VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System in Gainesville, Florida

Figure 1. North Florida/South Georgia Veterans Health System in Gainesville, Florida.

Source: https://vaww.va.gov/directory/guide/ (accessed March 4, 2021).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CBOC	Community-Based Outpatient Clinic
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
FDA	Food and Drug Administration
FY	fiscal year
OIG	Office of Inspector General
QSV	quality, safety, and value
RN	registered nurse
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
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 the quality of care delivered in the inpatient and outpatient settings of the North Florida/South Georgia Veterans Health System, which includes two divisions—Malcom Randall VA Medical Center (Gainesville) and the Lake City VA Medical Center—and multiple outpatient clinics in Florida and Georgia. 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 health services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus each year.

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

1. COVID-19 pandemic readiness and response[1]

2. Quality, safety, and value

3. Registered nurse credentialing

4. Medication management (targeting remdesivir use)

5. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)

6. Care coordination (spotlighting inter-facility transfers)

7. High-risk processes (examining the management of disruptive and violent behavior)

The OIG conducted an unannounced virtual review of both divisions of the North Florida/South Georgia Veterans Health System during the week of March 15, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the health system's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this health system and other Veterans

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[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)."

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

Inspection Results

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

Leadership and Organizational Risks

At the time of the OIG's virtual review, the health system's leadership team consisted of the Director; Chief of Staff; Associate Director for Patient Care Services; Deputy Director; Associate Director, Lake City; Associate Director, Primary Care/Outpatient Clinics; and Assistant Director. Organizational communications and accountability were managed through a committee reporting structure, with Executive Leadership Council oversight of several working groups. Leaders monitored patient safety and care through the Quality Executive Council, which was responsible for tracking and trending quality of care and patient outcomes.

When the OIG conducted this inspection, all but one of the system's leaders had worked together for over one year. The Director, who was assigned in June 2012, was the most tenured leader. The Associate Director, Primary Care/Outpatient Clinics, who was assigned in January 2021, was the newest member of the leadership team. The assistant director position had been vacant since November 2019, so the Deputy Director and Associate Director, Lake City shared the responsibilities.

During an interview with the OIG, the Director indicated the fiscal year 2020 budget increase helped the system hire clinical documentation specialists. Additionally, leaders reported clinical and nonclinical staffing shortages, recruitment and retention challenges, and strategies taken to address these issues.

Employee survey data revealed satisfaction with leadership and a workplace where staff felt respected and discrimination was not tolerated. Scores for most of the executive leaders were notably higher than the system and VHA averages.

Selected patient experience scores implied general satisfaction. However, survey results highlighted opportunities to improve satisfaction for male and female veterans in inpatient and outpatient settings.

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

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on health quality, employee satisfaction, access to care, and efficiency."[3] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[4]

The executive leaders were generally knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and Community Living Center SAIL measures and should continue to take actions to improve performance.[5] In individual interviews, the executive leaders were able to speak in depth about actions taken during the previous 12 months to maintain or improve employee satisfaction and patient experiences.

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The health system complied with requirements for a committee responsible for quality, safety, and value oversight functions; the Systems Redesign and Improvement Program; and protected peer reviews.[6] However, the OIG identified an opportunity for improvement with the surgical work group.

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

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

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

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

[6] 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.

Registered Nurse Credentialing

The OIG reviewers found that all 213 registered nurses hired between January 1, 2020, and February 15, 2021, were free from potentially disqualifying licensure actions. However, the OIG identified a deficiency with primary source verification.

Care Coordination

Generally, the health system met expectations for an inter-facility transfer policy, monitoring and evaluation of inter-facility transfers, use of the required VA *Inter-Facility Transfer Form*, and nurse-to-nurse communication between facilities. However, the OIG identified deficiencies with transfer documentation requirements.

High-Risk Processes

The health system met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified opportunities for improvement with staff training.

Conclusion

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

Comments

The Veterans Integrated Service Network Director and System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 63–64, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
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Contents

Purpose and Scope

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

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

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

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

1. Leadership and organizational risks

2. COVID-19 pandemic readiness and response[5]

3. Quality, safety, and value (QSV)

4. Registered nurse credentialing

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

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

[3] Danae Sfantou et al., "Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4, (October 14, 2017): 73, https://doi.org/10.3390/healthcare5040073.

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

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

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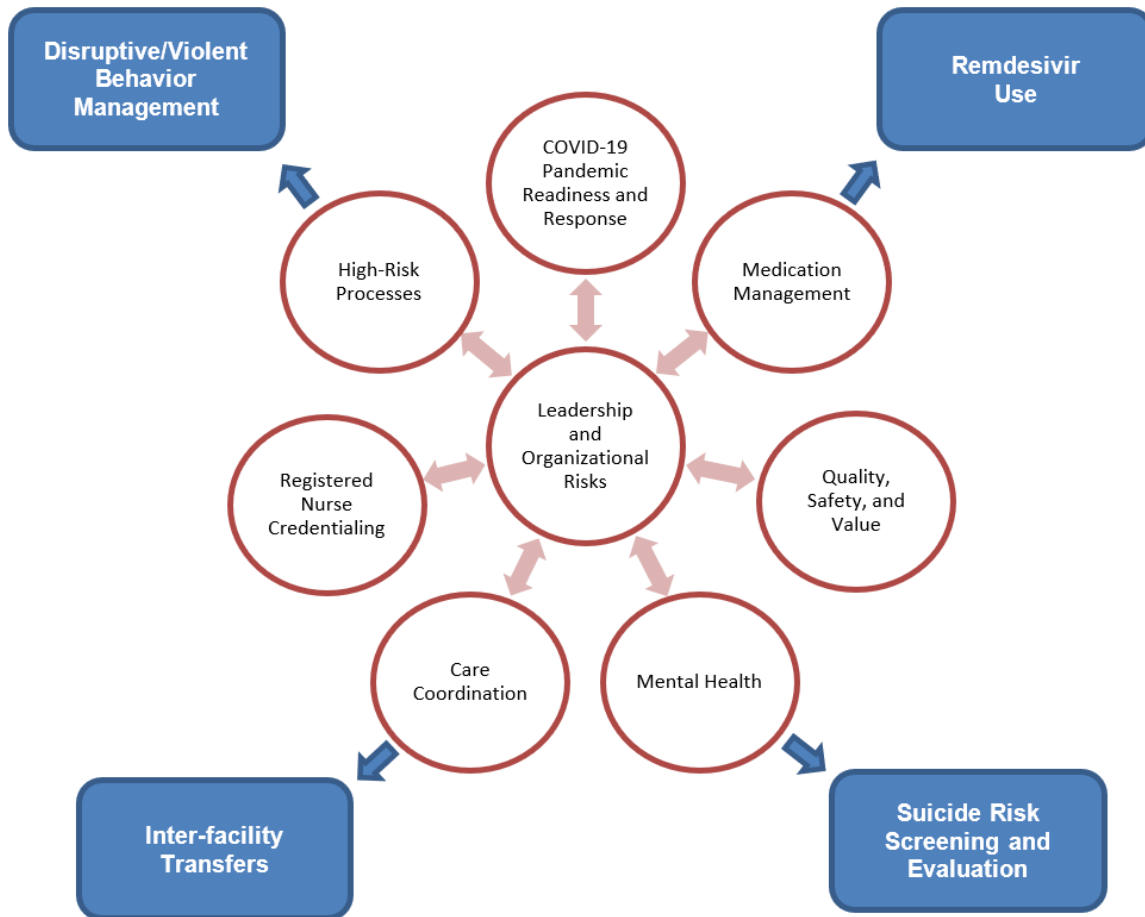
Figure 2. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services. *Source: VA OIG.*

Methodology

The North Florida/South Georgia Veterans Health System includes the Malcom Randall (Gainesville) VA Medical Center (VAMC), the Lake City VAMC, and multiple outpatient clinics in Florida and Georgia. Additional details about the types of care provided by the health system can be found in appendixes B and C.

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

The inspection examined operations from January 19, 2019, through March 19, 2021, the last day of the unannounced multiday evaluation.[7] During the virtual site visit, the OIG referred concerns beyond the scope of this inspection to the OIG's hotline management team for further review.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[8] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the health system completes corrective actions. The System Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that system leaders developed based on the reasons for noncompliance.

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

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

[7] The range represents the time period from the prior CHIP site visit to the completion of the unannounced, multiday virtual CHIP visit in March 2021.

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can affect a healthcare system's ability to provide care in the clinical focus areas.[9] To assess this health system's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement

2. Budget and operations

3. Staffing

4. Employee satisfaction

5. Patient experience

6. Accreditation surveys and oversight inspections

7. Identified factors related to possible lapses in care and the health system response

8. VHA performance data (health system)

9. VHA performance data (community living centers (CLCs))[10]

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this health system's reported organizational structure. The health system had a leadership team consisting of the Director; Chief of Staff; Associate Director for Patient Care Services (ADPCS); Deputy Director; Associate Director, Lake City; Associate Director, Primary Care/Outpatient Clinics; and Assistant Director. The Chief of Staff; ADPCS; and Associate Director, Primary Care/Outpatient Clinics oversaw patient care, which required managing service directors and chiefs of programs and practices.

