DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 5: VA Capitol Health Care Network in Linthicum, Maryland

CHIP REPORT | **REPORT #21-00239-180** | **JULY 14, 2022**

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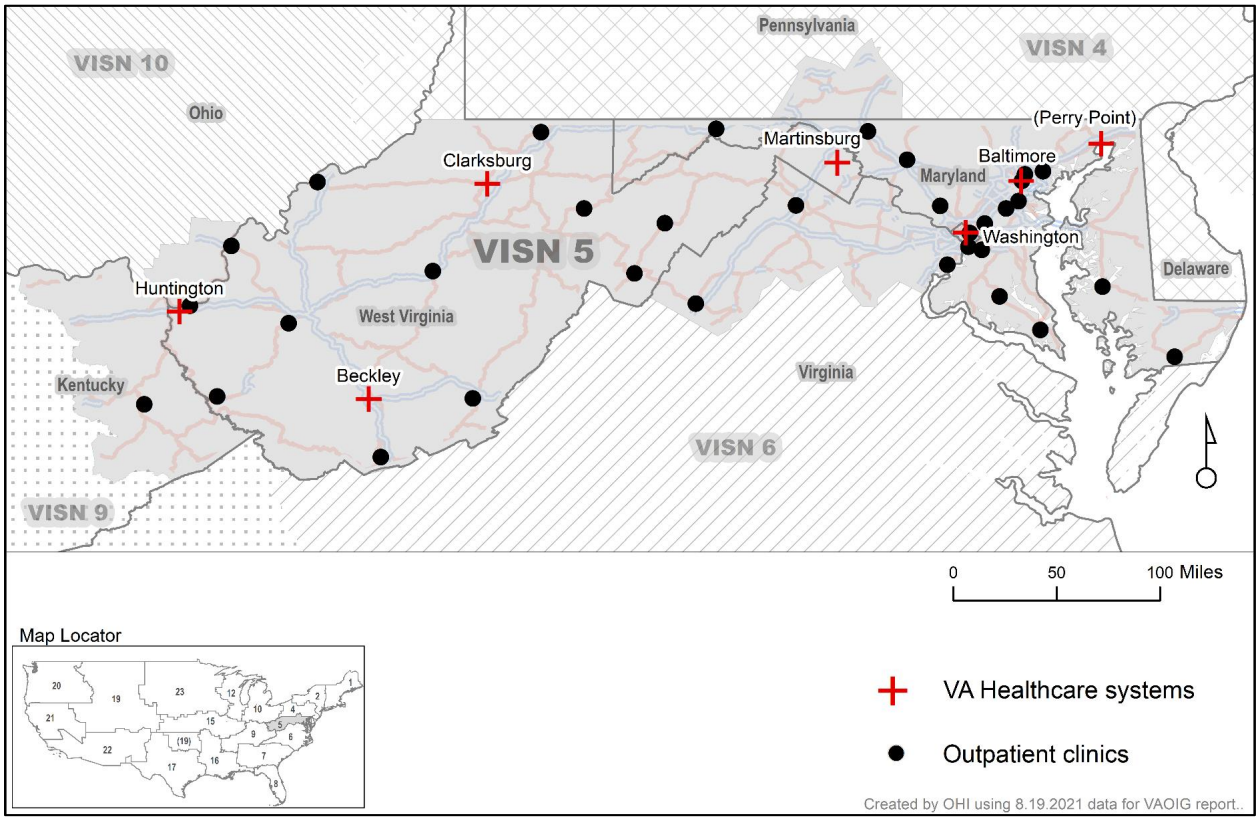


Figure 1. *Veterans Integrated Service Network 5: VA Capitol Health Care Network.*
Source: Veterans Health Administration Site Tracking System (accessed August 19, 2021).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
FTE	full-time equivalent
FY	fiscal year
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCS	health care system
HEDIS	Healthcare Effectiveness Data and Information Set
HRO	Human Resources Officer
OIG	Office of Inspector General
QMO	Quality Management Officer
SAIL	Strategic Analytics for Improvement and Learning
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of leadership performance and oversight by the Veterans Integrated Service Network (VISN) 5: VA Capitol Health Care Network in Linthicum, Maryland. 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 OIG selects and evaluates specific areas of focus each year.

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

1. COVID-19 pandemic readiness and response[1]
2. Quality, safety, and value
3. Medical staff credentialing
4. Environment of care
5. Mental health (focusing on suicide prevention)
6. Care coordination (targeting inter-facility transfers)
7. Women's health (examining comprehensive care)

The OIG conducted this unannounced virtual inspection during the week of August 23, 2021. The OIG also performed virtual inspections of the following VISN 5 facilities during the weeks of August 9 and 23, 2021:

- Beckley VA Medical Center (West Virginia)
- Hershel "Woody" Williams VA Medical Center (Huntington, West Virginia)
- Louis A. Johnson VA Medical Center (Clarksburg, West Virginia)
- Martinsburg VA Medical Center (West Virginia)
- VA Maryland Health Care System (Baltimore)

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

- Washington DC VA Medical Center (District of Columbia)

The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. The findings presented in this report are a snapshot of VISN 5 and facility performance within the identified focus areas at the time of the OIG inspection. The findings may help VISN leaders identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement in two areas reviewed and issued one recommendation attributable to the Chief Medical Officer. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual inspection, the VISN's leadership team consisted of the Network Director, Deputy Network Director, Chief Medical Officer, and Quality Management Officer/Chief Nursing Officer. The executive leaders had worked together since August 2020. The Chief Medical Officer, who was appointed in 2011, was the longest-serving executive leader. The Network Director and Deputy Network Director were assigned in 2019. The Quality Management Officer/Chief Nursing Officer joined the team in 2020.

VISN leaders managed organizational communication and accountability through a committee reporting structure, with the Executive Leadership Council's oversight of the Organizational Health; Healthcare Operations; Healthcare Delivery; Quality, Safety and Value; and Strategic Planning Committees.

The OIG reviewed selected employee satisfaction and patient experience survey results. The OIG concluded that VISN leaders were engaged and promoted a culture of safety, where employees felt safe bringing forward issues and concerns. However, the Deputy Network Director appeared to have an opportunity to improve the Servant Leader Index Composite score, which is a summary measure of employees' assessments of their supervisors' listening, respect, trust, favoritism, and response to concerns. Survey results also indicated that although patients appeared satisfied with their outpatient and specialty care experiences, they were less satisfied with the inpatient care they received at VISN 5 facilities, particularly the VA Maryland Health Care System and the Martinsburg and Washington DC VA Medical Centers.

The OIG team also evaluated VISN access metrics and clinical vacancies. The OIG identified potential organizational risks at selected facilities with wait times over 20 days and higher rates of clinical vacancies, as well as challenges with timely support of facility hiring efforts and retention of human resources staff.

The VA Office of Operational Analytics and Reporting developed 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."[2] Leaders were knowledgeable within their scope of responsibilities about selected SAIL and Community Living Center SAIL measures. However, the OIG identified opportunities for the Network Director, Chief Medical Officer and Quality Management Officer/Chief Nursing Officer to improve their oversight of facility-level quality, safety, and value; care coordination; and high-risk processes. Effective oversight is critical to ensuring delivery of quality care and effective facility operations.

The OIG also spoke to VISN leaders about their actions at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, following an OIG criminal investigation of a VA nursing assistant who was convicted and sentenced for the murder of seven veterans. VISN leaders reported taking actions such as ensuring staff completed Morbidity and Mortality reviews, engaging an Administrative Investigation Board to evaluate quality of care, and ensuring VISN human resources staff conducted suitability for hire and background checks on all applicants.

COVID-19 Pandemic Readiness and Response

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 5 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional Veterans Health Administration (VHA) challenges and ongoing efforts.[3]

Medical Staff Credentialing

The OIG identified weaknesses in the review and approval of physicians who had potentially disqualifying licensure actions prior to their VA appointment.

Environment of Care

The VISN complied with most requirements for a comprehensive environment of care program. However, the OIG identified a weakness with the annual assessment of facilities' inventory management programs.

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

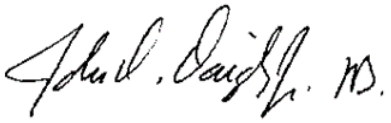
[3] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

Conclusion

The OIG conducted a detailed inspection across eight key areas and subsequently issued one recommendation for improvement to the Chief Medical Officer. The recommendation should not be used as a gauge for the overall quality of care provided within this VISN. The intent is for the VISN leader to use the recommendation to help guide improvements in operations and clinical care throughout the network of assigned facilities. The recommendation addresses a medical staff privileging issue that may eventually interfere with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director agreed with the comprehensive healthcare inspection findings and recommendation and provided an acceptable improvement plan (see appendix G, page 53, and the response within the body of the report for the full text of the Network Director's comments). The OIG will follow up on the planned actions for the open recommendation until completion.



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Contents

Purpose and Scope

The purpose of this Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report is to evaluate leadership performance and oversight by Veterans Integrated Service Network (VISN) 5: VA Capitol Health Care Network. This focused evaluation examines a broad range of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to VISN leaders so they can make informed decisions to improve care.

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.[1] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[2]

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual inspection and initiated a 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:[3]

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[4]
3. Quality, safety, and value
4. Medical staff credentialing
5. Environment of care
6. Mental health (focusing on suicide prevention)
7. Care coordination (targeting inter-facility transfers)
8. Women's health (examining comprehensive care)

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[1] 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.

[2] 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.

[3] 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.

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

Methodology

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

The inspection examined operations from August 12, 2017, through August 27, 2021, the last day of the unannounced multiday virtual inspection.[5] The OIG also performed inspections of the following VISN 5 facilities during the weeks of August 9 and 23, 2021:

- Beckley VA Medical Center (VAMC) (West Virginia)
- Hershel "Woody" Williams VAMC (Huntington, West Virginia)
- Louis A. Johnson VAMC (Clarksburg, West Virginia)
- Martinsburg VAMC (West Virginia)
- VA Maryland Health Care System (HCS) (Baltimore)
- Washington DC VAMC (District of Columbia)

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 5 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[6]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[7] 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 recommendation for improvement addresses a problem that can influence the quality of patient care significantly enough to warrant OIG follow-up until the VISN leader completes corrective actions. The Network Director's response to the report recommendation appears within the topic area. The OIG accepted the action plan that VISN leaders developed based on the reasons for noncompliance.

