DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Durham VA Health Care System in North Carolina

CHIP REPORT | REPORT #21-00276-67 | FEBRUARY 3, 2022

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Figure 1. *Durham VA Health Care System in North Carolina.*
Source: https://www.durham.va.gov/ (*accessed August 16, 2021*).

Abbreviations

ADPCS	Associate Director Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
DBC	disruptive behavior committee
FDA	Food and Drug Administration
FY	fiscal year
OIG	Office of Inspector General
QSV	quality, safety, and value
RN	registered nurse
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Durham VA Health Care System and multiple outpatient clinics in North Carolina. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

1. COVID-19 pandemic readiness and 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 the Durham VA Health Care System during the week of May 3, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this healthcare system and other Veterans Health Administration (VHA)

[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)."

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 eight recommendations to the Executive Director, Chief of Staff, and Associate Director Patient Care Services. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual review, the healthcare system's leadership team consisted of the Executive Director, Chief of Staff, Associate Director Patient Care Services, Associate Director [of] Operations, and Greenville Health Care Center Administrator Assistant Director. Organizational communications and accountability were managed through a committee reporting structure, with Governance Board oversight of several working groups. Leaders monitored patient safety and care through the Quality, Safety, Value Council, which was responsible for tracking and trending quality of care and patient outcomes.

The healthcare system's fiscal year 2020 annual medical care budget of $896,345,182 increased by approximately 15 percent compared to the previous year's budget of $782,823,537, and executive leaders were able to discuss occupational shortages and recruiting strategies.

When the team conducted this inspection, the healthcare system's leaders had worked together in a permanent capacity for just under four months, although the Executive Director and the Chief of Staff had served in their positions for over three years. The Greenville Health Care Center Administrator, hired in January 2020, also functioned as the Assistant Director, and in February 2020 the positions were combined under the new title of Greenville Health Care Center administrator assistant director. The Associate Director [of] Operations served in an acting capacity for about nine months before being permanently assigned to the position in January 2021. The healthcare system created a second assistant director (healthcare system) position in April 2021, which was vacant at the time of the inspection.

During an interview with the OIG, the Executive Director indicated the fiscal year 2020 budget increase helped healthcare system leaders hire additional staff, construct a new outpatient clinic and an oncology center for excellence program building, and expand operating room space.

Selected employee survey responses generally revealed satisfaction with leadership and a workplace where staff felt respected, and discrimination was not tolerated. However, survey

results also highlighted opportunities to reduce employees' feelings of moral distress at work.[2] Patient experience survey data generally implied less satisfaction with care than the VHA average, and leaders have opportunities to improve patient satisfaction in the inpatient and outpatient settings for both male and female veterans.

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.[3]

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[4] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[5]

The executive leaders were generally knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and Community Living Center SAIL models.[6] 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 healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

[2] "2020 VA All Employee Survey (AES): Questions by Organizational Health Framework," VA Workforce Surveys Portal, VHA Support Service Center, accessed July 29, 2021, http://aes.vssc.med.va.gov/SurveyInstruments/_layouts/15/DocIdRedir.aspx?ID=QQVSJ65U5ZMQ-229890423-174. (This is an internal website not publicly accessible.) The 2020 All Employee Survey defines moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing."

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

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

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

[6] 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.

Registered Nurse Credentialing

The OIG reviewers found that registered nurses hired from July 1, 2020, through April 4, 2021, were free from potentially disqualifying licensure actions. However, staff did not consistently complete primary source verification of each registered nurse license prior to appointment.

Medication Management

The OIG team observed compliance with many elements of expected performance. However, the OIG noted concerns with patient/caregiver education prior to remdesivir administration.

Mental Health

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

Care Coordination

The healthcare system met expectations for maintaining a current inter-facility transfer policy and conducting nurse-to-nurse communication between sending and receiving facilities. However, the OIG identified deficiencies with monitoring and evaluation of inter-facility transfers, completion of the required VA *Inter-Facility Transfer Form* or facility-defined equivalent, documentation of patients' stability for transfer, and transmission of patients' active medication lists and advance directives to receiving facilities.[7]

High-Risk Processes

The healthcare system met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified noncompliance with disruptive behavior committee meeting attendance, patient notification of an Order of Behavioral Restriction, and staff training requirements.

