavior Committee documents patient notification of an Order of Behavioral Restriction, with information regarding the right to appeal, in the Disruptive Behavior Reporting System.

⁹⁴ DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018.

Healthcare system concurred.

Target date for completion: December 31, 2021

Healthcare system response: The Chief of Staff reviewed and evaluated additional reasons for noncompliance. Patient notification template has been updated to include information regarding the right to appeal. Tracking of Order of Behavioral Restriction documentation in Disruptive Behavior Reporting System [DBRS] has been added as a standing agenda item for Disruptive Behavior Committee. The Chair of the Disruptive Behavior Committee will monitor Disruptive Behavior Committee documentation of an Order of Behavioral Restriction including information regarding the right to appeal in the DBRS until a 90% compliance rate is demonstrated for six consecutive months. Evidence of compliance will be documented each month in the Disruptive Behavior Committee Minutes and reported to the Quality, Safety, and Value Board.

VHA requires the System Director to ensure that staff are assigned prevention and management of disruptive behavior part 1 training at hire and “additional levels of PMDB [prevention and management of disruptive behavior] training based on the risk for exposure to disruptive behaviors as determined in the facility Workplace Behavioral Risk Assessment.”⁹⁵ The OIG found that 9 of 10 selected staff did not complete the required part 2 training based on the risk level assigned to the work area. This could result in staff’s lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Chief of Staff and the Nurse Manager for Inpatient Psychiatry reported following system leaders’ guidance to cease face-to-face encounters to prevent staff exposure to COVID-19.

Recommendation 11

11. The System Director evaluates and determines any additional reasons for noncompliance and ensures staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.⁹⁶

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

⁹⁶ The OIG recognizes that COVID-19 has affected facility operations and makes no comment on the timeline for safely accomplishing this important training.

Healthcare system concurred.

Target date for completion: December 31, 2021

Healthcare system response: The System Director reviewed and evaluated additional reasons for noncompliance. As of May 2021, the facility approved a Standard Operating Procedure for resumption of face-to-face trainings during the COVID-19 pandemic. Individuals in need of prevention and management of disruptive behavior (PMDB) training have been assigned training levels appropriate to their work assignment. Weekly PMDB classes have been scheduled with employees mandated to attend. Due to the small maximum class size, it is anticipated to take several months to complete. The Chief of Education will be responsible for monitoring training completion and reporting compliance rates to the Disruptive Behavior Committee monthly until a 90% compliance rate has been achieved. Evidence of compliance will be documented in the Disruptive Behavior Committee minutes and reported to the Quality, Safety and Value board at least quarterly.

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 seven clinical and administrative areas and provided 11 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 11 OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the System Director, Chief of Staff, and ADPNS. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address system issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

| Healthcare Processes | Review Elements | Critical Recommendations for Improvement | Recommendations for Improvement |
|--|---|---|--|
| Leadership and Organizational Risks | <ul style="list-style-type: none"> • Executive leadership position stability and engagement • Budget and operations • Staffing • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Identified factors related to possible lapses in care and healthcare system response • VHA performance data (healthcare system) • VHA performance data (CLC) | <ul style="list-style-type: none"> • None | <ul style="list-style-type: none"> • None |
| COVID-19 Pandemic Readiness and Response | <ul style="list-style-type: none"> • Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback | <p>The OIG will report the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.</p> | |

| Healthcare Processes | Review Elements | Critical Recommendations for Improvement | Recommendations for Improvement |
|--|--|---|--|
| Quality, Safety, and Value | <ul style="list-style-type: none"> • QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program | <ul style="list-style-type: none"> • Systems Redesign and Improvement Coordinator participates on the QSV Board to review program data and information. • Peer Review Committee submits quarterly summaries of peer review data for review by the Clinical Executive Board. | <ul style="list-style-type: none"> • Surgical Work Group meets monthly and the Chief of Staff attends the meetings. |
| RN Credentialing | <ul style="list-style-type: none"> • RN licensure requirements • Primary source verification | <ul style="list-style-type: none"> • None | <ul style="list-style-type: none"> • None |
| 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"> • None | <ul style="list-style-type: none"> • None |

| Healthcare Processes | Review Elements | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|--|--|
| <p>Care Coordination: Inter-facility Transfers</p> | <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"> • Providers document patients' informed consent prior to inter-facility transfers. • Appropriately privileged providers complete or co-sign the VA <i>Inter-Facility Transfer Form</i> or equivalent note prior to patient transfers. • Nurse-to-nurse communication between the sending and receiving facility occurs during the inter-facility transfer process. | <ul style="list-style-type: none"> • The system maintains a current written policy to ensure the safe, appropriate, orderly, and timely transfer of patients. • The Inter-Facility Transfer Committee monitors and evaluates patient transfers. |
| <p>High-Risk Processes: Management of Disruptive and Violent Behavior</p> | <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"> • The Disruptive Behavior Committee documents patient notification of an OBR, with information regarding the right to appeal, in the Disruptive Behavior Reporting System. | <ul style="list-style-type: none"> • All required representatives attend Disruptive Behavior Committee meetings. • Staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas. |