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

[10] VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers*, June 1, 2017. CLCs, previously known as nursing home care units, provide a skilled nursing environment and a variety of interdisciplinary programs for persons needing short- and long-stay services.
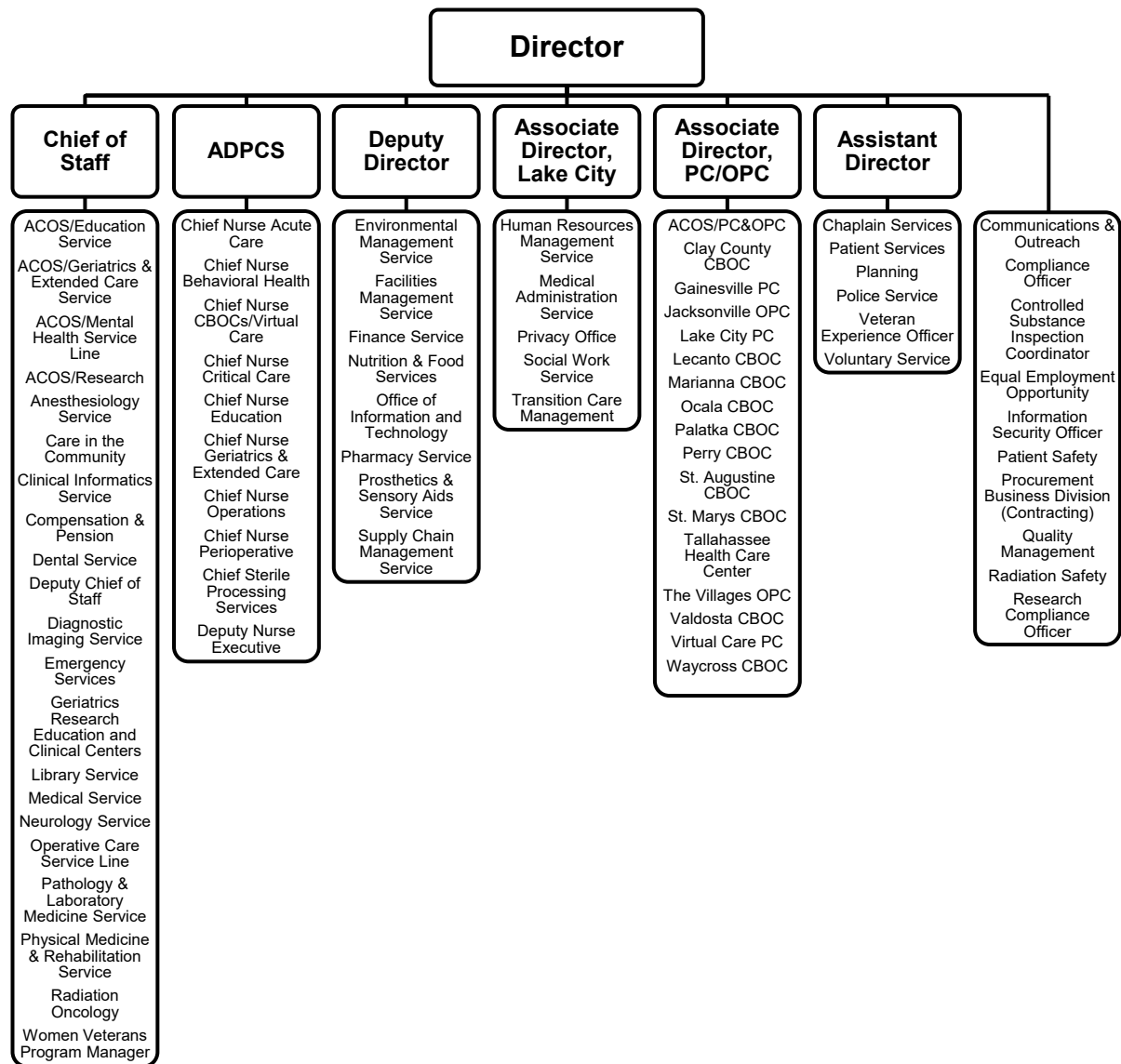
Figure 3. Health system organizational chart.

Source: North Florida/South Georgia Veterans Health System (received March 15, 2021).

ACOS = Associate Chief of Staff.
CBOC = Community-Based Outpatient Clinic.
OPC = Outpatient Clinics.
PC = Primary Care.

At the time of the OIG inspection, all but one of the system's leadership team members had worked together for over one year (see table 1). The assistant director position had been vacant since November 2019. The Director had not assigned a temporary leader to fill the vacancy, but the Deputy Director and Associate Director, Lake City reportedly shared the assistant director responsibilities. The Director stated that system staff were recruiting and scheduling interviews during the week of the OIG virtual review.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	June 3, 2012
Chief of Staff	September 15, 2019
Associate Director for Patient Care Services	November 25, 2018
Deputy Director	August 21, 2016
Associate Director, Lake City	November 24, 2019
Associate Director, Primary Care/Outpatient Clinics	January 31, 2021
Assistant Director	Vacant

Source: North Florida/South Georgia Veterans Health System Human Resources Officer (received March 16, 2021).

To help assess the health system executive leaders' engagement, the OIG interviewed the Director; Chief of Staff; ADPCS; Deputy Director; and Associate Director, Lake City regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance. The Associate Director, Primary Care/Outpatient Clinics had been in the role for less than two months and was not interviewed.

The executive leaders were generally knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific Strategic Analytics for Improvement and Learning (SAIL) measures. In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

The Director served as the chairperson of the Executive Leadership Council, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Council oversaw various working groups such as the Environment of Care and Medical Executive Committees and the Nursing Executive Council. These leaders monitored patient safety and care through the Quality Executive Council, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Leadership Council (see figure 4).
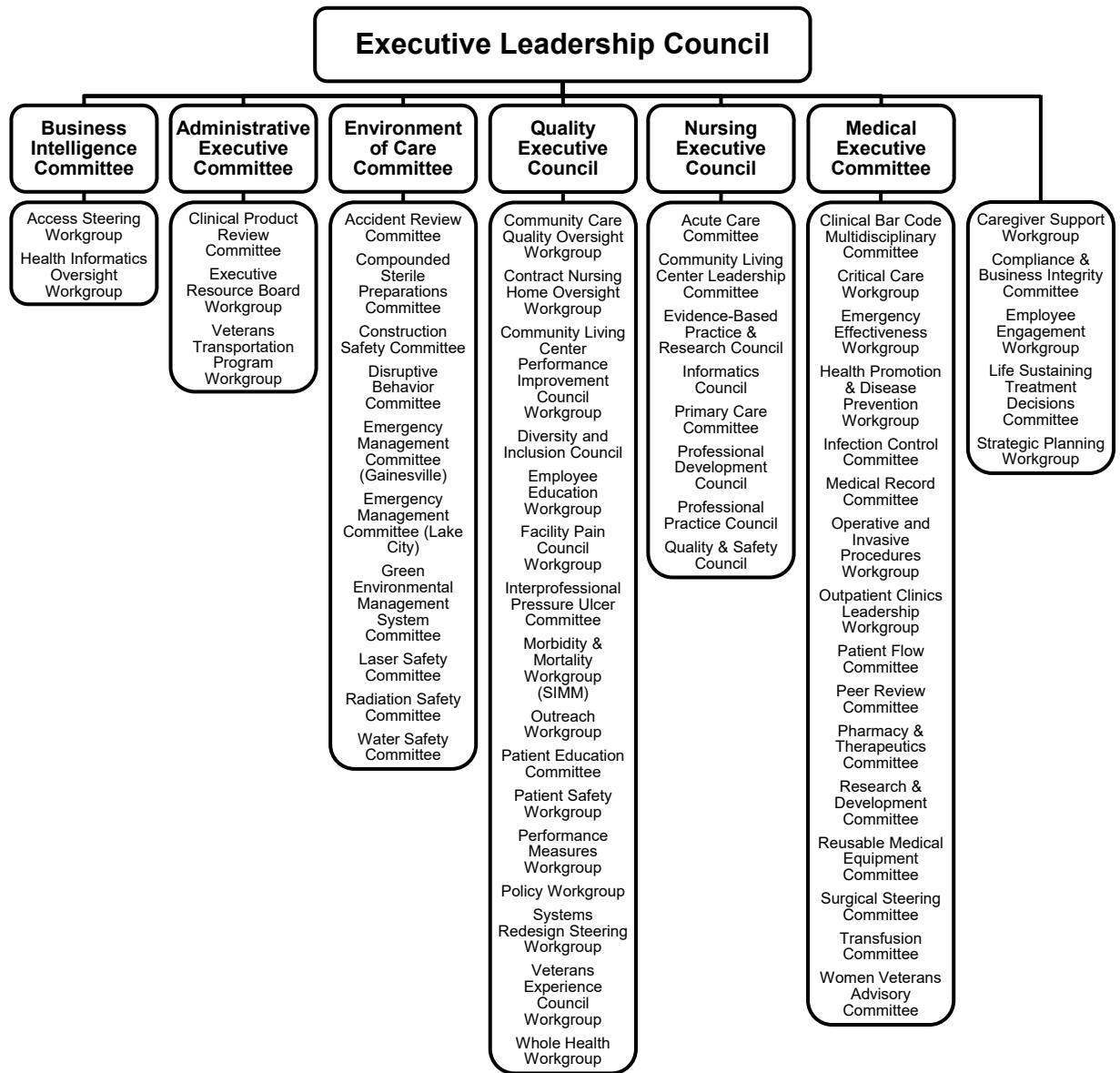
Figure 4. *Health system committee reporting structure.*

Source: North Florida/South Georgia Veterans Health System (received March 16, 2021).