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued eight recommendations for improvement to the Executive Director, Chief of Staff, and Associate Director Patient Care Services. However, the number of

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

recommendations should not be used as a gauge for the overall quality of care provided at this healthcare system. The intent is for healthcare system leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues and other less-critical findings that may eventually interfere with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and Interim Executive 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.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

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 healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Durham VA Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so that informed decisions can be made to improve care.[1]

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

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

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

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[5]
3. Quality, safety, and value (QSV)
4. Registered nurse credentialing

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

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

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

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

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

5. Medication management (targeting remdesivir use)
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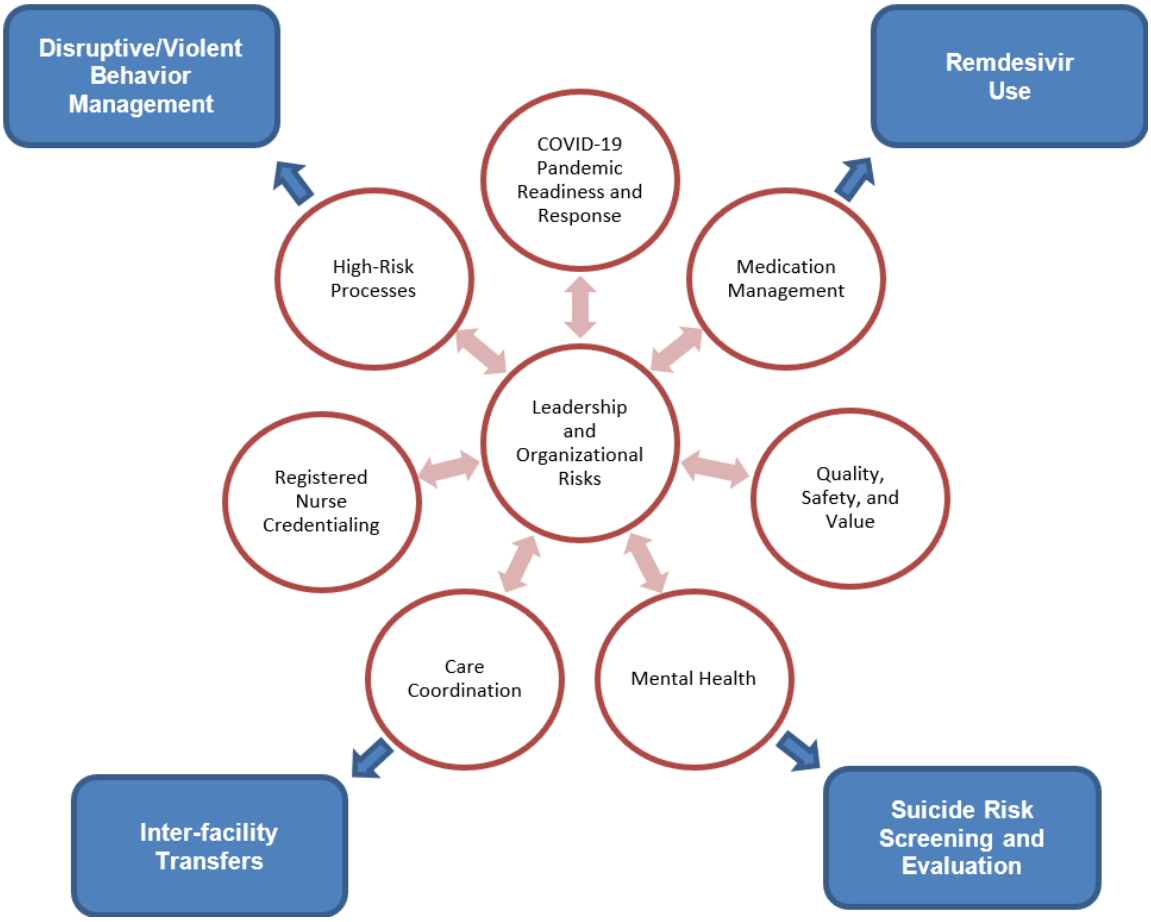


Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
Source: VA OIG.