[5] The range represents the time from the comprehensive healthcare inspection of the Hershel "Woody" Williams VAMC to the completion of the unannounced multiday virtual CHIP visit on August 27, 2021 (see appendix D).

[6] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

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

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.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can affect the ability to provide care in the clinical focus areas.[8] To assess this VISN's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Access to care
5. Clinical vacancies
6. Oversight inspections
7. VHA performance data

The OIG reviewed VISN oversight actions following the deaths of several veterans at the Louis A. Johnson VAMC in Clarksburg, West Virginia. The OIG also briefed VISN leaders on identified trends in noncompliance for facility virtual CHIP visits performed during the weeks of August 9 and 23, 2021.

Executive Leadership Position Stability and Engagement

A VISN consists of a geographic area that encompasses a population of veteran beneficiaries. The VISN is defined based on VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary, and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among medical facilities, clinics, and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is the basic budgetary and planning unit of the veterans' healthcare system.[9]

VISN 5 serves veterans from economically and demographically diverse areas in the District of Columbia, Kentucky, Maryland, Ohio, Pennsylvania, Virginia, and West Virginia. According to the VHA Site Tracking system, the network includes 1 HCS with facilities in Baltimore, Perry

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

[9] *The Curious Case of the VISN Takeover: Assessing VA's Governance Structure, Hearing Before the House Committee on Veterans' Affairs*, 115th Cong. (2018) (statement of Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration).

Point, and Loch Raven; 5 medical centers; 30 community-based outpatient clinics; and 2 homeless clinics.[10]

According to data from the VA National Center for Veterans Analysis and Statistics, VISN 5 had a veteran population of 770,658 at the beginning of fiscal year (FY) 2021 and a projected decreased population of 758,268 by the end of FY 2022. The FY 2020 annual medical care budget of $2,736,667,203 increased approximately 16 percent compared to the previous year's budget of $2,360,815,788. Leaders explained that future budgets were expected to decline after the COVID-19 and American Rescue Plan Act authorizations end.

The OIG recognizes that the COVID-19 pandemic has caused significant and widespread changes in the delivery of healthcare services. As a result, productivity data and supporting reports may require further analysis to reach specific actionable conclusions.

VISN 5 had an executive leadership team consisting of the Network Director, Deputy Network Director, Chief Medical Officer (CMO), and Quality Management Officer (QMO)/Chief Nursing Officer (CNO). The CMO and QMO/CNO oversaw facility-level patient care programs. Figure 2 illustrates the VISN's reported organizational structure.[11]

[10] VHA Directive 1229(1), *Planning and Operating Outpatient Sites of Care*, July 7, 2017, amended October 4, 2019. "The VHA site tracking (VAST) system (or database) is a centralized and dynamic inventory of VHA clinical care service sites that serves as the authoritative source of all VHA clinical sites of care with a unique address and an official station number."

[11] For this VISN, the Network Director is responsible for the directors of the Beckley VAMC (West Virginia), Hershel "Woody" Williams VAMC (Huntington, West Virginia), Louis A. Johnson VAMC (Clarksburg, West Virginia), Martinsburg VAMC (West Virginia), VA Maryland HCS (Baltimore), and Washington DC VAMC.

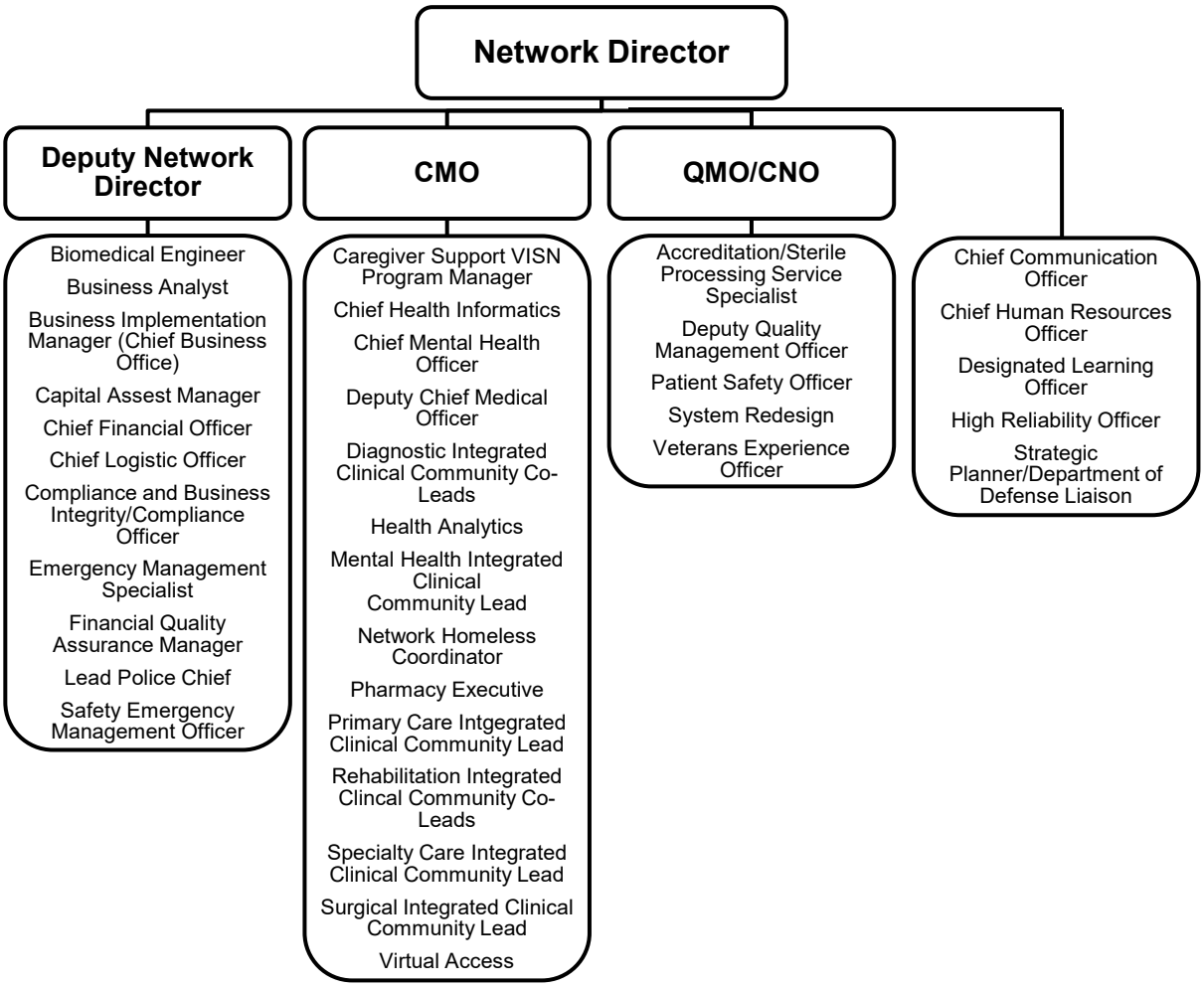

Figure 2. *VISN 5 organizational chart.*

Source: VA Capitol Health Care Network (received August 20, 2021).

At the time of the OIG virtual inspection, the VISN's executive leadership team had worked together since August 2020. The CMO, who was assigned in 2011, was the longest-tenured member of the team. The Network Director and Deputy Network Director were assigned in 2019 and the QMO/CNO in 2020 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network Director	February 3, 2019
Deputy Network Director	May 12, 2019
Chief Medical Officer	June 5, 2011
Quality Management Officer/Chief Nursing Officer	August 20, 2020

Source: VA Capitol Health Care Network (received August 26, 2021).

The leaders were members of the VISN's Executive Leadership Council, which was responsible for processes that enhance network performance by

- providing organizational values and strategic direction,
- developing policy and making decisions,
- managing compliance and financial performance,
- reviewing organizational performance and capabilities,
- identifying priorities for improvement and opportunities for innovation, and
- developing and communicating organizational goals and objectives across the network.

The Network Director served as the chairperson of the Executive Leadership Council, which had direct oversight of the Organizational Health; Healthcare Operations; Healthcare Delivery; Quality, Safety and Value; and Strategic Planning Committees (see figure 3).