Appendix B: Healthcare System Profile

The table below provides general background information for this medium complexity (2) affiliated healthcare system reporting to VISN 1.¹

**Table B.1. Profile for VA Maine Healthcare System (402)
(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 | \$371,426,319 | \$402,479,721 | \$469,667,457 |
| Number of: | | | |
| • Unique patients | 42,333 | 42,452 | 40,833 |
| • Outpatient visits | 476,279 | 478,702 | 397,454 |
| • Unique employees§ | 1,359 | 1,320 | 1,260 |
| Type and number of operating beds: | | | |
| • Community living center | 100 | 100 | 100 |
| • Intermediate | 8 | 8 | 8 |
| • Medicine | 26 | 26 | 26 |
| • Mental health | 20 | 20 | 20 |
| • Surgery | 4 | 4 | 4 |
| Average daily census: | | | |
| • Community living center | 64 | 60 | 53 |
| • Intermediate | 4 | 5 | 7 |
| • Medicine | 18 | 17 | 19 |
| • Mental health | 11 | 9 | 6 |

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 “2” indicates a facility with “medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs.”

| Profile Element | Healthcare System Data FY 2018* | Healthcare System Data FY 2019 | Healthcare System Data FY 2020† |
|---|------------------------------------|-----------------------------------|------------------------------------|
| <ul style="list-style-type: none"> Surgery | 2 | 2 | 1 |

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

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

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

†October 1, 2018, through September 30, 2019.

‡October 1, 2019, through September 30, 2020.

§Unique employees involved in direct medical care (cost center 8200).

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 |
|-------------|-------------|-----------------------------------|------------------------------------|-----------------------------------|------------------------------|--|
| Caribou, ME | 402GA | 3,969 | 1,749 | Dermatology Infectious disease | – | Nutrition Pharmacy Weight management |
| Calais, ME | 402GB | 2,047 | 374 | Dermatology Infectious disease | – | Nutrition Pharmacy Weight management |
| Rumford, ME | 402GC | 2,326 | 763 | Dermatology Infectious disease | – | Nutrition Pharmacy Weight management |

¹ VHA Directive 1230(4), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended June 17, 2021. An encounter is a “professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.” Specialty care services refer to non-primary care and non-mental health services provided by a physician.