Methodology

The Durham VA Health Care System includes the Durham VA Medical Center and multiple outpatient clinics in North Carolina. Additional details about the types of care provided by the healthcare system can be found in appendixes B and C.

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

The inspection examined operations from July 28, 2018, through May 7, 2021, the last day of the unannounced multiday evaluation.[7] During the virtual review, the OIG did not receive any complaints beyond the scope of the inspection.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[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 healthcare system completes corrective actions. The Executive Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that the system leaders developed based on the reasons for noncompliance.

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

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

[7] The range represents the time period from the prior CHIP site visit to the completion of the unannounced, multiday virtual CHIP visit in May 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 healthcare system's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the healthcare system response
8. VHA performance data (healthcare system)
9. VHA performance data (community living center (CLC))[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 healthcare system's reported organizational structure. The healthcare system had a leadership team consisting of the Executive Director, Chief of Staff, Associate Director Patient Care Services (ADPCS), Associate Director [of] Operations, and Greenville Health Care Center Administrator Assistant Director. The Chief of Staff and ADPCS oversaw patient care, which required managing service directors and chiefs of programs and practices.

[9] Laura Botwinick, Maureen Bisognano, and Carol Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare 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.

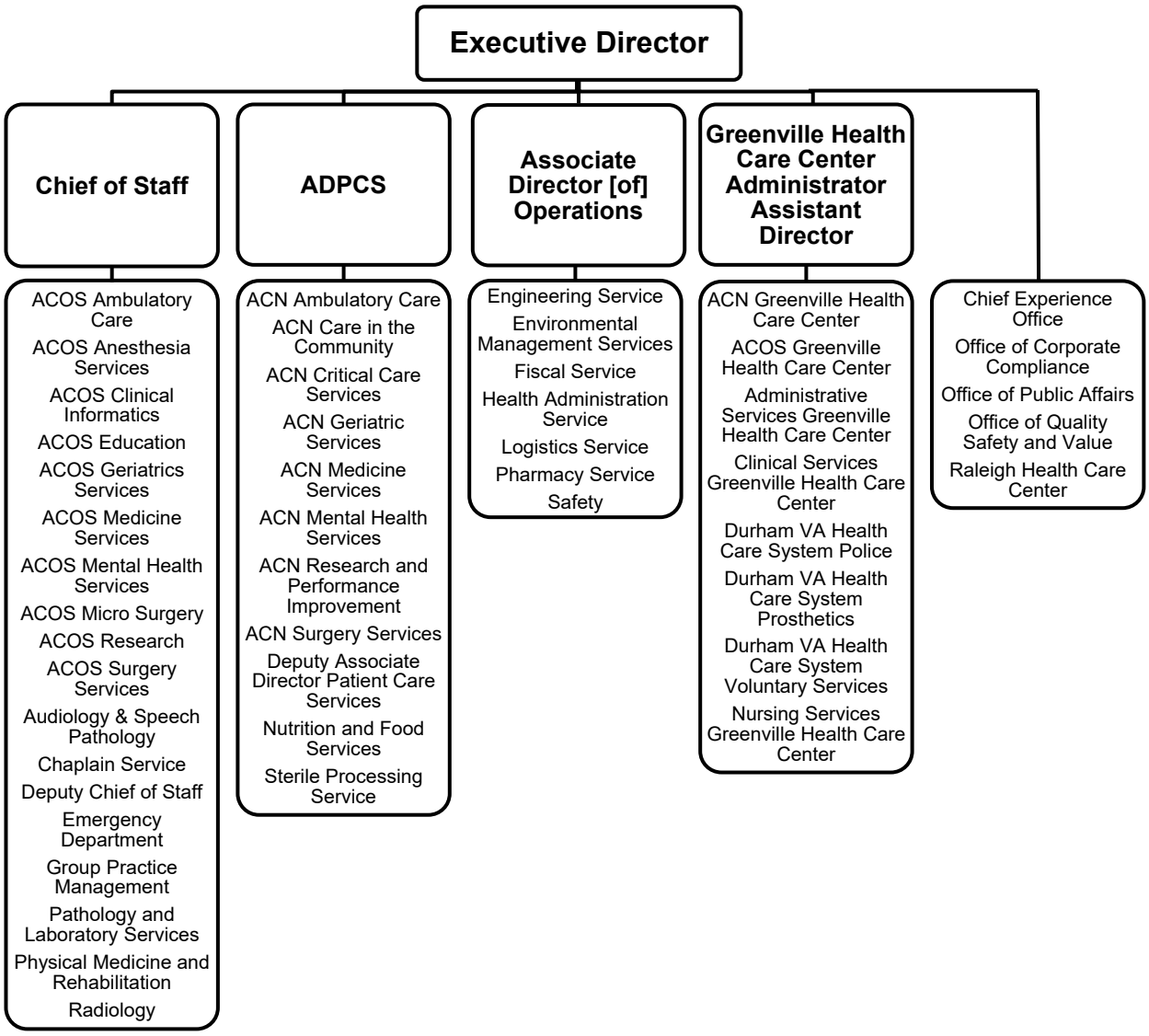


Figure 3. *Healthcare system organizational chart.*

ACN = Associate Chief Nurse ACOS = Associate Chief of Staff

Source: Durham VA Health Care System (received May 3, 2021).