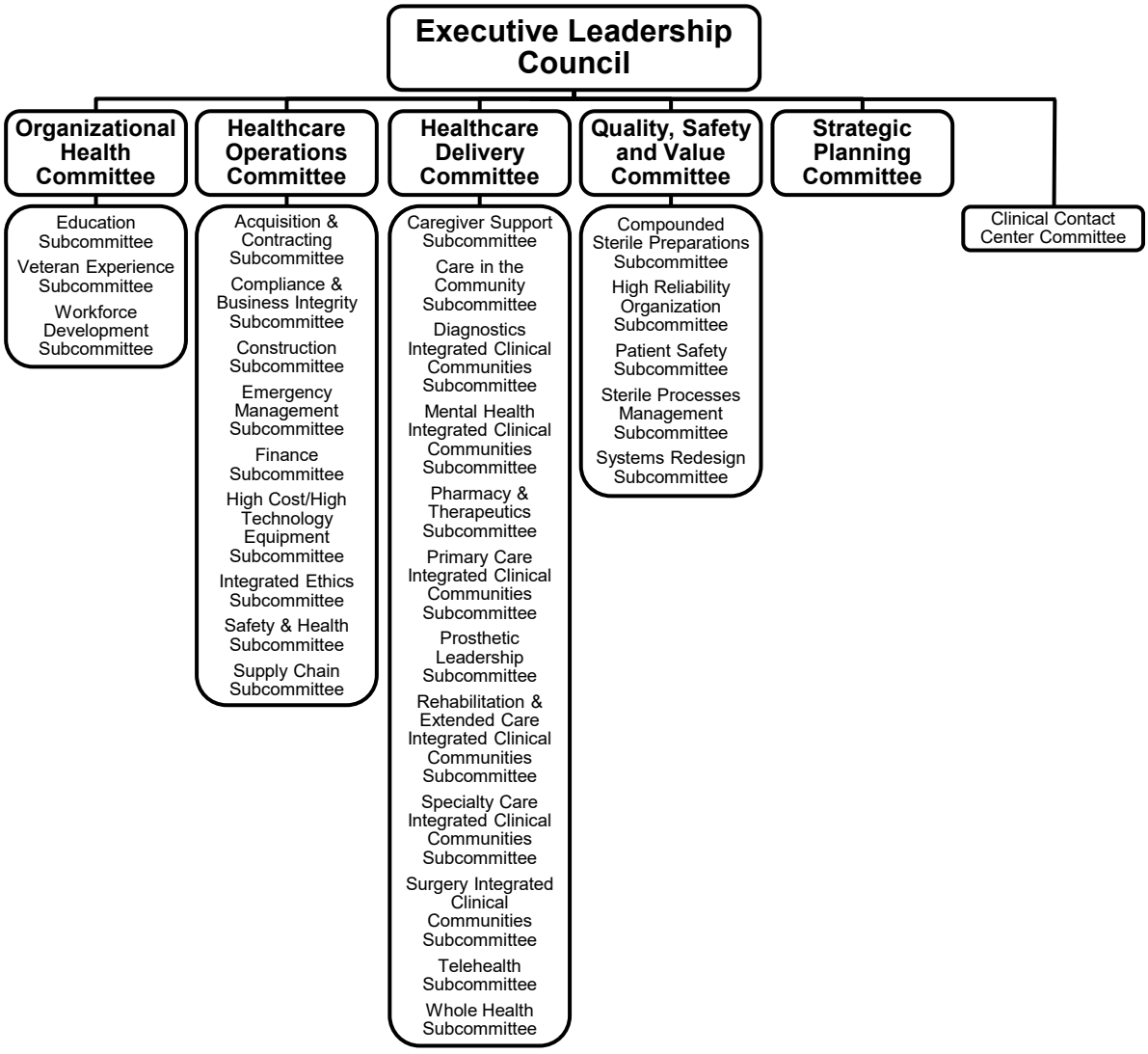

Figure 3. *VISN 5 committee reporting structure.*

Source: VA Capitol Health Care Network (received August 23, 2021).

To help assess VISN executive leaders' engagement, the OIG interviewed the Network Director; Deputy Network Director; CMO, QMO/CNO; and Chief, Human Resources Officer (HRO) regarding their knowledge of various performance metrics and involvement and support of actions to improve or sustain performance. In individual interviews, the executive leaders spoke knowledgeably about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[12] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[13] 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 with other information on VISN leaders.

To assess employee attitudes toward VISN leaders, the OIG reviewed VHA All Employee Survey satisfaction results from October 1, 2019, through September 30, 2020.[14] Table 2 summarizes those results. Leaders' average scores for the selected survey leadership questions were generally higher than VHA averages. However, the Deputy Network Director appeared to have an opportunity to improve the Servant Leader Index Composite score. For the FY 2020 survey results, leaders met with staff and the VISN Organizational Development Psychiatrist to review scores and develop action plans to improve employee satisfaction.[15]

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

[13] "AES Survey History."

[14] Ratings are based on responses by employees who report to or are aligned under the Network Director, Deputy Network Director, and CMO. The QMO/CNO did not have enough direct employee reports to calculate a score, so the QMO/CNO staff responses were included in the Network Director's totals.

[15] 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.

Table 2. Survey Results on Employee Attitudes toward VISN 5 Leadership (October 1, 2019, through September 30, 2020)

Questions/Survey Items	Scoring	VHA Average	VISN 5 Office Average	Network Director Average	Deputy Network Director Average	CMO Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	75.1	91.4	69.2	82.8
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.3	4.6	4.0	3.9
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.6	4.5	4.2	4.3
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.6	4.5	4.2	4.2

Source: VA All Employee Survey (accessed July 26, 2021).

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

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The leaders' averages for employee attitudes toward the workplace were better than the VHA averages.

Table 3. Survey Results on Employee Attitudes toward the VISN 5 Workplace (October 1, 2019, through September 30, 2020)

Questions/Survey Items	Scoring	VHA Average	VISN 5 Office Average	Network Director Average	Deputy Network Director Average	CMO Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.3	4.2	4.4
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	4.0	4.4	3.9	4.3
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day) lower is better	1.4	1.6	1.0	0.7	0.9

Source: VA All Employee Survey (accessed July 26, 2021).

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[16] 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 felt secure and respected.[17]

Table 4 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. Scores for VISN leaders were similar to or higher than VHA

[16] "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/. (This is an internal website not publicly accessible.) Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*, October 23, 2019.

[17] "Stand Up to Stop Harassment Now!"

averages. The leaders appeared to promote an environment where discrimination was not tolerated, and staff felt safe bringing up problems and tough issues.

Table 4. Survey Results on Employee Attitudes toward Workgroup Relationships (October 1, 2019, through September 30, 2020)

Questions/Survey Items	Scoring	VHA Average	VISN 5 Office Average	Network Director Average	Deputy Network Director Average	CMO Average
All Employee Survey: *People treat each other with respect in my workgroup*.	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	4.1	4.2	4.2	4.4
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	4.1	4.3	4.0	4.4
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues*.	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.9	4.4	4.0	4.0

Source: VA All Employee Survey (accessed July 26, 2021).

Patient Experience

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 collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.

The OIG reviewed patient experience survey responses to three relevant questions that reflect patients' attitudes toward their healthcare experiences from October 1, 2019, through September 30, 2020. Table 5 provides relevant survey results for VHA and VISN 5.[18] The VISN average was lower for inpatients' willingness to recommend the hospital, which indicated that VISN 5 patients were less satisfied with their inpatient care compared to VHA patients nationally.

VISN 5 facility scores for the selected survey questions are in appendix C. The OIG noted that inpatient satisfaction scores for the VA Maryland HCS and Washington DC VAMCs were the

[18] Ratings are based on responses by patients who received care within the VISN.

lowest in the VISN. The OIG found that the VISN Veterans Experience Officer tracked patient satisfaction scores, patient advocate data, and facility action plans, and reported the information during the Network Director's morning huddles and Healthcare Delivery Committee meetings. The CMO stated that previous inpatient satisfaction initiatives such as staff ensuring timely response to call buttons, making efforts to reduce noise, and conducting hourly rounds were successful in improving inpatient scores but not sustaining them.

Table 5. Survey Results on Patient Attitudes within VISN 5 (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA Average	VISN 5 Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	61.8
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	82.5	83.3
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.8	84.7

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2020).

Access to Care

Achieving and maintaining an optimal workforce to ensure timely access to the best care and benefits for our nation's veterans is a priority for VA. VHA has a goal of providing patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[19] VHA has used various measures to determine whether access goals are met for both new and established patients, including wait time statistics

[19] VHA Directive 1230(3), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended June 17, 2021. The "Clinically Indicated Date (CID) is the date an appointment that is deemed clinically appropriate by a VA health care provider. The CID is contained in a provider entered Computerized Patient Record System (CPRS) order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request…The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity."

based on appointment creation and patient preferred dates.[20] Wait time measures based on "create date" have the advantage of not relying on the accuracy of the "preferred date" entered into the scheduling system. These measures are particularly applicable for new primary care patients where the care is not initiated by a referral or consultation that includes a "clinically indicated date."[21] The disadvantage to "create date" metrics is that wait times do not account for specific patient requests or availability.[22] Wait time measures based on patient preferred dates consider patient preferences but rely on appointment schedulers accurately recording the patients' wishes into the scheduling software.[23]

When patients could not be offered appointments within 30 days of their clinically indicated or preferred dates, patients became eligible to receive non-VA (community) care through the VA Choice program—eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.[24] However, with the passage of the VA MISSION Act of 2018 and its enactment on June 6, 2019, eligibility criteria for obtaining care in the community now include average drive times and appointment wait times:[25]

- Average drive time
  - 30-minute average drive time for primary care, mental health, and noninstitutional extended care services
  - 60-minute average drive time for specialty care
- Appointment wait time
  - 20 days for primary care, mental health care, and noninstitutional extended care services, unless the veteran agrees to a later date in consultation with a VA health care provider
  - 28 days for specialty care from the date of request, unless the veteran agrees to a later date in consultation with a VA health care provider

To examine access to primary and mental health care within VISN 5, the OIG reviewed clinic wait time data for completed new patient appointments in selected primary and mental health

[20] "Completed appointments cube data definitions," VA Business Intelligence Office, accessed March 28, 2019.

[21] Office of Veterans Access to Care, *Specialty Care Roadmap*, November 27, 2017.

[22] Office of Veterans Access to Care, *Specialty Care Roadmap*.

[23] Office of Veterans Access to Care, *Specialty Care Roadmap*.

[24] VHA Directive 1700, *Veterans Choice Program*, October 25, 2016.

[25] The VA MISSION Act of 2018, Pub. L. No. 115-182 Stat. 1393; VA Office of Public Affairs Media Relations, *Fact Sheet: Veteran Community Care – Eligibility, VA MISSION Act of 2018,* April 2019.

clinics for the most recently completed quarter. Tables 6 and 7 provide wait time statistics for completed primary care and mental health appointments from April 1 through June 30, 2021.[26]

Table 6. Primary Care Appointment Wait Times (April 1 through June 30, 2021)

Facility	New Patient Appointments	Average New Patient Wait from Create Date (Days)
VISN 5	3,314	16.9
Beckley VAMC (WV)	276	11.5
Hershel "Woody" Williams VAMC (Huntington, WV)	522	12.9
Louis A. Johnson VAMC (Clarksburg, WV)	228	13.1
Martinsburg VAMC (WV)	727	15.8
VA Maryland HCS (Baltimore)	822	15.9
Washington DC VAMC (District of Columbia)	739	23.2

Source: VHA Support Service Center (accessed July 26, 2021).

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

Table 7. Mental Health Appointment Wait Times (April 1 through June 30, 2021)

Facility	New Patient Appointments	Average New Patient Wait from Create Date (Days)
VISN 5	773	18.6
Beckley VAMC (WV)	53	8.4
Hershel "Woody" Williams VAMC (Huntington, WV)	33	12.0
Louis A. Johnson VAMC (Clarksburg, WV)	62	9.0
Martinsburg VAMC (WV)	177	14.4
VA Maryland HCS (Baltimore)	198	23.7
Washington DC VAMC (District of Columbia)	250	21.1

Source: VHA Support Service Center (accessed July 26, 2021).