SIMM = System Inpatient Morbidity & Mortality.

Budget and Operations

The health system's FY 2020 annual medical care budget of $1,423,054,196 increased 16 percent compared to the previous year's budget of $1,223,076,351.[11] When asked about the effect of this change on the health system's operations, the Director indicated that the funds

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[11] VHA Support Service Center.

helped the system hire new staff. The Director reported hiring clinical documentation specialists to ensure more comprehensive documentation and shared plans to hire additional clinical pharmacists for Patient Aligned Care Teams.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[12] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[13] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[14]

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[15] The executive leaders confirmed that occupations listed in table 2 remained the top clinical and nonclinical shortages at the time of the OIG inspection. Leaders reported ongoing recruitment and retention challenges with mental health providers, engineers, and nurses in various departments. To address nursing shortages, the ADPCS reported conducting career fairs; implementing special pay rates for critical care, emergency department, and operating room nurses; and offering retention bonuses. The Chief of Staff reported using incentive programs, such as loan forgiveness and education debt reduction, and adjusting the pay structure to address mental health staffing shortages. The Chief of Staff also indicated that there was an ongoing shortage of engineers despite aggressive recruitment strategies.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. RN Staff–Critical Care*	1. General Engineering
2. RN Staff–Emergency Department/Urgent Care	2. Electrical Engineering
3. RN Staff–Peri-operative	3. Biomedical Engineering
4. RN Staff–Outpatient Mental Health	4. – †

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

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

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

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
5. Psychiatrists	5. – †

Source: VA OIG.

*RN = Registered Nurse.
† Not applicable.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[16] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[17] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on health system leaders.

To assess employee attitudes toward health system leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[18] Table 3 provides relevant survey results for VHA, the health system, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the health system average for the selected survey leadership questions was similar to the VHA average.[19] Scores for most of the executive leaders were notably higher than the system and VHA averages. The survey results for the ADPCS were similar to the system and VHA averages, except for the servant leader index, which was slightly lower.

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

[17] "AES Survey History."

[18] Ratings are based on responses by employees who report to or are aligned under the Director; Chief of Staff; ADPCS; Associate Director, Lake City; and Deputy Director.

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

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

Questions/ Survey Items	Scoring	VHA Average	Health System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director, Lake City Average	Deputy Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	74.8	92.0	88.3	71.9	95.6	92.3
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	3.5	4.3	4.2	3.5	4.6	4.6
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.6	3.7	4.5	4.5	3.6	4.8	4.8
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.7	3.7	4.6	4.3	3.7	4.8	4.8

Source: VA All Employee Survey (accessed February 16, 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 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[20] The health system averages for the selected survey questions were similar to

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[20] Ratings are based on responses by employees who report to or are aligned under the Director; Chief of Staff; ADPCS; Associate Director, Lake City; and Deputy Director.

the VHA averages. Scores related to the executive team were similar to or more favorable than those for VHA and the health system.

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

Questions/ Survey Items	Scoring	VHA Average	Health System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director, Lake City Average	Deputy Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.9	4.4	4.4	3.8	4.9	5.0
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	3.8	4.6	4.5	3.7	4.3	4.6

Questions/ Survey Items	Scoring	VHA Average	Health System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director, Lake City Average	Deputy Director Average
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)–6 (Every Day)	1.4	1.3	1.1	1.3	1.5	0.3	0.8

Source: VA All Employee Survey (accessed February 16, 2021).

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[21] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[22]

The Director expressed a commitment to a harassment-free environment and reported establishing a zero tolerance policy for harassment, offering equal employment opportunity trainings for staff, and assigning senior leaders and service line supervisors supplemental trainings to help them focus beyond themselves and identify a common ground when interacting with others.

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

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

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

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

Questions/ Survey Items	Scoring	VHA Average	Health System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director, Lake City Average	Deputy Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.9	3.9	4.6	4.6	3.8	4.9	4.8
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)– 5 (Strongly Agree)	4.1	4.1	4.6	4.8	3.9	4.5	4.6
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.8	4.5	4.6	3.7	4.7	4.7

Source: VA All Employee Survey (accessed February 16, 2021).

Patient Experience

To assess patient experiences with the health system, which directly reflect on its leaders, the OIG team reviewed survey results from October 1, 2019, through September 30, 2020. VHA's Patient Experiences Survey Reports provide results from the Survey of Health Experiences of Patients program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and support benchmarking its performance against the private sector.

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the health system's Gainesville and Lake City medical centers.[23] For this health system, patients appeared generally satisfied with the care provided.

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

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

Questions	Scoring	VHA Average	Health System Average
Survey of Health 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	71.4
Survey of Health Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	81.8
Survey of Health Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.8	83.4

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[24] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

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

The OIG noted concerns with several patient satisfaction scores. While male and female patients would recommend the hospital to their friends and family, both genders scored their experience related to being treated with courtesy and respect by doctors and nurses lower than the corresponding VHA averages. The Chief of Staff cited the pandemic as a major contributing factor to the low satisfaction scores. Reportedly, patients had difficulties understanding clinicians when speaking to them through a mask. To mitigate communication issues, doctors and nurses were encouraged to maintain eye contact when speaking to patients, speak slowly and with more

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

volume, and clearly enunciate words. Various male and female veterans' scores were lower than the VHA averages for patient-centered medical home and specialty care settings. The Director and Chief of Staff reported efforts to correctly route calls and encourage patients to use "My HealtheVet" to facilitate communication with their healthcare team and manage appointments and health records.[25]

Table 7. Inpatient Survey Results on Experiences by Gender
(October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Health System †	
		Male Average	Female Average	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	71.5	70.5
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	80.6	80.8
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	83.4	77.6

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

*The VHA averages are based on 48,907–49,521 male and 2,395–2,423 female respondents, depending on the question.
† The health system averages are based on 907–928 male and 54 or 55 female respondents, depending on the question.

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[25] "MyHealtheVet," accessed May 19, 2021, https://www.myhealth.va.gov.

Table 8. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Health System †	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	48.6	40.8
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	59.4	51.1
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	72.0	68.8

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

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

† The health system averages are based on 1,260–4,005 male and 114–291 female respondents, depending on the question.

Table 9. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Health System †	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	44.5	35.9

Questions	Scoring	VHA*		Health System †	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	54.8	61.9
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	75.8	64.5

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

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

† The health system averages are based on 906–2,730 male and 75–193 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.[26] Table 10 summarizes the relevant system inspections most recently performed by the OIG and The Joint Commission (TJC).[27] At the time of the OIG review, the system had closed all but three recommendations for improvement issued since the previous CHIP site visit conducted in January 2019. The Chief, Quality Management provided a summary of actions taken to address the three open recommendations related to medical staff privileging and reported plans to submit the system's response to the VISN after the OIG virtual review.

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

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

The OIG team also noted the system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[28] Additional results included the Long Term Care Institute's inspection of the CLCs at Gainesville and Lake City VAMCs.[29]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System, Gainesville, Florida,* Report No. 19-00010-237, September 27, 2019)	January 2019	28	3*
TJC Hospital Accreditation	July 2019	74	0
TJC Behavioral Health Care Accreditation		1	0
TJC Home Care Accreditation		7	0

Source: OIG and TJC (inspection/survey results received from the Accreditation Specialist on March 15, 2021).

*As of September 2021, one recommendation remained open.

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

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

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

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

Table 11 lists the reported patient safety events from January 19, 2019 (the prior OIG CHIP site visit), through March 16, 2021.[30]

**Table 11. Summary of Selected
Organizational Risk Factors
(January 19, 2019, through March 16, 2021)**

Factor	Number of Occurrences
Sentinel Events	15
Institutional Disclosures	20
Large-Scale Disclosures	0

Source: North Florida/South Georgia Veterans Health System's Patient Safety Coordinator, Risk Manager, and Peer Review Coordinator (received March 15 and March 17, 2021).

The Director spoke knowledgeably about serious adverse event reporting processes, including discussing all adverse events during daily morning report and receiving information about institutional disclosures and root cause analyses from the Chief of Staff and Chief, Quality Management. The Director reported having an active patient safety program and cited examples such as reviewing root cause analyses weekly, conducting patient safety rounds, implementing a "great catch" award program for employees who report safety events, and following up on corrective actions with quality management staff and individuals responsible for completing action plans.