At the time of the OIG inspection, the executive team had worked together in a permanent capacity for four months, although the Executive Director and the Chief of Staff had served in their positions for over three years (see table 1). The Associate Director [of] Operations served in an acting capacity for about nine months before being permanently assigned in January 2021. The Assistant Director, hired in January 2020, also functioned as the Administrator of the Greenville Health Care Center, the largest of the facility's outpatient care facilities in the community. In February 2020, the leader's positions were combined under the new title of Greenville Health Care Center administrator assistant director. In April 2021, the healthcare system received approval for another assistant director (healthcare system) position. The

Executive Director shared ongoing recruitment efforts and stated that the individual selected would be based in Durham.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Executive Director	March 18, 2018
Chief of Staff	August 23, 2015
Associate Director Patient Care Services	January 2, 2019
Associate Director [of] Operations	January 17, 2021
Greenville Health Care Center Administrator Assistant Director*	January 19, 2020
Assistant Director (healthcare system)	Vacant

Source: Durham VA Health Care System, Assistant Human Resources Officer/Senior Business Strategic Partner (received May 17, 2021).

**In January 2020, the Greenville Health Care Center administrator and assistant director positions were separate. These positions were combined on February 21, 2020, under the new title of Greenville Health Care Center administrator assistant director.*

The Executive Director served as the chairperson of the Governance Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Governance Board oversaw various working groups such as the Medical Executive Committee and the Quality, Safety, Value; Organizational Health; Business Operations; and Nursing Executive Coordinating councils. These leaders monitored patient safety and care through the Quality, Safety, Value Council, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Governance Board (see figure 4).