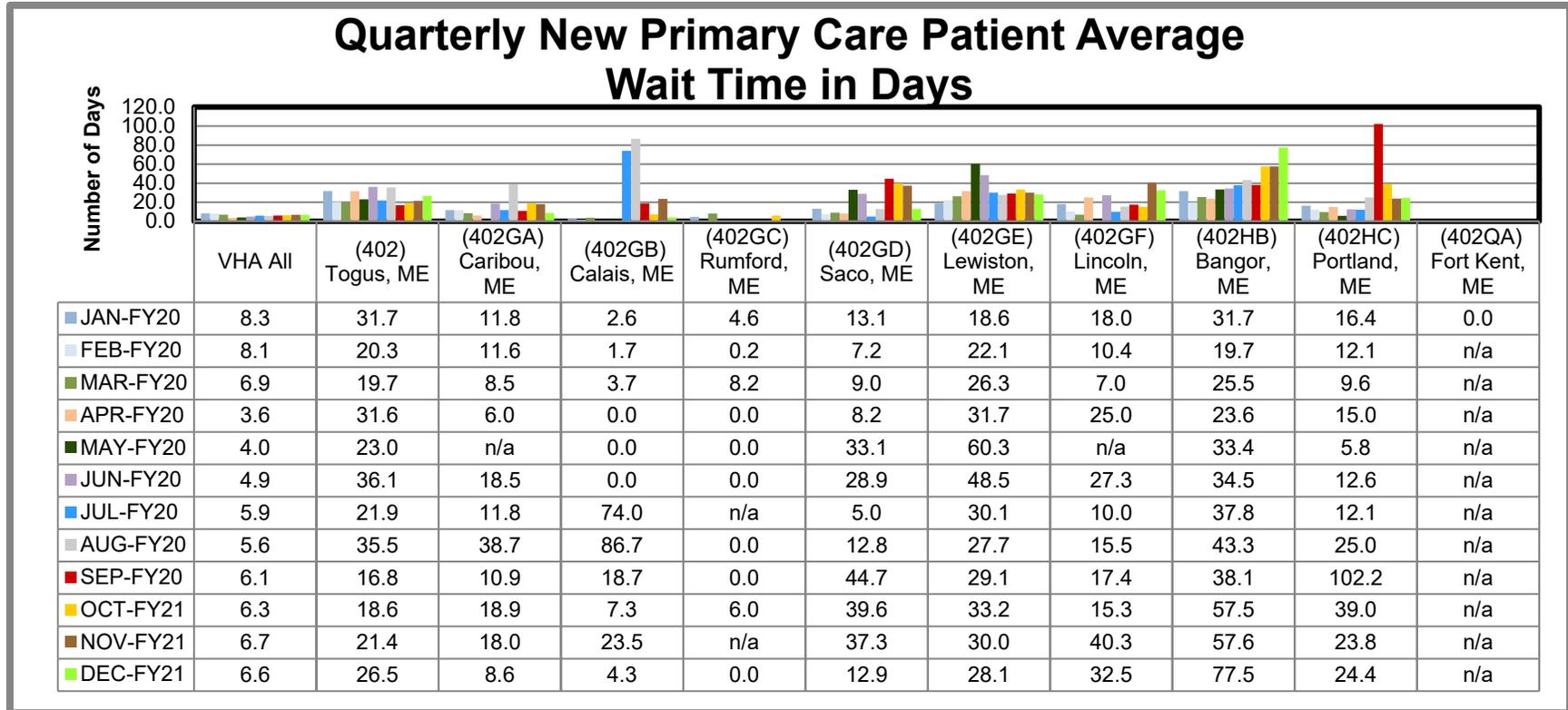
| Location | Station No. | Primary Care Workload/ Encounters | Mental Health Workload/ Encounters | Specialty Care Services Provided | Diagnostic Services Provided | Ancillary Services Provided |
|--------------|-------------|-----------------------------------|------------------------------------|---|------------------------------|--|
| Saco, ME | 402GD | 3,808 | 3,377 | Allergy Anesthesia Dermatology Infectious disease | – | Nutrition Pharmacy Weight management |
| Lewiston, ME | 402GE | 6,187 | 2,979 | Cardiology Dermatology Eye Pulmonary/ Respiratory disease | Radiology | Nutrition Pharmacy Weight management |
| Lincoln, ME | 402GF | 1,581 | 265 | Dermatology | – | Nutrition Pharmacy Weight management |
| Bangor, ME | 402HB | 9,313 | 7,647 | Cardiology Dermatology Eye Infectious disease | Radiology | Dental Nutrition Pharmacy Weight management |

| Location | Station No. | Primary Care Workload/ Encounters | Mental Health Workload/ Encounters | Specialty Care Services Provided | Diagnostic Services Provided | Ancillary Services Provided |
|---------------|-------------|-----------------------------------|------------------------------------|--|------------------------------|--|
| Portland, ME | 402HC | 4,867 | 3,826 | Cardiology Dermatology Endocrinology Gastroenterology Infectious disease Nephrology Pulmonary/ Respiratory disease Rheumatology | – | Nutrition Pharmacy Weight management |
| Fort Kent, ME | 402QA | 213 | – | – | – | – |
| Houlton, ME | 402QB | 70 | – | – | – | – |