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

[26] Reported primary care wait times are for appointments designated as clinic stop 323, Primary Care Medicine, and records visits for comprehensive primary care services. Reported mental health wait times are for appointments designated as clinic stop 502, Mental Health Clinic Individual, and records visits for the evaluation, consultation, and/or treatment by staff trained in mental diseases and disorders.

Based on wait times alone, the MISSION Act may improve access to primary care for patients at the Washington DC VAMC, where the average wait time for new primary care appointments was 23.2 days. The VISN's overall average wait time for new mental health appointments was 18.6 days, and the longest average wait times were for the VA Maryland HCS and the Washington DC VAMC, at 23.7 and 21.1 days, respectively. The OIG noted that these wait times highlighted opportunities for these facilities to improve the timeliness of care provided "in house" and thus decrease the potential for fragmented care among patients referred to community providers.

The VISN's Primary Care Integrated Care Committee regularly monitored primary care wait times. The CMO reported that primary care wait times at the Fort Belvoir Outpatient Clinic in Northern Virginia were higher due to space issues, which contributed to the increased wait times for the parent facility—the Washington DC VAMC. To improve access at the Washington DC VAMC, facility group practice managers reviewed wait time data and made recommendations to increase available appointments by distributing patients more evenly among providers.

VISN leaders took the following actions to improve mental health appointment wait times and maintain continuity of care for patients:

- Consulted with staff at the VISN 2 clinical resource hub on best practices for implementing a mental health hub at the VA Maryland HCS
- Coordinated telehealth staffing assistance with VISN 2
- Tracked mental health hiring data in weekly meetings between the HRO and the VISN Mental Health Lead
- Worked with VA community care network contractors to increase the number of mental health providers available for in-network referrals

Clinical Vacancies

Within the healthcare field, there is general acceptance that staff turnover—or instability—and high clinical vacancy rates negatively affect access to care, quality, patient safety, and patient and staff satisfaction. Turnover can reduce employee and organizational performance through the loss of experienced staff.[27]

To assess the extent of clinical vacancies across VISN 5 facilities, the OIG held discussions with the HRO and reviewed the total number of vacancies by facility, position, service or section, and full-time equivalent (FTE) employees. Table 8 provides the vacancy rates across the VISN as of August 23, 2021.

[27] James Buchanan, "Reviewing the Benefits of Health Workforce Stability," *Human Resources for Health* 8, no. 29 (December 14, 2010), https://doi.org/10.1186/1478-4491-8-29.

Table 8. Reported Vacancy Rates for VISN 5 Facilities (as of August 23, 2021)

Facility	Clinical Vacancies	Clinical Vacancy Rate (%)	Total Vacancy Rate (%)
VISN 5	1,620.1	7.7	7.9
Beckley VAMC (WV)	84.5	4.5	5.0
Hershel "Woody" Williams VAMC (Huntington, WV)	106.6	4.0	4.7
Louis A. Johnson VAMC (Clarksburg, WV)	119.4	8.6	8.6
Martinsburg VAMC (WV)	247.5	7.7	7.6
VA Maryland HCS (Baltimore)*	555.6	11.8	10.9
Washington DC VAMC	506.5	9.9	10.8

Source: VISN 5: VA Capitol Health Care Network Deputy Human Resources Officer (received August 23, 2021).

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

**The vacancies for the VA Maryland HCS include the Baltimore, Loch Raven, and Perry Point VAMCs.*

The OIG found the following FTE primary care clinical vacancies across VISN 5:

- Physicians ~12
- Nurse practitioners ~20
- Nurses ~124

Clinical staffing may contribute to primary care wait time challenges at the Washington DC VAMC, where 4 physician, 6 nurse practitioner, and 35 nurse FTE positions were vacant.

For mental health, the OIG found the following FTE clinical vacancies across VISN 5:

- Psychiatrists ~32
- Psychologists ~46
- Nurses ~36
- Social workers ~116

The VISN's average wait time for new mental health patients was 18.6 days. The longest mental health wait times were at the VA Maryland HCS (23.7 days) and the Washington DC VAMC (21.1 days). Given the potential opportunities to improve mental health wait times, clinical staffing may be a contributing factor at the VA Maryland HCS, where 12 psychiatrist, 19 psychologist, 13 nurse, and 48 social worker FTE positions were vacant; and at the Washington DC VAMC, where 11 psychiatrist, 9 psychologist, 8 nurse, and 40 social worker FTE positions were vacant.

VISN leaders acknowledged a high turnover rate for mental health providers. The HRO reported regularly informing executive leaders about vacancy and recruitment data and meeting weekly with VISN mental health staff to review the status of hiring actions, time-to-hire statistics, and gains and losses data.

To improve access to care, VISN leaders included action items to increase patients' ability to obtain virtual care in their operational plan. As of the date of the OIG visit, VISN leaders had completed 6 of 10 action items.[28] The VISN has two Clinical Resource Hubs—a primary care hub at the Hershel "Woody" Williams VAMC and a mental health hub at the VA Maryland HCS. Both hubs are staffed with licensed independent practitioners who provide patients with virtual care through VA Video Connect.[29] The Network Director reported that in June 2021, VISN leaders hired a Health Systems Specialist to help manage resource hub operations and analyze existing hubs for improvement opportunities.

The HRO reported staff recruitment challenges across the VISN, with rural western facilities experiencing difficulty attracting healthcare providers, especially specialists who required increased incentives and pay. The Washington DC VAMC and VA Maryland HCS competed for staff against major university hospitals like Georgetown, George Washington, and Johns Hopkins, where salary competition was a considerable factor.

As of August 23, 2021, the VISN employed 12,940 FTE employees. During the COVID-19 pandemic, VISN leaders used VA's rapid hiring processes to increase facility staffing levels and had added 375 FTE employees since March 1, 2020. In FY 2021, the VISN had a growth rate of 3 percent, for a net change of 346 FTE employees. VISN leaders also used resources for incentives like pay adjustment by locality; the Education Debt Reduction Program; and recruitment, relocation, and retention bonuses.[30] In FY 2021, by the time of the OIG inspection, leaders had authorized expenditures of $13,713,165 on the bonuses and quality step

[28] Action items included education for all primary care and mental health providers, increasing patient use of telehealth from non-VA locations (from 11.5 to 18.7%), and expanding telehealth to specialty care (executive approval was received for a pain telehealth clinic and an endocrinology telehealth clinic, which will be operational in FY 2022).

[29] "VA Mobile: Veterans VA Video Connect," Department of Veterans Affairs, accessed August 17, 2021, https://www.mobile.va.gov/app/va-video-connect. VA Video Connect allows veterans to see and talk with their healthcare team from anywhere. It uses encryption to ensure a secure and private session. This technology makes VA health care more convenient and reduces travel times for veterans, especially those in very rural areas with limited access to VA healthcare facilities. It also allows quick and easy healthcare access from any mobile or web-based device.

[30] "Hiring Programs and Incentives," Department of Veterans Affairs, accessed January 5, 2022, https://www.vacareers.va.gov/Benefits/HiringProgramsInitiatives/. The "Education Debt Reduction Program (EDRP) authorizes VA to provide student loan reduction payments to employees with qualifying loans who are in positions providing direct patient care and that are considered hard to recruit or retain." Each VHA facility determines which positions will qualify for the Education Debt Reduction Program.

improvement awards. The HRO reported a FY 2021 Education Debt Reduction Program allocation of $40,000.

The OIG found the VISN had met VHA Human Resources Modernization milestones like direct reporting of facility senior strategic business partners to the VISN HRO and establishment of VISN-level shared service units (like consolidated classification, employee/labor relations, quality, and human resources information systems). According to the HRO, although modernization milestones had been met, unanticipated high staff turnover affected the timely delivery of human resources services to the facilities. This turmoil was reflected in the HRO's All Employee Survey scores, which were significantly lower than other VISN leaders' scores in key areas.[31]

In January 2021, VISN leaders recognized developing problems in Human Resources and distributed a Team Effectiveness Survey to program managers and supervisors; consulted with the VA National Center for Organization Development in February 2021; and developed action plans (e.g., communication improvement, SharePoint use and access, and weekly supervisor updates) that were implemented prior to the OIG's virtual inspection.

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders respond to identified problems. At the time of the virtual inspection, 27 recommendations remained open; however, as of April 2022, VISN and facility leaders had completed action plans for all but 6 recommendations for improvement listed in appendix D. The 6 open recommendations were from reports published in 2021.

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting developed 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."[32] 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.[33]

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[31] All Employee Satisfaction survey scores for the HRO were less favorable in all categories compared to other VISN leaders and VHA Averages. Specifically, the Servant Leader Index score was 66.9 compared to the VHA average of 73.8; the moral distress score was 1.9 compared to the VHA average of 1.4 (lower scores are better for this measure); and the score related to employees' perceptions of being treated with respect was 3.6 compared to the VHA average of 4.1.

[32] "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.)

[33] "Strategic Analytics for Improvement and Learning (SAIL) Value Model."