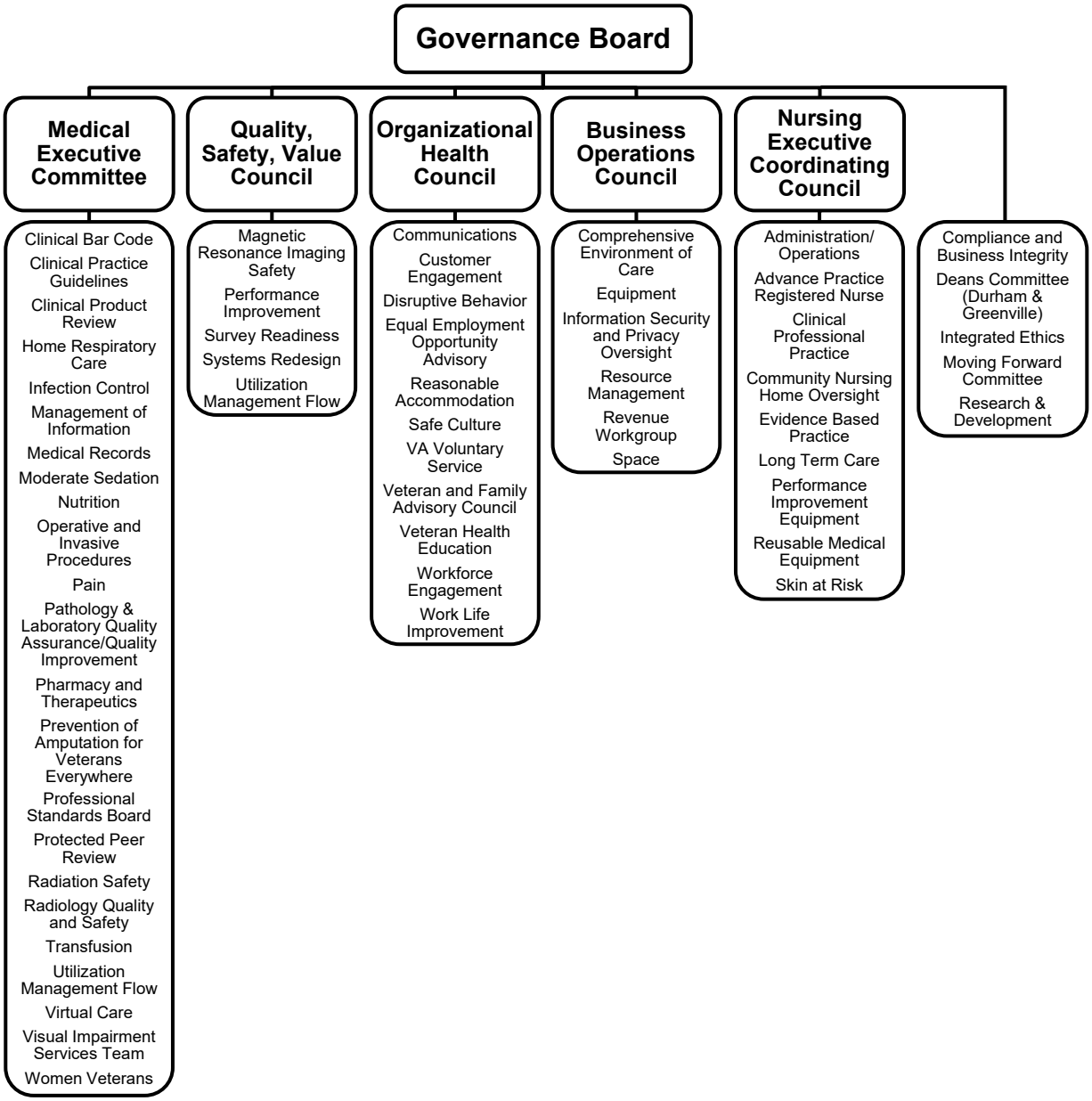


Figure 4. *Healthcare system committee reporting structure.*

Source: Durham VA Health Care System (received May 3, 2021).

To help assess the healthcare system executive leaders' engagement, the OIG interviewed the Executive Director, Chief of Staff, ADPCS, and Associate Director [of] Operations regarding their knowledge of various performance metrics and involvement and support of actions to improve or sustain performance. In individual interviews, leaders were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of $896,345,182 increased by approximately 15 percent compared to the previous year's budget of $782,823,537.[11] When asked about the effect of this change on the healthcare system's operations, the Executive Director indicated the budget increase helped leaders hire additional staff for mental health, construct a new outpatient clinic and an oncology center for excellence program building, and expand operating room space.

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. The Chief of Staff reported ongoing recruitment challenges with providers because of the healthcare system's inability to compete with the private sector's salaries and stated that staffing shortages existed throughout the system. To address physician shortages, the Chief of Staff described offering hiring incentives such as the Education Debt Reduction Program, providing opportunities to pursue research and teaching, and leveraging the healthcare system's training programs. The Executive Director reported ongoing efforts to attract staff by using recruiters and recruitment incentives. For nonclinical staff, the Associate Director [of] Operations described implementing new hiring practices and training for medical support assistants, providing career growth opportunities for biomedical engineers, and offering special salary rates for police officers.