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

Veterans Health Administration Performance Data for the Health System

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on health quality, employee satisfaction, access to care, and efficiency." [31] 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.[32]

Figure 5 and 6 illustrate the system divisions' quality of care and efficiency metric rankings and performance compared with other VA facilities as of September 30, 2020. Figure 5 shows the Gainesville VAMC's performance in the first through fifth quintiles. The first quintile (blue data point) measure is high performing (Centers for Medicare & Medicaid Services (CMS) mortality (MORT)). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, care transition, rating (of) primary care (PC) provider, specialty care (SC) survey access, and All Employee Survey (AES) data use).[33]

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

[32] "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] For information on the acronyms in the SAIL metrics, please see appendix E.
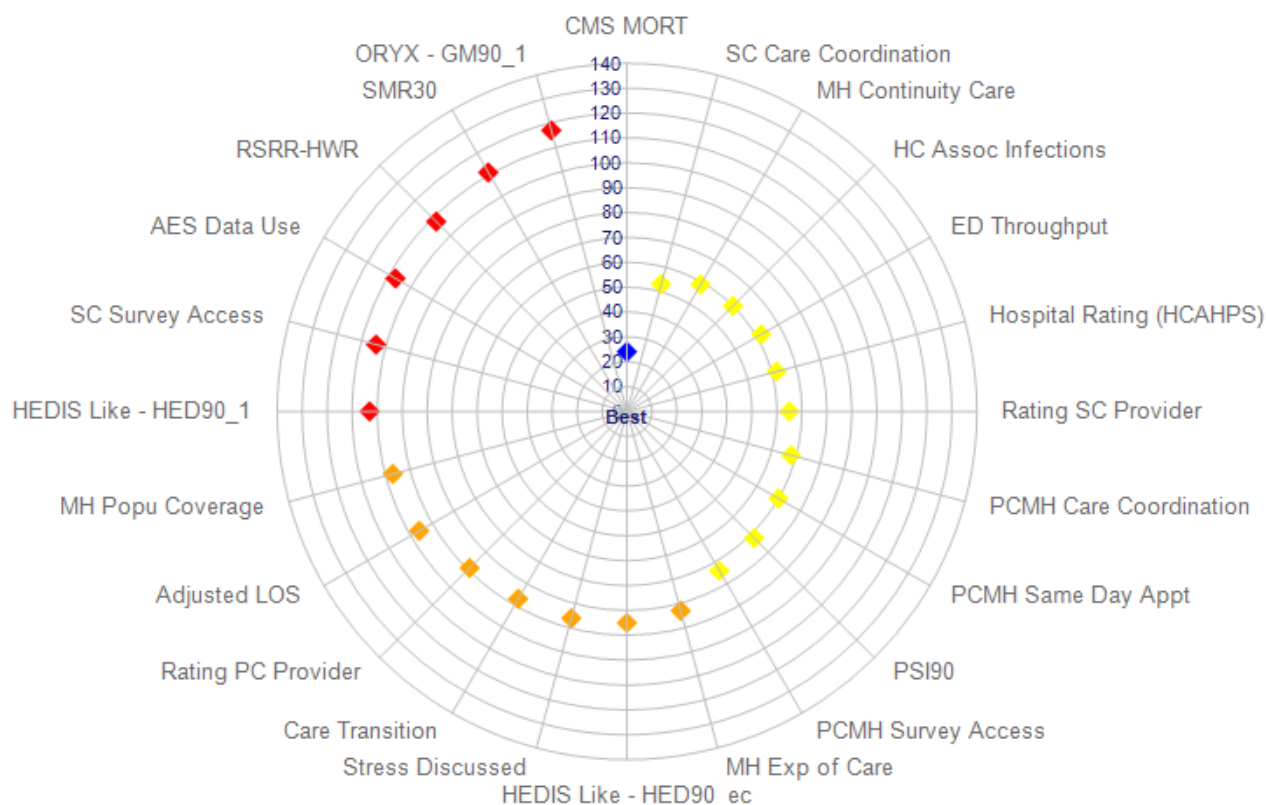
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Figure 5. Gainesville VAMC quality of care and efficiency metric rankings (as of September 30, 2020).
Source: VHA Support Service Center.

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

Figure 6 displays blue and green data points to indicate high performance for the Lake City VAMC (for example, in the areas of rating (of) SC provider and healthcare (HC) associated (assoc) infections). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red (for example, mental health (MH) experience (exp) of care, SC survey access, AES data use, and rating (of) PC provider).[34]

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[34] For information on the acronyms in the SAIL metrics, please see appendix E.
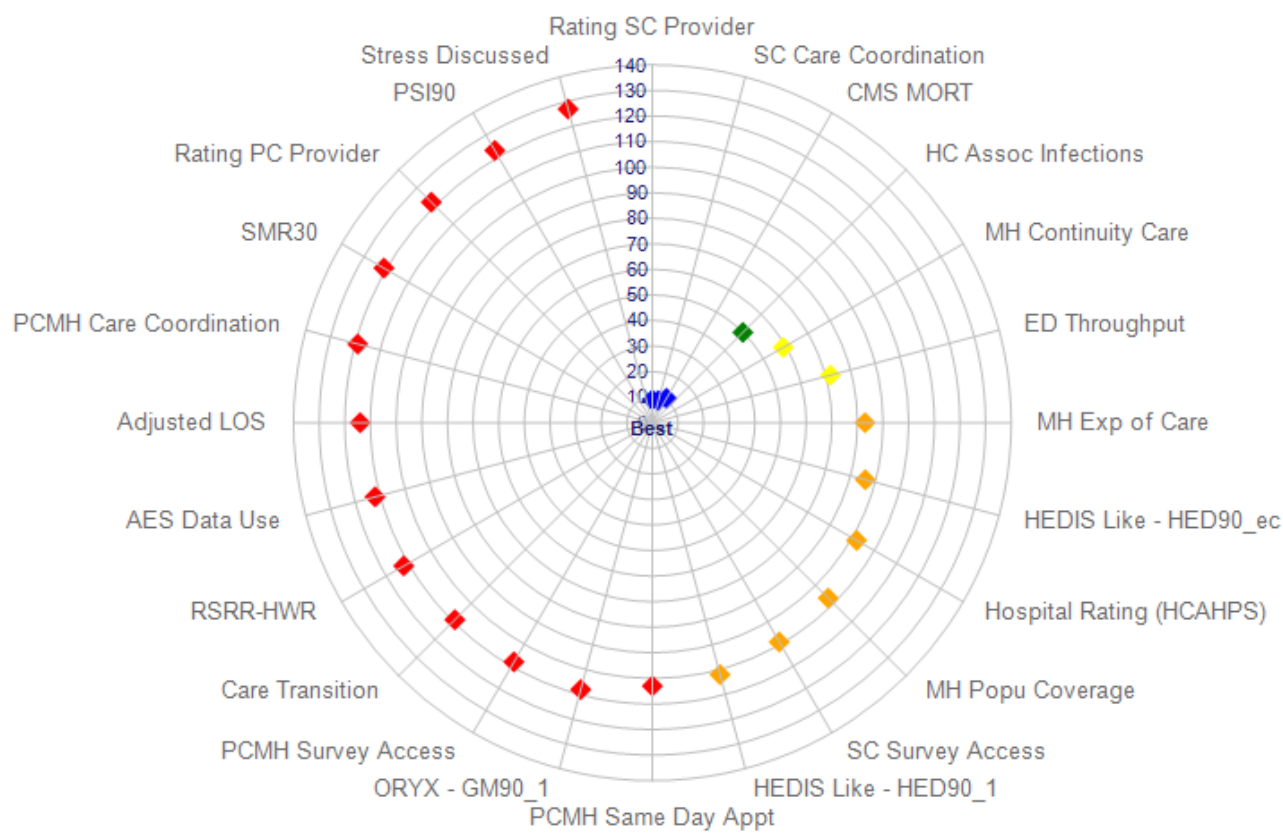
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Figure 6. Lake City VAMC quality of care and efficiency metric rankings (as of September 30, 2020).

Source: VHA Support Service Center.

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

Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA."[35] The model "leverages much of the same data" used in the Centers for Medicare &

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[35] 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.

Medicaid Services' *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[36]

Figures 7 and 8 illustrate the system's CLCs' quality rankings and performance compared with other VA CLCs as of June 30, 2020. Figure 7 displays the Gainesville VAMC's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of urinary tract infections (UTI)–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), and improvement in function (SS)). Metrics in the fifth quintile need improvement and are denoted in red (for example, moderate-severe pain (LS), help with activities of daily living (ADL) (LS), and moderate-severe pain (SS)).[37]

Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.
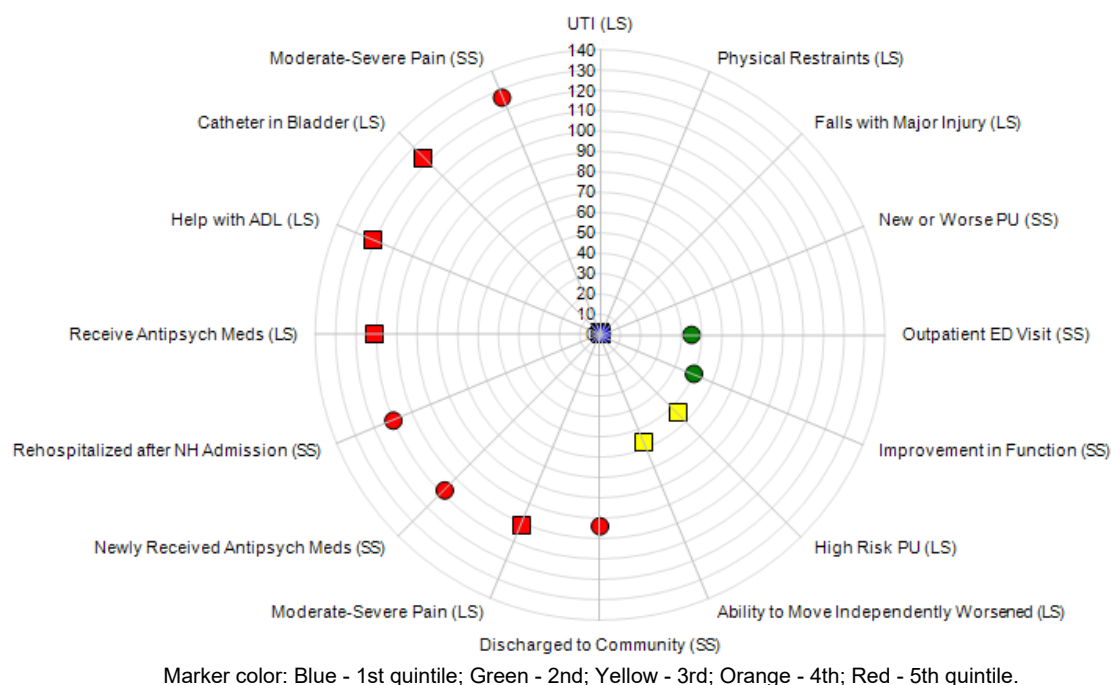
Figure 7. Gainesville CLC quality measure rankings (as of June 30, 2020).