Figure 4 illustrates the VISN's quality of care and efficiency metric rankings and performance as of March 31, 2021. The figure uses blue and green data points to indicate high performance (for example, hospital-wide readmissions (RSRR-HWR), rating [of] primary care (PC) provider, and stress discussed). Metrics that need improvement are in orange and red (for example, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) hospital rating; mental health (MH) continuity [of] care; and specific metrics included in the Healthcare Effectiveness Data and Information Set (HEDIS), which are also referenced in table 9.[34]

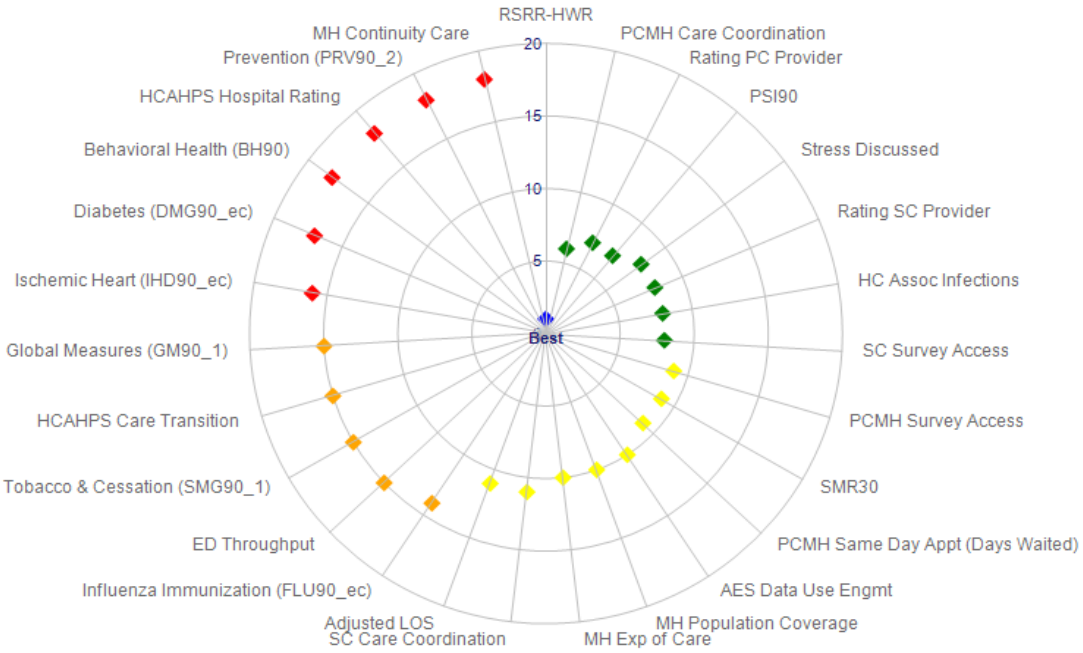


Figure 4. *VISN 5 quality of care and efficiency metric rankings for FY 2021 quarter 2 (as of March 31, 2021).*

Source: VHA Support Service Center.

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

The executive leaders were aware of the fifth quintile measures and stated that each facility leader submitted action plans to VISN leaders to address them. The Executive Leadership Council and other healthcare committees monitored performance measures through the VISN's

[34] "Healthcare Effectiveness Data and Information Set: HEDIS Measures," Centers for Medicare & Medicaid Services, accessed October 28, 2021, https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-HEDIS. HEDIS is a set of outpatient performance measures that compares health plan performance to national or regional benchmarks. HEDIS is one component of the National Committee for Quality Assurance's (NCQA) accreditation process. "The HCAHPS Survey – Frequently Asked Questions," Centers for Medicare & Medicaid Services, accessed October 28, 2021, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/HospitalHCAHPSFactSheet201007.pdf. HCAHPS is a standardized survey tool that measures "patients' perspectives of hospital care." For additional data definitions of acronyms in the SAIL metrics, please see appendix E.

Clinical Operations Dashboard, which displays performance measure data reported by facility leaders. The Network Director and CMO reported that the poorly performing mental health continuity of care measure was related to several issues:

- Inadequate staffing
- Disjointed care resulting from community referrals
- Insufficient performance measure monitoring, including suicide risk
- Fragmented discharge follow-up[35]

The CMO discussed various actions to improve mental health continuity of care including hiring psychiatrists, psychologists, and social workers, meeting weekly to report staffing updates to the VISN Mental Health Lead, and ensuring staff follow up with patients after discharge from inpatient psychiatry.

The Deputy CMO reported that the Veteran Experience Subcommittee presented HCAHPS data to the Organizational Health Committee on a quarterly basis and worked with staff at lower performing facilities to address additional measures. As of August 2021, the VISN's HCAHPS overall hospital rating was 65.2, which placed it in the lowest 10 percent of VISN scores.

Table 9 lists the 5th quintile HEDIS outpatient composite measures that are displayed in figure 4 above.

Table 9. VISN 5 HEDIS Outpatient Composite Performance Measures (as of March 31, 2021)

HEDIS Outpatient Composite (Measure)	VISN 5	VISNs 10th Percentile	VISNs 90th Percentile
Behavioral Health (BH90)	89.1	90.0	92.7
Diabetes (DMG90_ec)	72.2	72.2	76.9
Ischemic Heart (IHD90_ec)	71.6	70.5	75.7
Prevention (PRV90_2)	79.4	79.7	84.0

Source: Strategic Analytics for Improvement and Learning (SAIL), VHA Support Service Center as of October 28, 2021.

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

The CMO reported being aware of the lower HEDIS scores and stated that the Primary Care Integrated Clinical Communities Subcommittee tracked measures but had not formulated a formal plan of action to address the lower scores.

[35] The fragmented discharge follow-up refers to patients who initially received outpatient mental health care at the Beckley VAMC but then transferred to the inpatient unit at the Louis A. Johnson VAMC.

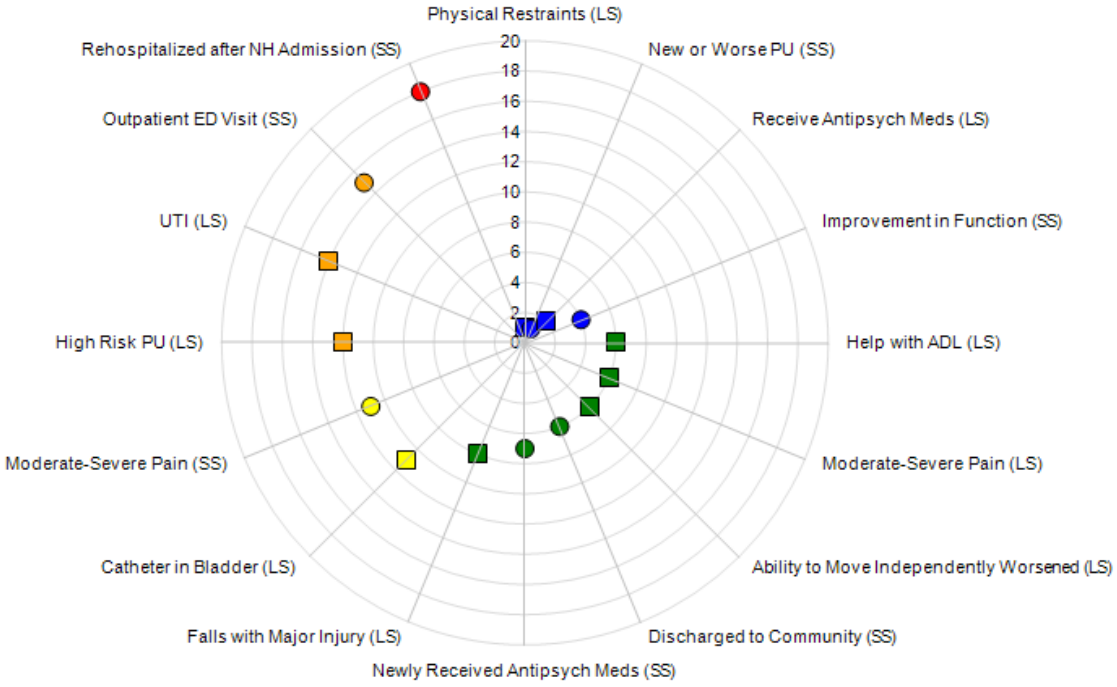
The SAIL Value Model also includes a community living center (CLC) model, which is a tool to "summarize and compare performance of CLCs in the VA."[36] The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[37]

Figure 5 illustrates the VISN's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2020. The figure uses blue and green data points to indicate high performance (for example, physical restraints–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), and moderate-severe pain (LS)). Measures that need improvement are denoted in orange and red (for example urinary tract infection (UTI) (LS), outpatient emergency department (ED) visit (SS), and rehospitalized after nursing home (NH) admission (SS)).[38]

[36] 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.

[37] 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*. "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."

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



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

Figure 5. *CLC quality measure rankings for FY 2021 quarter 1 (as of December 31, 2020).*

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

Source: VHA Support Service Center.

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

Individual CLC facilities are ranked by VHA on a 1- through 5-star scale in the areas of unannounced surveys, staffing, quality, and overall rating. The OIG found that quality scores showed all CLCs were ranked at 5 stars except the Beckley CLC, which was ranked at 2 stars. For unannounced surveys, the Baltimore and Washington DC CLCs were the lowest scoring, each with 2 stars.

The Deputy CMO attributed the quality and unannounced survey scores at the Beckley CLC in part to unstable staffing; high turnover rates; and, in some cases, a low number of patients skewing scores when only one patient had a fall or an issue with medications. The Deputy CMO and VISN Geriatric and Extended Care Lead stated they reviewed performance measures and reported monthly to the Health Care Delivery Committee.

To improve quality of care, leaders reported that VISN staff assisted in developing action plans for the Beckley CLC that focused on prescribing practices, infection control, and mentoring and leadership training modules. Leaders also explained that mock survey teams—staffed by providers from another CLC within the VISN—conducted surveys and helped staff to better understand the process. This resulted in an improved March 2021 unannounced survey score at the Washington DC CLC, where only one deficiency was noted.

Observed Trends in Noncompliance

The OIG identified that the Network Director and QMO/CNO had opportunities to improve their oversight of facility-level quality, safety, and value; care coordination; and high-risk processes. During virtual CHIP inspections of the VISN 5 facilities performed during the weeks of August 9 and 23, 2021, the OIG noted trends in noncompliance for the following areas:

- Quality, safety, and value
  - Surgical work group attendance
- Care coordination (inter-facility transfers)
  - Transfer note completion
  - Pertinent medical records sent to receiving facilities
  - Communication between nurses at sending and receiving facilities
  - Transfer monitoring and evaluation
- High-risk processes (management of disruptive and violent behavior)
  - Committee meeting attendance
  - Staff training

In response to these trends, the Network Director stated that VISN staff would follow up with responsible facility directors, associate directors for patient care services, and associate directors and ensure that action plans are implemented, and improvements are sustained.

Louis A. Johnson VA Medical Center

On May 11, 2021, a former VA nursing assistant was sentenced to seven consecutive life sentences for the murder of seven veterans at the Louis A. Johnson VAMC in Clarksburg, West Virginia. A criminal investigation and OIG review followed the discovery of these deaths.