[11] VHA Support Service Center.

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

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

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

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

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Primary Care	1. Medical Support Assistance
2. Cardiac Electrophysiology	2. Biomedical Engineering
3. Psychiatry	3. Police
4. Cardiology Non-Interventionist	4. Logistics Management
5. Radiation Oncology	5. Electrician

Source: VA OIG.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[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 healthcare system leaders.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[18] Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. The OIG found the healthcare system averages for the selected survey leadership questions were similar to the VHA averages.[19] Except for the Associate Director [of] Operations and Greenville Health Care Center Administrator Assistant Director, scores for the executive leaders were consistently higher than those for VHA and the healthcare system.[20]

[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 Executive Director, Chief of Staff, ADPCS, Associate Director [of] Operations, and Greenville Health Care Center Assistant Director.

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

[20] The 2020 All Employee Survey results are not fully reflective of employee satisfaction with the Associate Director [of] Operations or the Greenville Health Care Center Administrator Assistant Director, who were either not in their roles when the survey was administered or not in their roles for the full survey review period.

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Exec. Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director [of] Ops. Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	73.9	83.7	92.7	87.9	73.2	67.1
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	4.4	4.3	4.0	3.4	3.3
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	4.4	4.5	4.3	3.8	3.6
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.8	4.5	4.4	4.6	3.6	3.3

Source: VA All Employee Survey (accessed April 5, 2021).

**The Servant Leader Index is a summary measure based upon 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.[21] The healthcare system and leaders' averages for the selected survey questions were similar to or better than VHA averages. However, scores for the senior leaders,

[21] Ratings are based on responses by employees who report to or are aligned under the Executive Director, Chief of Staff, ADPCS, Associate Director [of] Operations, and Greenville Health Care Center Administrator Assistant Director.

except the Executive Director, highlighted opportunities to reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing).[22]

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Exec. Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director [of] Ops. Average	Asst. 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	3.8	4.4	4.4	4.4	3.6	4.1
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	4.0	4.6	4.3	3.5	3.7

[22] The 2020 All Employee Survey results are not fully reflective of employee satisfaction with the Associate Director [of] Operations or Greenville Health Care Center Administrator Assistant Director, who were either not in their roles when the survey was administered or not in their roles for the full survey review period.

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Exec. Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director [of] Ops. Average	Asst. 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	1.4	1.1	1.7	2.1	2.3	2.2

Source: VA All Employee Survey (accessed April 5, 2021).

VHA leaders have articulated that the agency "is committed to a harassment-free health care environment."[23] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[24]

The Executive Director stated that the entire leadership team signed the "Stand Up to Stop Harassment Now!" campaign declaration and that posters of the signed declaration and anti-harassment signs were created and prominently displayed in high-traffic areas throughout the healthcare system.[25] The Executive Director also reported raising awareness by developing educational videos and asking staff to write and role-play scenarios and stop harassment in the workplace.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The healthcare system and executive leadership team averages for the selected survey questions were generally similar to or slightly better than VHA averages. However, the Associate Director [of] Operations and the Greenville Health Care Center Administrator Assistant Director scores were lower than VHA averages. Leaders generally appeared to maintain an environment where staff felt respected and safe, and discrimination was not tolerated.

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

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

[25] Executive in Charge, Office of Under Secretary for Health Memorandum, *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-care System Average	Exec. Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director [of] Ops. Average	Asst. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.9	3.9	4.3	4.8	3.9	3.7	3.6
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree) –5 (Strongly Agree)	4.1	4.0	4.1	4.7	4.2	3.7	4.0
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	4.1	4.6	4.1	3.5	3.6

Source: VA All Employee Survey (accessed April 5, 2021).

Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the healthcare system.[26] For this healthcare system, the overall patient satisfaction survey results reflected lower care ratings than the VHA average. Leaders have opportunities to improve patient satisfaction in the inpatient and outpatient settings and attributed the low scores primarily to an aging facility infrastructure. For

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

inpatients, the Chief of Staff reported implementing noise abatement efforts such as eliminating overhead paging at night, scheduling patient rounds at a time when family could attend or participate, and having staff identify themselves when entering a patient's room. Additionally, the Executive Director stated that the healthcare system had included more options for patient meal menus and hired additional housekeepers and intermediate care technicians. For outpatient settings, the Chief of Staff considered the survey results difficult to analyze because the data did not drill down to specific specialties. Nevertheless, the Chief of Staff reported efforts to improve communication through secure messaging and My HealtheVet, answering phones in a timely manner, conducting veterans' town halls, and not turning patients away when they arrive at clinics without a scheduled appointment.[27]

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

Questions	Scoring	VHA Average	Healthcare System Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	64.7
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	80.5
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.8	81.5

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

[27] "About My HealtheVet: How to Use My HealtheVet," accessed October 7, 2021, https://www.myhealth.va.gov/mhv-portal-web/how-to-use-mhv. My HealtheVet is VA's online personal health record for veterans, active-duty service members, their dependents, and caregivers. It allows users to refill prescriptions, access medical records, communicate securely with clinical staff for non-urgent information or questions, and manage appointments, including receiving email reminders.

2048.[28] 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). For inpatients, both genders scored their experiences less favorably than VHA respondents, except for male patients who indicated that doctors treated them with courtesy and respect, highlighting opportunities to improve patients' perceptions of their care while hospitalized. In outpatient settings, both genders scored the healthcare system lower than VHA respondents for obtaining an appointment as soon as needed. Additionally, male veterans rated routine care availability and provider quality higher than VHA averages, while female veterans rated their care experiences below VHA averages. The results also revealed opportunities to improve specialty care experiences for both genders.

The Executive Director and the Chief of Staff cited the aging structure of the healthcare system and noise from various construction projects for the low inpatient setting scores. The Executive Director also reported that the Women Veterans Program Manager was conducting a program evaluation to ensure women veterans had adequate resources, including private rooms, and developing competencies for gender-specific care. The Executive Director also stated that staff made efforts to accommodate veterans' desire for face-to-face appointments instead of care provided via telephone. The Chief of Staff reported conducting town hall meetings and seeing patients without scheduled appointments to improve patient communication and satisfaction. Further, the Chief of Staff mentioned that limited parking was a challenge, especially when it caused patients to show up late for their appointments.

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

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

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
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	65.2	58.5
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	88.6	82.8
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	84.0	67.1

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

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

The healthcare system averages are based on 431–440 male and 22 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
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	45.3	35.8
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	62.1	41.3
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	76.6	68.4

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

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

The healthcare system averages are based on 473–1,405 male and 55–123 female respondents, depending on the question.

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

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
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	45.0	42.6
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	55.6	45.4
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	73.2	73.4

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

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

The healthcare system averages are based on 601–1,819 male and 41–111 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.[29] Table 10 summarizes the relevant healthcare system inspections most recently performed by the OIG and

[29] "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 reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization."

The Joint Commission (TJC).[30] At the time of the OIG review, the healthcare system had closed all recommendations for improvement issued since the previous CHIP site visit conducted in July 2018.

The OIG team also reviewed the healthcare system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[31] Additional results included the Long Term Care Institute's inspection of the healthcare system's CLC.[32]

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 Program Review of the Durham VA Medical Center, North Carolina*, Report No. 18-01146-35, December 19, 2018)	July 2018	2	0
TJC Hospital Accreditation	October 2020	33	0
TJC Behavioral Health Care Accreditation		7	0
TJC Home Care Accreditation		1	0

Source: OIG and TJC (inspection/survey results received from the Deputy Chief and Nurse Manager, Quality, Safety, and Value on May 5, 2021).

[30] 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."

[31] 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.

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

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

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

Table 11 lists the reported patient safety events from July 28, 2018 (the prior OIG CHIP site visit), through May 4, 2021.[33] The OIG confirmed that for all applicable sentinel events and institutional disclosures, program managers conducted required investigations, such as root cause analyses and peer review, and took corrective actions by developing and improving processes and enhancing staff education and training.