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

Source: VHA Support Service Center.

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

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[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.* "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."

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

Figure 8 displays the Lake City VAMC's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of physical restraints (LS), new or worse PU (SS), and high risk PU (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, UTI (LS), moderate-severe pain (SS), and improvement in function (SS)).[38]

Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.
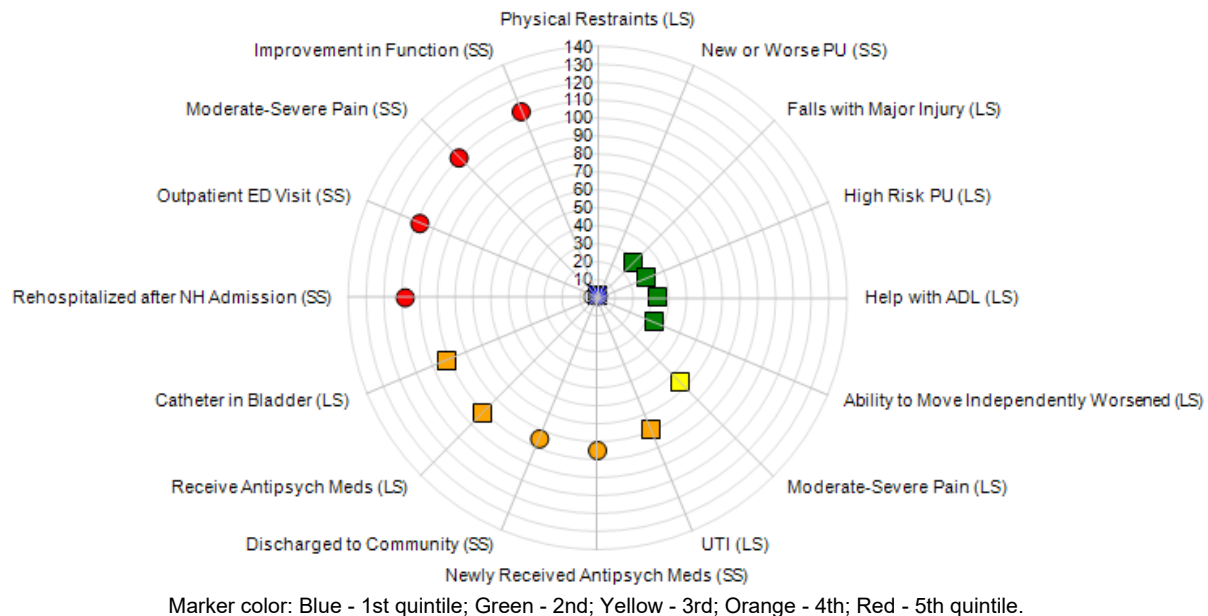
Figure 8. *Lake City CLC quality measure rankings (as of June 30, 2020).*

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

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

At the time of the OIG's virtual review, the Associate Director, Primary Care/Outpatient Clinics had been in the position for less than two months, and the assistant director position was vacant. However, the other executive leaders had worked together for over one year.

During an interview with the OIG, the Director indicated the FY 2020 budget increase helped the system hire clinical documentation specialists. Additionally, leaders reported clinical and nonclinical staffing shortages and recruitment and retention challenges with mental health providers, engineers, and nurses despite aggressive recruitment strategies.

Specific employee survey data revealed satisfaction with leaders and a workplace where staff felt respected and discrimination was not tolerated. Selected patient experience scores implied

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

general satisfaction; however, gender-specific survey results highlighted opportunities for doctors and nurses to improve male and female patients' experiences related to being treated with courtesy and respect.

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

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[39] 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.[40]

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."[41] "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."[42]

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

- Emergency preparedness

- Supplies, equipment, and infrastructure

- Staffing

- Access to care

- CLC patient care and operations

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

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

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

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

[41] 38 U.S.C. § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the provision of hospital care and medical services during certain disasters and emergencies: "During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[43] 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.[44] 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 health services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[45]

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

- Review of aggregated QSV data

- Recommendation and implementation of improvement actions

- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the health system's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization." [46] Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[47] The OIG team examined various requirements related to systems redesign and improvement:

- Designation of a systems redesign and improvement coordinator

- Tracking of facility-level performance improvement capability and projects

- Participation on the facility quality management committee and VISN Systems Redesign Review Advisory Group

- Staff education on performance improvement principles and techniques

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

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

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

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

[47] VHA Directive 1026.01.

Next, the OIG assessed the health system's processes for conducting protected peer reviews of clinical care.[48] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[49] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[50] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)

- Peer review of all applicable deaths within 24 hours of admission to the hospital

- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[51]

- Completion of final reviews within 120 calendar days

- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[52]

- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the health system's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[53] The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) Operational oversight of surgical services and quality improvement activities;

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

[49] VHA Directive 1190.

[50] VHA Directive 1190.

[51] VHA Directive 1190.

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

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

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[54] The health system's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery

- Assignment and duties of a surgical quality nurse (registered nurse)

- Establishment of a surgical work group with required members who meet at least monthly

- Surgical work group tracking and review of quality and efficiency metrics

- Investigation of adverse events[55]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[56]

Quality, Safety, and Value Findings and Recommendations

The health system complied with requirements for a committee responsible for QSV oversight functions, the Systems Redesign and Improvement Program, and protected peer reviews. However, the OIG identified an opportunity for improvement with the surgical work group.

VHA requires medical facility directors to ensure that facilities have a surgical work group that meets monthly and documents meeting minutes; this work group must be chaired by the Chief of Surgery and include the Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.[57] The OIG reviewed the surgical work group meeting minutes, locally referred to as the Surgical Steering Committee, from January through December 2020 and found that the Chief of Staff did not attend 5 of 12 (42 percent) meetings. The lack of core member attendance may have resulted in the review and analysis of surgery program data without the perspectives of key staff. The Chief, Quality Management reported that the Chief of Staff had conflicting priorities due to crisis management responsibilities at the height of the COVID-19 pandemic.

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[54] "NSO Reporting, Resources, & Tools."

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

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

[57] VHA Directive 1102.01(1).

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures the Chief of Staff consistently attends Surgical Steering Committee meetings.

Health system concurred.

Target date for completion: March 15, 2022

Health system response: The System Director reviewed and evaluated additional reasons for noncompliance when developing the action plan and is responsible to ensure all attendance requirements are met.

Required attendees include the Chief of Surgery, Chief of Staff, Surgical Quality Nurse and OR Nurse Manager. All required attendees will designate a surrogate to attend when they are unavailable to participate. This will be reflected in the Surgical Steering Committee minutes.

The Chief of Surgery will monitor and report attendance issues to the Medical Executive Committee quarterly until 90% compliance is maintained for two consecutive quarters. After two quarters of compliance is achieved, reporting will be changed to bi-annually. If compliance falls below 90% then a new action plan will be developed, and reporting will resume quarterly until target of 90% of compliance is reached.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[58] Licensure is defined by VHA as "the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration."[59]

VA requires all RNs to hold at least one active, unencumbered license.[60] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[61] When an action has been "taken against [an] applicant's sole license or against any of the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA's licensure requirements," and documented as required.[62] Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA's electronic credentialing system, prior to appointment to a VA medical facility.[63]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and staff and reviewing relevant documents for 213 RNs hired from January 1, 2020, through February 15, 2021. The OIG determined whether

- the RNs were free from potentially disqualifying licensure actions, or

- the Chief, Human Resources Management Service or Regional Counsel determined that the RNs met VA licensure requirements.

The OIG also reviewed credentialing files for 30 of the 213 RNs to determine whether health system staff completed primary source verification prior to the appointment.

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

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

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

[61] 38 U.S.C. § 7402.

[62] VHA Directive 2012-030.

[63] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

The OIG determined that all 213 RNs reviewed were free from potentially disqualifying licensure actions. However, the OIG identified a deficiency with primary source verification.