The OIG's review found that Louis A. Johnson VAMC staff did not maintain a process to conduct rigorous reviews of mortality data to identify outliers or track and trend results. The OIG recommended that VISN managers conduct reviews of the murdered patients' care and arrange an external clinical evaluation of patients who may have been harmed by the nursing assistant while employed at the facility. At the time of the OIG visit, the two VISN-level recommendations remained open.

The Network Director explained that leaders were not holding Morbidity and Mortality meetings at the Louis A. Johnson VAMC when the murders occurred. However, since then VISN leaders have ensured that all facility leaders within the VISN conduct required Morbidity and Mortality

reviews, which are reported through the Healthcare Delivery Committee.[39] The CMO reported regularly reviewing facility mortality data while detailed to the Louis A. Johnson VAMC and stated that three facility teams also followed mortality rates.

The QMO/CNO reported that at the time of the incidents, facility leaders' efforts had been reactive as there was no effective quality framework in place. The QMO/CNO also stated that in the aftermath of the events, facility staff expressed frustration at the number of acting leadership rotations and, at times, had been unwilling to follow orders in attempts to wait out the acting leaders' details. Per the QMO/CNO, after the incidents were discovered, VISN efforts to address quality issues included updating nurse competencies and reviewing patient safety processes. The QMO/CNO also emphasized the need for consistent messaging by acting leaders and finalization of nurse proficiency standards.

Since the incident, an Administrative Investigation Board evaluated the quality of care and leadership at the Louis A. Johnson VAMC.[40] The board recommended the following improvement actions for the facility and VISN:

- Safety stand down training[41]
- Joint Patient Safety Reporting training[42]
- High reliability organization baseline training[43]
- Annual patient safety education and weekly activities
- Standardized training content and evaluation tools
- Monthly rounds with facility leaders

[39] VHA Directive 1320, *Quality Management (QM) and Patient Safety Activity That Can Generate Confidential Documents,* July 10, 2020. Morbidity and mortality reviews are quality management activities that are "discussions among clinicians of the care provided to individual patients who died or experienced complications."

[40] VA Directive 0700, *Administrative Investigation Boards and Fact Findings*, August 10, 2021.

[41] Safety stand downs often occur after a specific incident and can range from short training sessions to day-long training sessions.

[42] "Confidential Reporting System," VHA National Center for Patient Safety, accessed April 14, 2022, https://www.patientsafety.va.gov/media/reporting.asp. The Joint Patient Safety Reporting system is a VHA and Department of Defense tool that standardizes the way in which medical errors are reported.

[43] "VHA's Vision for a High Reliability Organization," Health Services Research & Development, accessed May 5, 2022, https://www.hsrd.research.va.gov/publications/forum/summer20/default.cfm?ForumMenu=summer20-1. A high reliability organization (HRO) is "an organization that experiences fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments where even small errors can lead to tragic results." Baseline training includes "frontline staff, supervisors, and executive leaders."

As of August 8, 2021, leaders had overseen several changes:

- There was a continuous increase in staff who completed Joint Patient Safety Reporting training
- Over 90 percent of staff finished high reliability organization training
- The acting facility Director conducted "We Care Rounds" every two weeks beginning in February 2021[44]
- Facility and VISN leaders carried out monthly patient safety rounds at the medical center and community-based outpatient clinics

The board also recommended that VHA follow up to ensure that human resources staff conduct suitability for hire and background checks on all applicants, which help determine if a prospective candidate is suitable for employment in the federal government. VISN leaders reported providing weekly suitability adjudication completion rates for all VISN 5 newly hired employees to VHA. The OIG found that the HRO also produced a delinquency report for VISN and VHA leaders that contained the number of staff with pending adjudication of background and suitability information.

At the time of the virtual CHIP visit at the Louis A. Johnson VAMC, the facility's director, associate director, chief of staff, associate director for patient care services, and quality manager positions were vacant. While these positions were encumbered, VISN leaders coordinated filling the positions with acting staff from within the network and other VISNs; this vacancy coverage included a 240-day detail of an acting Director, a two-month detail by the VISN CMO, and multiple shorter details by the VISN QMO/CNO and other staff.[45]

The Network Director reported that the VISN HRO provided weekly hiring updates to track progress on filling the facility's leadership positions. At the time of the OIG virtual inspection, the Network Director stated that all leadership positions had been advertised, with final hiring decisions pending for the director, associate director, and chief of staff positions. The associate director for patient care services and quality manager positions were pending additional hiring actions (e.g., incentive approvals, candidate selection, and interviews).

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[44] "VA Patient Experience: Changing the way Veterans experience their care," VA Vantage Point, January 29, 2019, accessed February 7, 2022, https://blogs.va.gov/VAntage/55966/va-patient-experience-changing-way-veterans-experience-care/. "WECARE Rounding: Medical Center Leaders and Administrators make "rounds," speaking directly with staff and visitors about the care and services they received."

[45] At the time of the Louis A. Johnson VAMC's comprehensive healthcare inspection, the executive team had no permanently assigned staff; acting staff had worked together for approximately seven weeks. Three of the leaders, who were in place at the time of the murders, were detailed to other positions: the Medical Center Director on December 23, 2020; Chief of Staff on February 22, 2021; and Associate Director for Patient Care Services on December 28, 2020. The leadership positions remained encumbered until July 2021, which meant they could not be permanently filled until the prior assigned staff were no longer eligible for return.

Leadership and Organizational Risks Conclusion

The executive leaders had worked together since August 2020 and had spent much of their time and efforts on improving care and leadership at the Louis A. Johnson VAMC in the aftermath of the murders at the facility. The CMO came to the VISN in 2011 and was the longest-serving executive leader. The Network Director and Deputy Network Director were assigned in 2019 and the QMO/CNO in 2020 (the QMO also served as the CNO).

Selected survey scores related to employees' satisfaction with the VISN leaders were generally higher than VHA averages, however, the Deputy Network Director appeared to have an opportunity to improve the Servant Leader Index score. In the review of patient experience survey data, the OIG noted that VISN averages for the selected survey questions were similar to VHA averages, except for the inpatient question "willingness to recommend the hospital to friends and family," which was substantially lower than the VHA average. The VISN leaders appeared actively involved with employees and patients and were working to sustain engagement and satisfaction.

The OIG's review of access metrics and clinical vacancies identified potential organizational risk factors at the VA Maryland HCS and Washington DC VAMC, where mental health wait times were over 20 days and the overall clinical vacancy rates were 10.9 and 10.8 percent, respectively.

The OIG also identified a potential organizational risk in the Human Resources Department related to the lack of sustained efforts for retaining human resources staff and supporting facility hiring efforts. Further, the OIG determined that the Network Director, CMO, and QMO/CNO had opportunities to improve their oversight of facility-level quality, safety, and value; care coordination; and high-risk processes.

The executive team leaders seemed to support efforts to improve and maintain patient safety, quality care, and other positive outcomes and were active in efforts to improve care and leadership at the Louis A. Johnson VAMC. The leadership team was knowledgeable within their scope of responsibilities about selected SAIL and CLC metrics and should continue to take actions to sustain and improve performance.

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.[46] 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.[47]

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."[48] "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."[49]

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 VISN 5 and its leaders' subsequent response. The OIG analyzed performance in the following domains:

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

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 5 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[50]

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[46] "WHO Director General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, accessed March 23, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

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

[48] 38 U.S.C. § 1785(a); 38 C.F.R. § 17.86(b). VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the "[p]rovision 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."

[49] 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.

[50] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

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.[51] 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.[52] Designated leaders are directly accountable for program integration and communication within their level of responsibility. 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."[53]

To determine whether the VISN implemented and incorporated OIG-identified key processes for quality and safety, the inspection team interviewed VISN managers and reviewed meeting minutes and other relevant documents. Specifically, OIG inspectors examined the following requirements:

- Designation of a systems redesign and improvement program manager[54]
- Establishment of a systems redesign and improvement advisory group that has representation from each VISN medical facility[55]
- Assignment of a chief surgical consultant who also serves as chairperson of the VISN surgical work group[56]
- Designation of a VISN lead surgical nurse who participates in the VISN surgical work group[57]
    - Chairperson of conference calls with VA facility surgical quality nurses
- Collection, analysis, and action, as appropriate, in response to VISN peer review data[58]

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

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

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

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

[55] VHA Directive 1026.01.

[56] VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended on April 19, 2022.

[57] VHA Directive 1102.01(2).

[58] 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.

  - Monitoring of facility outlier data and communication of follow-up actions to VISN and facility directors
  - Submission of quarterly VISN peer review data analysis reports to the Office of Quality, Safety, and Value
- Quarterly reporting of institutional disclosures to the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value[59]

Quality, Safety, and Value Findings and Recommendations

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

[59] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

Medical Staff Credentialing

VHA has defined procedures for the credentialing of medical staff—"the systematic process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training and experience, and current competence and health status."[60] When certain actions are taken against a physician's license, the Chief of Human Resources Management Service, or Regional Counsel, must determine whether the physician meets licensure requirements for VA employment.[61] Further, physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued, and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review" by Regional Counsel and concurrence and approval of the appointment by the VISN CMO.[62] The Deputy Under Secretary for Health for Operations and Management is responsible for "ensuring that VISN Directors maintain an appropriate credentialing and privileging process consistent with VHA policy," which includes VISN CMO oversight of facilities' processes.[63]

The OIG inspection team reviewed VISN facility physicians hired after January 1, 2018.[64] When reports from the National Practitioner Data Bank or Federation of State Medical Boards appear to confirm that a physician has a potentially disqualifying licensure action or licensure action requiring further review, inspectors examined evidence of the

- Chief of Human Resources Management Service, or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements,
- Regional Counsel or designee's documented review to determine if the physician meets appointment requirements, and
- VISN CMO concurrence and approval of the Regional Counsel or designee's review.

[60] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This handbook was in place at the time of the inspection. The credentialing portion of VHA Handbook 1100.19 was replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers,* September 15, 2021.)

[61] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. (This directive was in place at the time of the inspection. VHA Directive 2012-030 was replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers,* September 15, 2021.)

[62] VHA Handbook 1100.19.

[63] VHA Handbook 1100.19.