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

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

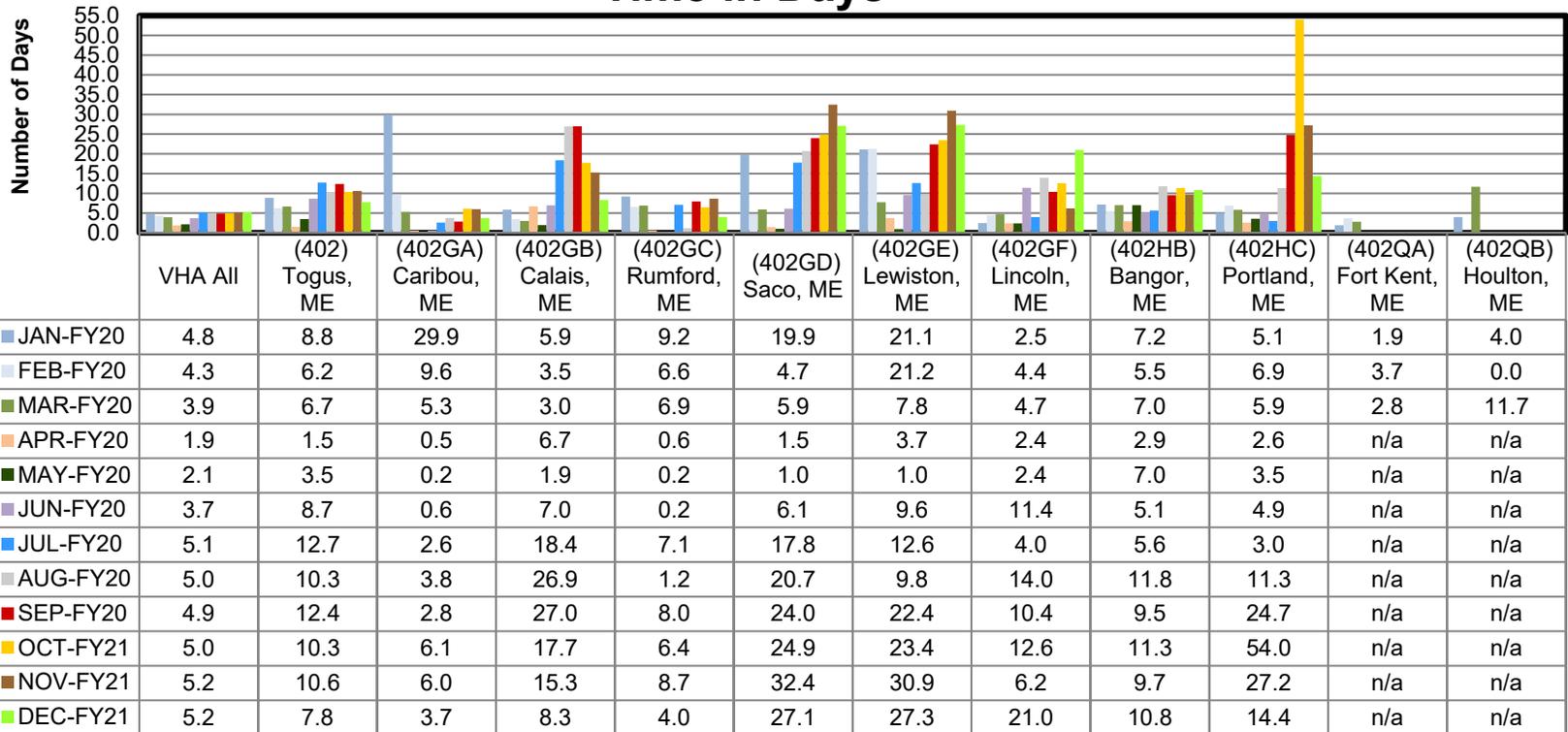
Appendix D: Patient Aligned Care Team Compass Metrics



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 community-based outpatient clinics in Bangor, Calais, Caribou, Lewiston, Lincoln, Portland, Saco, and Togus, ME. The OIG omitted (402QB) Houlton, ME, 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.”

Quarterly Established Primary Care Patient Average Wait Time in Days



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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the healthcare system's explanation for the increased wait time for the Lewiston, Portland, and Saco clinics. Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." The absence of reported data is indicated by "n/a."

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

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

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

Source: VHA Support Service Center.

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

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 11, 2021

From: Director, VA New England Healthcare System (10N1)

Subj: Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta, Maine

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

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

1. Thank you for the opportunity to review the findings from the Comprehensive Healthcare Inspection of the VA Maine HCS – Togus VAMC.
2. I concur with your findings. I have reviewed the Medical Center Director's action plans and I am confident they will result in successful resolution of each recommendation.

(Original signed by:)

Ryan S. Lilly

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: August 3, 2021

From: Director, VA Maine Healthcare System (402/00)

Subj: Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta, Maine

To: Director, VA New England Healthcare System (10N1)

I have reviewed the findings within the Comprehensive Healthcare Inspection Program Review for the VA Maine Healthcare System, Augusta Maine. The plan for corrective actions has been reviewed and approved by the medical center executive leadership team.

(Original signed by:)

Tracye B. Davis

OIG Contact and Staff Acknowledgments

| | |
|----------------|---|
| Contact | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
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Director, VA Maine Healthcare System (402/00)

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