VHA requires that the Health System Director ensures credentialing information of individuals' licensure is verified from primary sources prior to initial appointment.[64] The OIG found that 6 of 30 (20 percent) credentialing files lacked evidence of primary source verification of all licenses held by the RN prior to employment. This could lead to inappropriate hiring of nurses that could subsequently affect the provision of quality care. The Program Support Specialist Supervisor reported believing that verifying licenses disclosed by applicants was sufficient to meet the requirement and stated that until November 2020, there was no formal process to determine if candidates held additional licenses.

Recommendation 2

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

Health system concurred.

Target date for completion: March 15, 2022

Health system response: The ADPCS reviewed and evaluated additional reasons for noncompliance when developing the action plan and is responsible for ensuring that individuals' licensure is verified from primary sources prior to initial appointment.

The ADPCS will ensure credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment. North Florida/South Georgia Veterans Health System implemented Nursys, a credentialing cross-check website, as part of monthly primary source verification process.

The Credentialing Supervisory Program Specialist will monitor and report data quarterly to the Quality Executive Council until 90% compliance is maintained for two consecutive quarters. After two quarters of compliance is achieved, reporting will be changed to bi-annually. If compliance falls below 90% then a new action plan will be developed, and reporting will resume quarterly until target of 90% compliance is reached.

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[64] VHA Directive 2012-030.

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[65] The FDA provided information on specific laboratory tests to be ordered prior to and during the administration of remdesivir. Additionally, the FDA required providers to report potentially related adverse events.[66]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[67] Due to the limited supply and specific storage requirements of remdesivir, VA needed someone to be available 24 hours a day, 7 days a week to accept overnight, cold-chain shipments of the drug and report any unused medication to the Emergency Pharmacy Services group.[68]

On August 28, 2020, the FDA amended the Emergency Use Authorization criteria for remdesivir to include "suspected or laboratory-confirmed COVID-19 in all hospitalized adult and pediatric patients."[69] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[70]

To determine whether VHA facilities complied with requirements related to the administration of remdesivir, the OIG interviewed key employees and managers and reviewed electronic health records of 50 patients who were administered remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. The OIG assessed the following performance indicators:

- Staff availability to receive medication shipments

- Medication orders used proper name

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

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

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

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

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

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

- Staff determined patients met criteria for receiving medication prior to administration

- Required testing completed prior to medication administration for

    o Potential pregnancy

    o Kidney assessment (estimated glomerular filtration rate)[71]

    o Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[72]

- Patient/caregiver education provided

- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

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

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

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

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[73] The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.[74] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[75]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[76] The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.[77] The health system was assessed for its adherence to the following requirements for suicide safety plans:

- Completion of suicide safety plans by required staff

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

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

- relevant documents;

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

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

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

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

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

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

- staff training records.

Mental Health Findings and Recommendations

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

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[78]

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients."[79] Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.[80]

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

- Existence of a facility policy for inter-facility transfers

- Monitoring and evaluation of inter-facility transfers

- Completion of all required elements of the *Inter-Facility Transfer Form* or facility-defined equivalent by the appropriate provider(s) prior to patient transfer

- Transmission of patient's active medication list and advance directive to the receiving facility

- Communication between nurses at sending and receiving facilities

To determine whether the health system complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 38 patients who were transferred from the health system due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

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

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

[79] VHA Directive 1094.

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

VHA requires the Chief of Staff and ADPCS to ensure that referring providers document identification of receiving physicians.[81] The OIG estimated that 26 percent of transfer documentation did not identify the receiving physician.[82] This deficiency could result in the unsafe transfer of patients, inability to monitor and evaluate transfer data, and an incomplete medical record. For one transfer, the acting Chief, Emergency Department stated that the transferring physician did not complete documentation of the receiving physician due to competing priorities with managing a patient in critical condition. For the remaining transfers, the Chief of Psychiatry reported unawareness of the requirement for mental health patients.

Recommendation 3

3. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure the referring provider identifies the receiving physician in the electronic health record.

Health system concurred.

Target date for completion: March 30, 2022

Health system response: The Chief of Staff and ADPCS reviewed and evaluated additional reasons for noncompliance when developing the action plan. The Chief of Staff and ADPCS are responsible to ensure referring providers document identification of receiving physician.

A transfer flow chart was developed on April 30, 2021, to clearly define interfacility admission transfer roles and responsibilities. The computerized patient record system (CPRS) facility transfer template of form 10-2649A was updated to ensure all required elements were required fields in the template. The process was implemented in May 2021.

The Chief of Health Information Management Service will monitor monthly quality reviews on 30 interfacility transfers to monitor identification of accepting/receiving physician and report in the Medical Records Committee. Monthly quality reviews will continue until at least a 90% compliance rate is demonstrated for six consecutive months. If compliance falls below 90% then a new action plan will be developed, and reporting will resume quarterly until target of 90% compliance is reached.

The Chief of Staff will monitor Medical Records Committee reports to the Medical Executive Committee monthly.

VHA requires the Chief of Staff and ADPCS to ensure referring providers "send all pertinent medical records available, including an active patient medication list and any medications given

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[81] VHA Directive 1094.

[82] The OIG estimated that 95 percent of the time the true compliance rate is between 58.6 and 87.1, which is statistically significantly below the 90 percent benchmark.

to the patient prior to transfer with the patient, including documentation of the patient's advance directive made prior to transfer, if any."[83] The OIG estimated that 37 percent of transfers lacked evidence that staff sent patients' active medication lists to receiving facilities.[84] For patients with completed advance directives, the OIG estimated that for 83 percent of transfers, physicians did not send a copy to the receiving facility.[85] This could result in incorrect treatment decisions compromising patient safety. The acting Chief, Emergency Department reported that clinicians believed they met the requirement by using a transfer checklist to document sending patients' active medication lists. However, checklists were disposed and not recorded in the medical record. The Chief further stated that staff were unaware of how to access an advance directive in the medical record, resulting in failure to send a copy to the receiving facility. Due to the small number of patients identified for the advance directive review, the OIG made no recommendation.

Recommendation 4

4. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and make certain that referring providers send patients' active medication lists to receiving facilities.

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[83] VHA Directive 1094.

[84] The OIG estimated that 95 percent of the time, the true compliance rate is between 47.6 and 78.4 percent, which is statistically significantly below the 90 percent benchmark.

[85] The OIG estimated that 95 percent of the time, the true compliance rate is between 0.1 and 41.8 percent, which is statistically significantly below the 90 percent benchmark.

Health system concurred.

Target date for completion: March 30, 2022

Health system response: The Chief of Staff and ADPCS reviewed and evaluated additional reasons for noncompliance when developing the action plan. The Chief of Staff and ADPCS are responsible to ensure referring providers send patients' active medication list to the receiving facility.

A transfer flow chart was developed on April 30, 2021, to clearly define interfacility admission transfer roles and responsibilities. The CPRS facility transfer template of VA form 10-2649A was updated to ensure the active medication list automatically pulls into the note. The process was implemented in May 2021.

The Chief of Health Information Management Service will monitor monthly quality reviews on 30 interfacility transfers to monitor compliance for documentation of the patient's active medication list being sent to the receiving facility in the Medical Records Committee. Monthly quality reviews will continue until at least a 90% compliance rate is demonstrated for six consecutive months. If compliance falls below 90% then a new action plan will be developed, and reporting will resume quarterly until 90% compliance is reached.

The Chief of Staff will monitor Medical Records Committee reports to the Medical Executive Committee monthly.

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[86] Balancing the rights and health needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[87] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior

- Implementation of an employee threat assessment team[88]

- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[89]

- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[90]

- Patient notification of an Order of Behavioral Restriction

- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[91]

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

[87] VHA Directive 2012-026.

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

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

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

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

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[92] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[93] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The OIG determined that the health system met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified opportunities for improvement with staff training.

VHA requires that staff are assigned prevention and management of disruptive behavior training at hire based on the risk level assigned to their work area.[94] Additionally, transitory, part-time, and intermittent staff are required to complete the *Mandatory Training for Transitory, Part-Time, and Intermittent Clinical Staff* disruptive behavior training.[95] The OIG found that 13 of 30 (43 percent) selected staff did not complete the required training. This could result in lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Prevention and Management of Disruptive Behavior Coordinator and Training Administrator reported that staff did not complete training due to COVID-19-related patient care responsibilities and facility leadership guidance to cease face-to-face training to prevent staff exposure to COVID-19.

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

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

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

[95] VHA Memorandum, *Temporary Moratorium for Non-COVID-19 VHA Required Training*, April 23, 2020 (Corrected Copy); VHA Memorandum, *Mandatory Training for Employees to Address COVID-19 Crisis Response*, April 3, 2020.

Recommendation 5

5. The System Director evaluates and determines any additional reasons for noncompliance and ensures that staff complete the assigned prevention and management of disruptive behavior training or required training for transitory, part-time, and intermittent clinical staff.[96]

Health system concurred.

Target date for completion: September 3, 2022

Health system response: The System Director reviewed and evaluated additional reasons for noncompliance when developing the action plan. The Workplace Violence Prevention Manager coordinated with the Associate Chief of Staff, Education to mitigate challenges presented by COVID-19 and will conduct classes with new hires during new employee orientation and increase class offerings by hiring additional support staff.

The Workplace Violence Prevention Manager will monitor and report on reduction in number of staff delinquent in training monthly to Environment of Care Committee until a 90% compliance rate is demonstrated. Sustainment reports will then be presented quarterly to Environment of Care Committee.