[64] GAO, *Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*, GAO-19-6, February 2019. VHA Central Office directed VHA-wide licensure reviews that were "started and completed in January 2018, focused on the approximately 39,000 physicians across VHA and used licensure-action information from the Federation of State Medical Boards." The OIG reviewed VISN facility physicians hired after January 1, 2018, to continue efforts to identify staff not meeting VHA employment requirements since "VHA officials told us [GAO] these types of reviews are not routinely conducted…[and] that the initial review was labor intensive."

Medical Staff Credentialing Findings and Recommendations

The OIG identified weaknesses in the review and approval of physicians who had potentially disqualifying licensure actions prior to their VA appointment.

VHA policy states that physicians "who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review."[65] The physicians' "credentials file[s] must be reviewed with Regional Counsel, or designee, [and]...the review and the rationale for the conclusions must be forwarded to the VISN CMO for concurrence and approval of the appointment."[66]

The OIG reviewed profile information for 306 physicians, using publicly-available data and VetPro, and did not find evidence that Regional Counsel, or a designee, reviewed the credentials files for 2 physicians who had a potentially disqualifying licensure action. Further, the OIG did not find evidence that the VISN CMO approved the VA appointments.[67] In the following cases, failure to conduct the required review could result in inappropriate hiring decisions that jeopardize the quality of patient care.

The first physician, hired in January 2020, had a medical license placed on probation in March 2020, and the probation was terminated in April 2021. The CMO stated that the facility's human resources staff likely felt that their review met VHA requirements because the physician's license lacked any restrictions during the probationary period.

The second physician was hired in June 2021 and had a license placed on probation from December 2017 to June 2018. The CMO reported that the license was unrestricted, so the facility's human resources staff likely felt that the review process met the intent. The CMO shared that VISN staff took several proactive steps to improve their processes, including identifying adverse actions that need further review by facility leaders and reviewing all new credentialing-related standard operating procedures.

Recommendation 1

1. The Chief Medical Officer determines the reason for noncompliance, reviews the credentials file, and approves the VA appointment for physicians who had a potentially disqualifying licensure action.

[65] VHA Handbook 1100.19.

[66] VHA Handbook 1100.19.

[67] VHA Handbook 1100.19. "VetPro is an Internet enabled data bank for the credentialing of VHA health care practitioners that facilitates completion of a uniform, accurate, and complete credentials file."

VISN concurred.

Target date for completion: July 31, 2022

VISN response: The VISN Chief Medical Officer (CMO) evaluated and determined no additional reasons for non-compliance. The VISN conducted an immediate 100% lookback (January 2018 – August 2021) of license actions. The VISN 5 Credentialing and Privileging (C&P) Officer conducted training with all VISN 5 C&P Managers on October 14, 2021, and with all VISN 5 C&P Staff on January 27, 2022 on both the License Action Review (LAR) memo, CMO review triggers and the new national Medical Staff Affairs SOPs C25 and C40. An update was presented to the VISN Healthcare Delivery Committee and Chief Human Resources Officer on September 14, 2021. The VISN C&P Officer monitored CMO reviews monthly (if) required for completion until 90% or above compliance was achieved for six consecutive months. Compliance from September 2021 – May 2022 audits will be reported to the June Healthcare Delivery Committee, chaired by the CMO.

Month	CMO Reviews Required	CMO Review completed	%Compliance
September 2021	0	0	100%
October 2021	0	0	100%
November 2021	0	0	100%
December 2021	0	0	100%
January 2022	0	0	100%
February 2022	2	2	100%
March 2022	0	0	100%
April 2022	0	0	100%

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires that healthcare facilities provide a safe, clean, and functional environment of care for veterans, their families, visitors, and employees in accordance with applicable Joint Commission Environment of Care standards, federal regulatory requirements, and applicable VA and VHA requirements.[68] The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.[69] VHA provides policy, mandatory procedures, and operational requirements for implementing an effective supply chain management program at VA healthcare facilities which includes responsibility for VISN-level oversight.[70]

The OIG inspection team reviewed relevant documents and interviewed VISN managers. Specifically, inspectors examined the following requirements:

- Establishment of a policy that maintains a comprehensive environment of care program at the VISN level
- Establishment of a VISN Emergency Management Committee[71]
    - Met at least quarterly
    - Documented an annual review within the previous 12 months of the VISN's
        - Emergency Operations Plan
        - Continuity of Operations Plan
        - Hazards Vulnerability Analysis
    - Conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leaders for review and approval

[68] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (This directive was in place at the time of the inspection. It was rescinded and replaced by VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021.) VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[69] VHA Directive 1608. (VHA removed the requirement for VISNs to have a written policy in the updated directive.)

[70] VHA Directive 1761(2), *Supply Chain Inventory Management*, October 24, 2016, amended October 26, 2018. (The directive was rescinded and replaced by VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.)

[71] VHA Directive 0320.01.

- Assessment of inventory management programs through an annual quality control review[72]

Environment of Care Findings and Recommendations

The VISN complied with most requirements for a comprehensive environment of care program. However, the inspection team identified a weakness with assessment of inventory management programs through an annual quality control review.

VHA policy requires assessment of "inventory management programs at VISN medical facilities through a quality control review once per fiscal year."[73] The OIG found that staff did not assess inventory management programs in FY 2020. The failure to assess these programs at medical facilities could potentially hinder the allocation of resources to address deficiencies that may affect patient care. The Chief Supply Chain Officer stated that due to the COVID-19 pandemic, VHA issued a suspension of quality control reviews for FY 2020. However, the chief reported that VISN staff began virtual reviews in FY 2021 and completed the Louis A. Johnson VAMC quality control review, and were reviewing the VA Maryland HCS and Hershel "Woody" Williams, Martinsburg, Washington DC, and Beckley VAMCs at the time of this inspection. The chief further explained that the virtual quality control review timeline is flexible as they work with facility staff's schedules to accommodate COVID-19 priorities. Additionally, the chief stated that the VISN would undergo a VA Central Office audit of their quality control review process on September 22, 2021. Due to the VHA waiver for the assessment of inventory management programs, the OIG made no recommendations related to this finding.[74]

[72] VHA Directive 1761(2).

[73] VHA Directive 1761(2).

[74] Acting Executive Director, Logistics (10NA2) Memorandum, *Temporary Waiver of certain VHA Logistics Supply Chain Policy Requirements and Performance Measures,* April 17, 2020. Acting Executive Director, Logistics (10NA2) Memorandum, *Temporary Waiver of certain VHA Logistics Supply Chain Policy Requirements and Performance Measures*, May 7, 2020.

Mental Health: Suicide Prevention

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.[75] 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.[76] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[77]

VHA requires VISN leaders to appoint mental health staff to serve as a member of its primary governing body, participate on each state's suicide prevention council or workgroup, and coordinate activities with state and local mental health systems and community providers.[78]

The OIG reviewed relevant documents and interviewed managers to determine whether VISN staff complied with various suicide prevention requirements:

- Designation of a mental health professional to serve on the VISN's primary governing body and each state's suicide prevention council or workgroup
- Designation of a mental health liaison to coordinate activities with state, county, and local mental health systems and community providers

Mental Health Findings and Recommendations

Generally, the VISN achieved the requirements listed above. The OIG made no recommendations.

[75] "Suicide Prevention: Facts About Suicide," Centers for Disease Control and Prevention, accessed October 8, 2021, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.

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

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

[78] Principal Deputy Under Secretary for Health Operations and Management (10N) Memorandum, *Patients at High-Risk for Suicide*, April 24, 2008. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

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 an acutely ill patient when their needs can be better managed at another facility.[79]

When VA or non-VA staff transfer a patient "to a VA facility in a manner that violates [VA] policy," the VISN CMO is responsible for contacting the transferring facility and conducting a fact-finding review to determine if the transfer was appropriate.[80] Examples of patient transfers that do not comply with VA policy include

- patients who were not appropriately screened and/or did not consent prior to transfer,
- patients who were not transferred with qualified personnel or equipment,
- transfers that were not approved by a VA physician, or
- pertinent medical records were not sent with patients at the time of transfer.[81]

The OIG reviewed relevant documents and interviewed key managers to determine whether the VISN CMO contacted the transferring facility and conducted a fact-finding review for reported cases of possible inappropriate transfers to a VA facility in calendar year 2020.

Care Coordination Findings and Recommendations

The Deputy CMO reported that VISN staff had not received notifications of inappropriate facility transfers in calendar year 2020. The OIG made no recommendations.

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

Women's Health: Comprehensive Care

Women were estimated to represent approximately 10 percent of the veteran population as of September 30, 2019.[82] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans are anticipated to increase.[83] To help the VA better understand the needs of the growing women veterans population, VHA has made efforts to examine "health care use, preferences, and the barriers Women Veterans face in access to VA care."[84]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive health care services in all VA medical facilities.[85] VHA also requires that VISNs appoint a lead women veterans program manager to serve as the VISN representative on women veterans' issues and identify gaps through "VISN-wide needs assessments, site visits, surveys, and/or other means, including conducting yearly site visits at each facility within the VISN."[86]

To determine whether the VISN complied with OIG-selected VHA requirements, the inspection team reviewed relevant documents and interviewed selected managers on the following VISN-level requirements:

- Appointment of a lead women veterans program manager
- Establishment of a multidisciplinary team that executes strategic planning activities for comprehensive women's health care
- Provision of quarterly program updates to executive leaders
- Monthly calls held with facility women veterans program managers and women's health medical directors
- Completion of annual site visits at each VISN facility
    - Needs assessment conducted

[82] "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.

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

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

[85] VHA Directive 1330.01(4), *Health Care Services for Women Veterans,* February 15, 2017, amended January 8, 2021.

[86] VHA Directive 1330.02, *Women Veterans Program Manager*, August 10, 2018.

  - Progress toward implementation of recommended interventions tracked
- Assessments to identify staff education gaps
  - Educational programs and/or resources developed when needs are identified
- Availability of VISN-level support staff for implementing performance improvement projects
- Analysis of women veterans' access and satisfaction data
  - Improvement actions implemented when recommended

Women's Health Findings and Recommendations

Generally, the VISN achieved the requirements listed above. The OIG made no recommendations.