The Associate Director of Lake City will monitor for continued compliance at the Environment of Care Committee meetings.

VHA requires the System Director to ensure that the Employee Threat Assessment Team completes specific workplace violence prevention program training.[97] The OIG found that three of eight team members did not complete the required training. This could result in ineffective de-escalation of disruptive behaviors in times of crisis. The Prevention and Management of Disruptive Behavior Coordinator attributed the deficiencies to competing priorities and one member completing an incorrect training.

Recommendation 6

6. The System Director evaluates and determines any additional reasons for noncompliance and ensures that members of the Employee Threat Assessment Team complete the required the training.

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

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

Health system concurred.

Target date for completion: October 31, 2021

Health system response: The Associate Director of Lake City reviewed and evaluated additional reasons for noncompliance when developing the action plan. The Workplace Violence Prevention Manager will verify all members of the Employee Threat Assessment Team completed required training. New team members will not be added until they have completed the required training. The Workplace Violence Prevention Manager will report team member training compliance at quarterly Environment of Care Committee meetings until a 90% compliance rate is demonstrated.

The Associate Director of Lake City will monitor for continued compliance at the Environment of Care Committee meetings.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

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

Health Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• None	• The Chief of Staff consistently attends Surgical Steering Committee meetings.
RN Credentialing	• RN licensure requirements • Primary source verification	• Credentialing staff complete primary source verification of all RNs' licenses prior to initial appointment.	• None
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None

Health Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• The referring provider identifies the receiving physician in the electronic health record. • Referring providers send patients' active medication lists to receiving facilities.	• None
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• None	• Staff complete the assigned prevention and management of disruptive behavior training or required training for transitory, part-time, and intermittent clinical staff. • Employee Threat Assessment Team members complete required training.

Appendix B: Health System Profile

The table below provides general background information for this highest complexity (1a) affiliated health system reporting to VISN 8.[1]

Table B.1. Profile for North Florida/South Georgia Veterans Health System (573) (October 1, 2017, through September 30, 2020)

Profile Element	Health System Data FY 2018*	Health System Data FY 2019 †	Health System Data FY 2020‡
Total medical care budget	$1,151,218,428	$1,223,076,351	$1,423,054,196
Number of:			
• Unique patients	141,053	144,526	139,839
• Outpatient visits	1,760,571	1,792,757	1,616,726
• Unique employees§	4,853	5,003	5,129
Type and number of operating beds:			
• Community living center	221	221	221
• Domiciliary	74	76	76
• Medicine	170	170	184
• Mental health	48	48	48
• Neurology	4	4	4
• Surgery	69	78	78
Average daily census:			
• Community living center	114	112	107
• Domiciliary	70	70	49
• Medicine	115	110	103
• Mental health	43	43	39
• Neurology	3	3	2

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[1] "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing (OPES), accessed August 20, 2021, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. An affiliated health system is associated with a medical residency program. (This is an internal website not publicly accessible.) VHA medical centers are classified according to a facility complexity model; a designation of "1a" indicates a facility with "high volume, high risk patients, most complex clinical programs, and large research and teaching programs."

Profile Element	Health System Data FY 2018*	Health System Data FY 2019	Health System Data FY 2020‡
• Surgery	29	30	25

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

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

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

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Jacksonville, FL	573BY	23,533	5,324	Anesthesia Cardiology Dermatology Endocrinology Eye Gastroenterology GYN Hematology/ Oncology Orthopedics Podiatry	EMG Laboratory & Pathology Nuclear med Radiology	Dental Nutrition Pharmacy Social work Weight management

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Jacksonville, FL (continued)	573BY	23,533	5,324	Infectious disease Nephrology Neurology Pulmonary/ Respiratory disease Rehab physician Rheumatology Urology Vascular		
Valdosta, FL	573GA	8,897	3,983	Cardiology Dermatology Endocrinology Hematology/ Oncology Nephrology Neurology Poly-Trauma Urology	–	Dental Nutrition Pharmacy Social work Weight management
Ocala, FL	573GD	16,605	5,631	Cardiology Dermatology Endocrinology Eye Hematology/ Oncology Nephrology Podiatry	–	Nutrition Pharmacy Social work Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Saint Augustine, FL	573GE	10,044	6,886	Cardiology Dermatology Endocrinology Hematology/ Oncology Neurology Podiatry Rheumatology	EKG	Nutrition Pharmacy Social work Weight management
Tallahassee, FL	573GF	23,835	8,583	Anesthesia Cardiology Dermatology Endocrinology Eye Gastroenterology Hematology/ Oncology Infectious disease Nephrology Neurology Neurosurgery Plastic Podiatry Pulmonary/ Respiratory disease Urology Vascular	Laboratory & Pathology Radiology	Dental Nutrition Pharmacy Social work Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
The Villages, FL	573GI	26,886	9,647	Anesthesia Cardiology Dermatology Eye Gastroenterology Hematology/ Oncology Infectious disease Neurology Neurosurgery Podiatry Vascular	EKG Laboratory & Pathology Radiology	Dental Nutrition Pharmacy Social work Weight management
St. Marys, GA	573GJ	6,311	1,483	Dermatology Hematology/ Oncology Rheumatology	EKG	Nutrition Pharmacy Social work Weight management
Marianna, FL	573GK	5,407	2,001	Anesthesia Cardiology Dermatology Hematology/ Oncology Infectious disease	–	Nutrition Pharmacy Social work Weight management
Palatka, FL	573GL	7,645	1,007	Cardiology Dermatology Hematology/ Oncology Rheumatology	EKG	Nutrition Pharmacy Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Waycross, FL	573GM	3,838	2,449	Cardiology Dermatology Hematology/ Oncology Infectious disease Rheumatology	–	Nutrition Pharmacy Social work Weight management
Perry, FL	573GN	2,404	428	Cardiology Hematology/ Oncology	–	Pharmacy Social work
Middleburg, FL	573GO	162	8	–	–	–
Gainesville, FL (16th Street)	573QA	–	2,159	–	–	–
Gainesville, FL (64th Street)	573QC	–	757	Eye	–	–
Gainesville, FL 23rd Ave)	573QF	1	83	–	–	–
Jacksonville Southpoint, FL	573QG	15,584	18,294	Endocrinology Poly-Trauma Rehab physician	EMG	Nutrition Pharmacy Prosthetics Social work Weight management
Jacksonville, FL	573QJ	12,870	6,920	Endocrinology GYN Rheumatology	–	Pharmacy Social work

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Lake City Commerce Drive, FL	573QK	7,375	79	–	–	Nutrition Pharmacy

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

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

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days

	VHA All	(573) Gainesville, FL (Malcom Randall)	(573A4) Lake City, FL	(573BY) Jacksonville, FL	(573GA) Valdosta, GA	(573GD) Ocala, FL	(573GE) Saint Augustine, FL	(573GF) Tallahassee, FL (Sergeant Ernest I. "Boots" Thomas)	(573GI) The Villages, FL	(573GJ) St. Marys, GA	(573GK) Marianna, FL	(573GL) Palatka, FL	(573GM) Waycross, GA	(573GN) Perry, FL	(573GO) Middleburg, FL	(573QG) Jacksonville Southpoint, FL	(573QJ) Jacksonville, FL	(573QK) Lake City Commerce Drive, FL
JAN-FY19	8.3	6.7	6.3	7.7	3.4	0.5	3.5	4.0	13.6	9.8	4.2	13.1	3.4	0.7	n/a	3.7	7.5	2.0
FEB-FY19	8.1	4.8	5.0	14.0	5.7	1.3	1.8	4.2	12.1	9.3	6.4	12.4	2.8	2.4	n/a	2.5	5.9	3.3
MAR-FY19	6.9	3.6	4.8	12.0	6.0	1.1	1.2	5.0	10.5	8.4	2.7	13.2	3.5	3.5	n/a	5.5	4.6	1.9
APR-FY19	3.6	4.1	n/a	2.4	5.4	0.0	0.3	0.5	0.0	n/a	0.0	0.0	n/a	n/a	n/a	3.6	0.0	0.0
MAY-FY19	4.0	1.1	n/a	0.4	0.5	0.3	1.1	1.7	n/a	n/a	1.8	4.0	0.0	0.3	n/a	0.2	0.7	0.0
JUN-FY19	4.9	1.6	0.5	4.7	0.6	0.4	2.0	1.7	21.2	1.3	4.7	10.0	3.0	0.3	n/a	2.7	5.6	1.6
JUL-FY19	5.9	6.0	1.8	7.6	1.6	23.4	1.7	2.7	9.4	5.4	4.0	2.1	0.0	0.0	n/a	4.7	9.8	0.4
AUG-FY19	5.6	6.0	0.0	9.3	1.3	1.5	0.9	6.6	7.6	5.5	2.6	5.6	0.0	6.8	n/a	7.8	8.4	0.7
SEP-FY19	6.1	7.7	0.0	8.4	6.6	0.1	0.4	3.8	9.4	7.9	4.5	5.1	1.3	9.3	1.1	10.9	10.5	0.2
OCT-FY20	6.3	7.0	0.5	13.5	2.4	0.9	0.7	5.3	5.9	4.4	4.0	9.2	1.1	0.0	3.6	16.1	16.4	0.3
NOV-FY20	6.7	7.1	0.0	12.9	1.2	1.0	0.2	7.3	7.0	10.2	2.2	13.1	1.5	2.3	3.6	9.1	19.6	3.3
DEC-FY20	6.6	6.0	1.0	10.9	1.5	0.8	0.7	3.4	7.1	6.6	3.6	8.8	3.6	0.2	1.0	9.3	15.3	0.3

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

Note: The OIG did not assess VA's data for accuracy or completeness. Note: The OIG omitted (573BU) Gainesville, FL; (573QA) Gainesville–16th Street, FL; (573QB) Gainesville–98th Street, FL; (573QC) Gainesville–64th Street (C), FL; (573QD) Gainesville–64th Street (O), FL; (573QE) Gainesville–64th Street (D), FL; (573QF) Gainesville–23rd Avenue, FL; and (573QH) Ocala West, FL, as no data were reported.

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

Quarterly Established Primary Care Patient Average Wait Time in Days

	VHA All	(573) Gainesville, FL (Malcom Randall)	(573A4) Lake City, FL	(573BY) Jacksonville, FL	(573GA) Valdosta, GA	(573GD) Ocala, FL	(573GE) Saint Augustine, FL	(573GF) Tallahassee, FL (Sergeant Ernest I. "Boots" Thomas)	(573GI) The Villages, FL	(573GJ) St. Mary's, GA	(573GK) Marianna, FL	(573GL) Palatka, FL	(573GM) Waycross, GA	(573GN) Perry, FL	(573GO) Middleburg, FL	(573QG) Jacksonville Southpoint, FL	(573QJ) Jacksonville, FL	(573QK) Lake City Commerce Drive, FL
JAN-FY20	4.8	3.5	8.3	6.8	3.0	2.7	2.4	4.4	5.9	3.3	1.9	2.7	2.5	1.8	n/a	5.5	4.7	3.9
FEB-FY20	4.3	4.0	5.8	7.0	3.4	3.1	3.0	4.9	5.3	3.7	3.0	2.3	2.7	0.7	n/a	5.3	4.1	2.7
MAR-FY20	3.9	2.8	4.4	5.9	3.9	4.7	2.7	3.8	5.2	5.7	2.1	1.6	1.7	0.6	n/a	1.9	4.3	4.3
APR-FY20	1.9	3.0	0.4	3.5	0.4	0.3	3.4	2.1	1.4	0.8	0.4	0.2	1.3	0.0	n/a	1.5	2.4	1.2
MAY-FY20	2.1	1.1	2.3	1.3	0.4	0.7	4.2	3.1	16.7	1.2	1.6	0.2	2.2	0.5	n/a	0.2	1.3	4.3
JUN-FY20	3.7	3.7	3.6	2.8	0.8	1.4	4.5	3.6	8.2	5.4	1.8	0.6	3.1	0.8	n/a	1.1	6.1	6.2
JUL-FY20	5.1	3.4	5.7	5.3	1.1	2.0	3.7	5.1	6.4	4.2	2.4	1.8	4.4	1.9	n/a	1.9	5.4	4.1
AUG-FY20	5.0	4.0	3.2	4.6	1.5	2.5	3.1	6.3	12.0	3.3	2.5	1.0	1.8	0.8	n/a	2.6	7.5	2.4
SEP-FY20	4.9	4.3	3.3	3.1	2.4	2.1	3.3	9.4	5.7	3.3	5.0	1.1	2.0	1.0	1.2	2.6	8.3	1.9
OCT-FY21	5.0	3.6	3.7	6.3	1.3	1.4	3.4	10.6	8.6	4.3	5.1	1.6	2.5	0.9	3.6	6.7	8.8	3.3
NOV-FY21	5.2	4.5	3.9	6.2	2.2	2.5	3.7	9.3	7.5	6.2	5.3	1.5	3.9	0.7	6.6	2.1	9.9	3.3
DEC-FY21	5.2	4.3	2.2	7.4	3.0	2.2	4.2	9.0	7.6	3.2	5.6	1.4	3.3	0.7	5.4	2.9	15.1	4.2

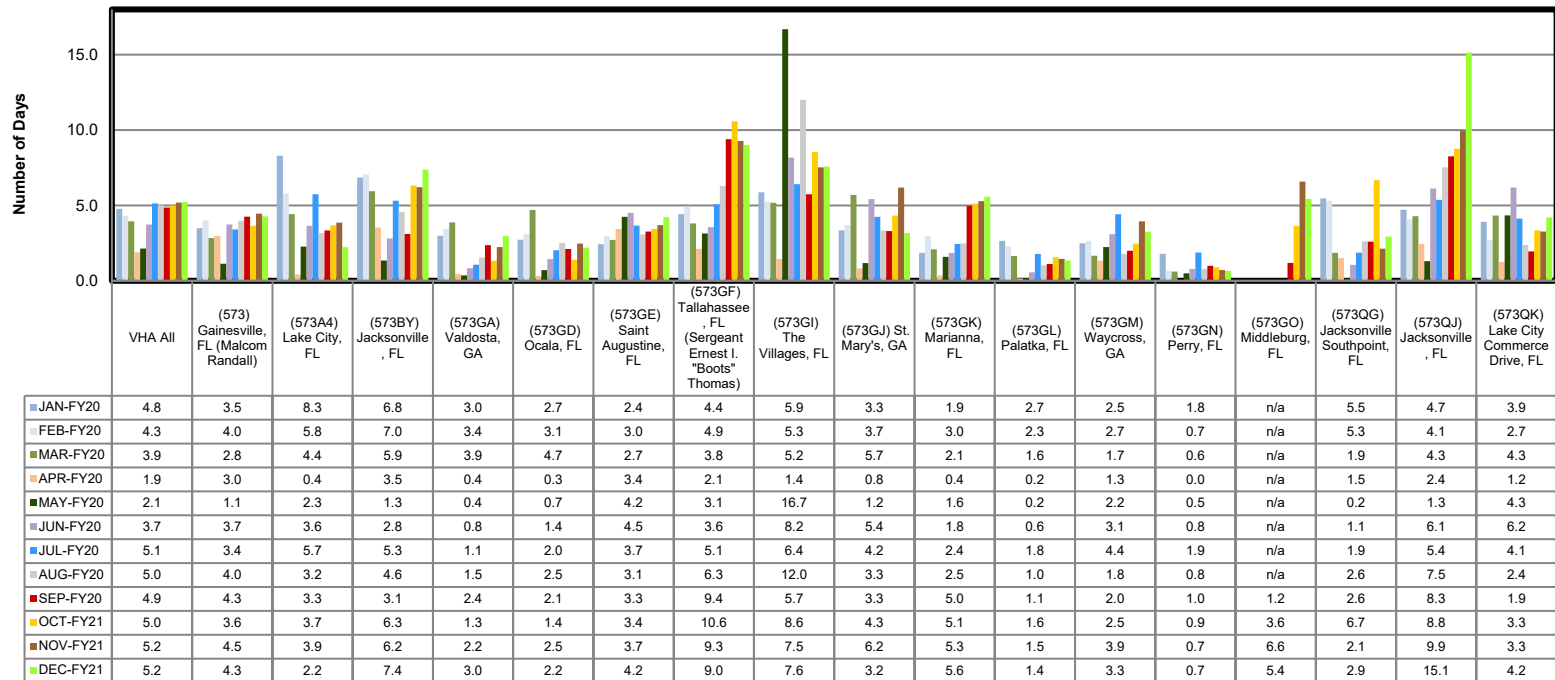*Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019.*

Note: The OIG did not assess VA's data for accuracy or completeness. Note: The OIG omitted (573BU) Gainesville, FL; (573QA) Gainesville–16th Street, FL; (573QB) Gainesville−98th Street, FL; (573QC) Gainesville–64th Street (C), FL; (573QD) Gainesville−64th Street (O), FL; (573QE) Gainesville–64th Street (D), FL; (573QF) Gainesville−23rd Avenue, FL; and (573QH) Ocala West, FL as no data were reported.

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

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

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

Measure	Definition	Desired Direction
Oryx – GM90_1	ORYX inpatient composite of global measures	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center.

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

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

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

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 2, 2021

From: Director, VA Sunshine Healthcare Network (10N8)

Subj: Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System in Gainesville, Florida

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

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

1. I have reviewed the Office of the Inspector General's report of their Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System in Gainesville, Florida. I concur with the recommendations. Additionally, I have reviewed the Healthcare System Director's response and concur with the system's actions. I am committed to ensuring all actions are completed timely.

2. For questions regarding the response, please contact the VISN 8 Chief Quality Management Officer.

(Original signed by:)

Miguel H. LaPuz, M.D., MBA
Network Director, VISN 8

Appendix H: Health System Director Comments

Department of Veterans Affairs Memorandum

Date: August 30, 2021

From: Director, North Florida/South Georgia Veterans Health System (573/00)

Subj: Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System in Gainesville, Florida

To: Director, VA Sunshine Healthcare Network (10N8)

1. I have reviewed and concur with the findings and the recommendations in the report of the Healthcare Inspection review.

2. Corrective actions plans have been established with completion dates, as detailed in the attached report.

(Original signed by:)

David B. Isaacks, FACHE
Executive Health System Director

OIG Contact and Staff Acknowledgments

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