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 within this VISN, the OIG conducted a detailed review of key clinical and administrative processes associated with promoting quality care and provided one recommendation on an issue that may adversely affect patients. The recommendation does not reflect the overall caliber of services delivered within this VISN. However, the OIG's findings illuminate a concern involving VISN responsibilities in medical staff privileging, and the recommendation may help guide improvement efforts. A summary of the recommendation is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendation

The table below outlines one OIG recommendation attributable to the Chief Medical Officer. The intent is for this VISN leader to use the recommendation to guide improvements in operations and clinical care. The recommendation addresses a finding that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Recommendation Summary Table

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Access to care • Clinical vacancies • Oversight inspections • VHA performance data • Observed trends in noncompliance	• None	• None
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback • Vaccine administration	The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for the facilities under VISN 5 jurisdiction in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Systems Redesign and Improvement Program staff and requirements • VISN Surgical Work Group • Collection, analysis, and action in response to VISN peer review data • Quarterly reporting of institutional disclosures for each facility	• None	• None
Medical Staff Credentialing	• Chief of Human Resources Management Service or Regional Counsel's review to determine whether the physician satisfies VA licensure requirements • Regional Counsel or designee's documented review to determine the if the physician meets appointment requirements and subsequent concurrence/approval by VISN CMO	• The Chief Medical Officer reviews the credentials file and approves the VA appointment for physicians who had a potentially disqualifying licensure action.	• None
Environment of Care	• Establishment of a policy that maintains a comprehensive environment of care program at the VISN level • Establishment of a VISN Emergency Management Committee • Assessment of inventory management programs through an annual quality control review	• None	• None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Mental Health: Suicide Prevention	• Designation of a mental health professional to serve on the VISN's primary governing body and each state's suicide prevention council or workgroup • Designation of a mental health liaison to coordinate activities with state, county, and local mental health systems and community providers	• None	• None
Care Coordination	• CMO contact and fact-finding review for reported cases of possible inappropriate inter-facility patient transfers	• None	• None
Women's Health: Comprehensive Services	• Lead women veterans program manager appointed • Multidisciplinary team that executes strategic planning activities established • Quarterly program updates provided to executive leaders • Monthly calls held with facility women veterans program managers and women's health medical directors • Annual site visits completed at each facility • Staff education gap assessments conducted • Support staff available • Women veterans' access and satisfaction data analyzed	• None	• None

Appendix B: VISN 5 Profile

The table below provides general background information for VISN 5.

Table B.1. Profile for VISN 5
(October 1, 2017, through September 30, 2020)

Profile Element	VISN Data FY 2018*	VISN Data FY 2019 †	VISN Data FY 2020‡
Total medical care budget	$2,293,736,240	$2,360,815,788	$2,736,667,203
Number of:			
• Unique patients	218,373	226,148	227,000
• Outpatient visits	2,877,883	2,993,698	2,755,672
• Unique employees§	12,198	12,717	13,021
Type and number of operating beds:			
• Community living center	566	586	594
• Domiciliary	443	434	439
• Hospital	524	544	536
Average daily census:			
• Community living center	371	408	359
• Domiciliary	335	320	185
• Hospital	291	292	238

Source: 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: Survey Results

Table C.1. Survey Results on Patient Attitudes within VISN 5 (October 1, 2019, through September 30, 2020)

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	VHA	69.5
		VISN 5	61.8
		Baltimore, MD	58.3
		Beckley, WV	69.9
		Clarksburg, WV	70.8
		Huntington, WV	69.8
		Martinsburg, WV	66.9
		Washington, DC	49.8
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	82.5
		VISN 5	83.3
		Baltimore, MD	82.2
		Beckley, WV	86.9
		Clarksburg, WV	86.0
		Huntington, WV	85.3
		Martinsburg, WV	86.3
		Washington, DC	79.7
Survey of Healthcare Experiences of Patients (outpatient specialty care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?	The response average is the percent of "Agree" and "Strongly Agree" responses.	VHA	84.8
		VISN 5	84.7
		Baltimore, MD	84.6
		Beckley, WV	84.1
		Clarksburg, WV	87.1
		Huntington, WV	89.6
		Martinsburg, WV	86.4
		Washington, DC	81.2

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2020).

Appendix D: Office of Inspector General Inspections

Table D.1. Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Comprehensive Healthcare Inspection Program Review of the Huntington VA Medical Center, Huntington, West Virginia, Report No. 17-01760-85, January 31, 2018.	August 2017	0	7	–	0
Postoperative Care Concerns for a Vascular Surgical Patient at the Martinsburg VA Medical Center, West Virginia, Report No. 17-05381-258, August 16, 2018.	September 2017	0	3	–	0
Comprehensive Healthcare Inspection Program Review of the Martinsburg VA Medical Center, Martinsburg, West Virginia, Report No. 17-05409-140, March 29, 2018.	October 2017	0	5	–	0
Comprehensive Healthcare Inspection Program Review of the Beckley VA Medical Center, West Virginia, Report No. 17-05401-240, August 13, 2018.	December 2017	0	8	–	0
Comprehensive Healthcare Inspection Program Review of the Louis A. Johnson VA Medical Center, Clarksburg, West Virginia, Report No. 18-01136-313, October 24, 2018.	May 2018	0	9	–	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center, Report No. 17-01757-50, January 28, 2019.	May 2018	0	18	–	1*
Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, Report No. 20-03593-140, May 11, 2021.†	July 2020	2	10	2‡	10§
Comprehensive Healthcare Inspection of the VA Maryland Health Care System, Baltimore, Maryland, Report No. 19-00016-61, January 9, 2020.	March 2019	0	23	–	4‖
Coordination of Care and Employee Satisfaction Concerns at the Community Living Center, Loch Raven VA Medical Center, in Baltimore, Maryland, Report No. 19-08857-171, June 11, 2020.	September 2019	0	5	–	2#
Inadequate Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center, Report No. 19-07507-214, July 28, 2020.	October 2019	1	10	0	0

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Alleged Deficiencies in Pharmacy Service Procedures at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, Report No. 19-09776-223, August 4, 2020.	November 2019	0	3	–	0
Communication of Test Results and Oncology Scheduling Concerns at the Beckley VA Medical Center in West Virginia, Report No. 20-00339-69, February 11, 2021.	June and July 2020	0	2	–	2**
Mammography Program Deficiencies and Patient Results Communication at the Washington DC VA Medical Center, Report No. 20-00563-68, February 25, 2021.††	–	0	6	–	6‡‡

Source: Inspection/survey results provided by the Quality Management Office/Chief Nursing Office Program Analyst on August 24, 2021.

**As of April 2022, no recommendations issued to the medical center remained open.*

This report also includes three recommendations under the purview of the VHA Under Secretary for Health. For the purpose of CHIP visits, the OIG references only those recommendations under the scope of the VISN and its facilities.

‡*As of July 2022, no recommendations issued to the VISN remained open.*

§*As of July 2022, no recommendations issued to the medical center remained open.*

‖*As of April 2022, no recommendations issued to the healthcare system remained open.*

#*As of April 2022, no recommendations issued to the healthcare system remained open.*

***As of April 2022, no recommendations issued to the medical center remained open.*

††*This report also includes one recommendation under the purview of the National Radiology Program Office. For the purpose of CHIP visits, the OIG references only those recommendations under the scope of the VISN and its facilities.*

‡‡*As of July 2022, 1 recommendation issued to the medical center remained open.*

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay (LOS)	A lower value is better than a higher value
AES data use engmt	Composite measure based on three individual All Employee Survey (AES) data use and sharing questions	A higher value is better than a lower value
Behavioral health (BH90)	Healthcare Effectiveness Data and Information Set (HEDIS) outpatient performance measure composite related to screening for depression, posttraumatic stress disorder, alcohol misuse, and suicide risk	A higher value is better than a lower value
Diabetes (DMG90_ec)	HEDIS outpatient performance measure composite for diabetes care	A higher value is better than a lower value
ED throughput	Composite measure for timeliness of care in the emergency department (ED)	A lower value is better than a higher value
Global measures (GM90_1)	ORYX inpatient composite of global measures related to influenza immunization, alcohol and drug use, and tobacco use	A higher value is better than a lower value
HC assoc infections	Health care (HC) associated infections	A lower value is better than a higher value
HCAHPS Care Transition	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) care transition (inpatient)	A higher value is better than a lower value
HCAHPS hospital rating	Patient overall rating of hospital (inpatient)	A higher value is better than a lower value
Influenza immunization (FLU90_ec)	HEDIS outpatient performance measure composite for outpatient influenza immunization	A higher value is better than a lower value
Ischemic heart (IHD90_ec)	HEDIS outpatient performance measure composite for ischemic heart disease care	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

Measure	Definition	Desired Direction
MH population coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
PCMH care coordination	Patient-centered medical home (PCMH) care coordination	A higher value is better than a lower value
PCMH same day appt (days waited)	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
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	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 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 readmissions	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
Tobacco & cessation (SMG90_1)	HEDIS outpatient performance measure composite related to tobacco screening and cessation strategies	A lower value is better than a higher value

Source: VHA Support Service Center.

Appendix F: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) 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: percent of residents that did not have a CLC stay or hospital stay or death within 30-days post discharge to community.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Outpatient ED visit (SS)	Short-stay measure: percent of residents admitted to nursing home from hospital after and outpatient ED visit (an ED visit not resulting in hospital admission).
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.

Measure	Definition
Rehospitalization after NH admission (SS)	Short-stay measure: percent of residents with unplanned hospital 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: May 25, 2022

From: Director, VA Capitol Health Care Network (10N5)

Subj: Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 5: VA Capitol Health Care Network

To: Director, Office of Healthcare Inspections (54CH04)

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

1. I have reviewed and concur with the findings and recommendation in the Office of Inspector General's (OIG's) draft report entitled Comprehensive Healthcare Inspection of the Veterans Integrated Service Network 5: VA Capitol Health Care Network.
2. Submitted for review in the response are corrective actions to the recommendation outlined in the response. Recommendation #1 will remain open and in progress.
3. Thank you for this opportunity to focus on continuous performance improvement. Should you require any additional information please contact the VISN 5 Quality Management Officer.

(Original signed by:)

Robert M. Walton, FACHE

OIG Contact and Staff Acknowledgments

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