Table 11. Summary of Selected Organizational Risk Factors (July 28, 2018, through May 4, 2021)

Factor	Number of Occurrences
Sentinel Events	19
Institutional Disclosures	52
Large-Scale Disclosures	0

Source: Durham VA Health Care System's Patient Safety and Risk Managers (received May 5, 2021).

The Executive Director spoke knowledgeably about serious adverse event reporting, including discussion of all adverse events cases at the Executive Director's daily morning huddle. Sentinel

[33] 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 Durham VA Health Care 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."

event and institutional disclosure determinations were reportedly made using the VA National Center for Patient Safety Handbook guidance and discussion with the Chief of Staff, Risk Manager, and Patient Safety Manager. Additionally, the Executive Director reported an active patient safety program that included weekly follow-ups on patient safety events and consistently performed root cause analyses, fact findings, and focused reviews.

Veterans Health Administration Performance Data for the Healthcare System

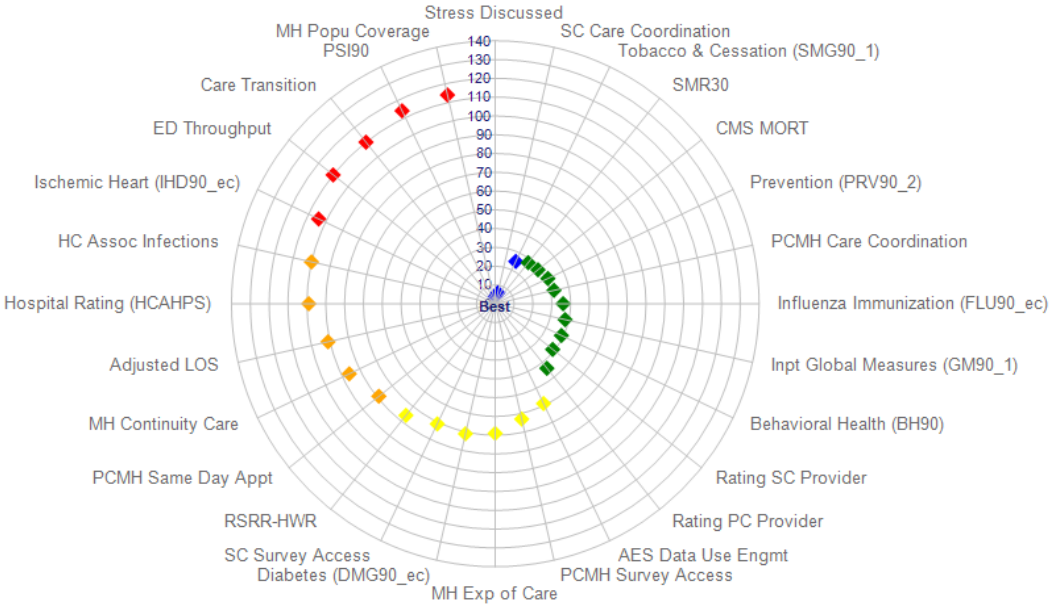
The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[34] Despite noted limitations 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.[35]

Figure 5 illustrates the healthcare system's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 5 shows the Durham VA Health Care System's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of stress discussed, patient-centered medical home (PCMH) care coordination, and behavioral health (BH90)). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, health care (HC) associated (assoc) infections, ED throughput, and care transition).[36] The executive leaders were knowledgeable about VHA data and/or system-level factors contributing to poor performance on specific SAIL measures.

[34] "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.)

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

[36] 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. *Healthcare system quality of care and efficiency metric rankings for FY 2021 quarter 1 (as of December 31, 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."[37] The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[38]

Figures 6 illustrates the healthcare system's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2020. Figure 6 displays the Durham VA Health Care System CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of catheter in bladder–long-stay (LS), new or worse pressure

[37] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC): A tool to examine Quality Using Internal VA Benchmarks,* July 16, 2021.

[38] 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."

ulcer (PU)–short-stay (SS), and moderate-severe pain (LS)). The metric in the fifth quintile needs improvement and is denoted in red (high risk PU (LS)).[39] There were no metrics in the fourth quintile. Leaders had an understanding of specific CLC SAIL measures.

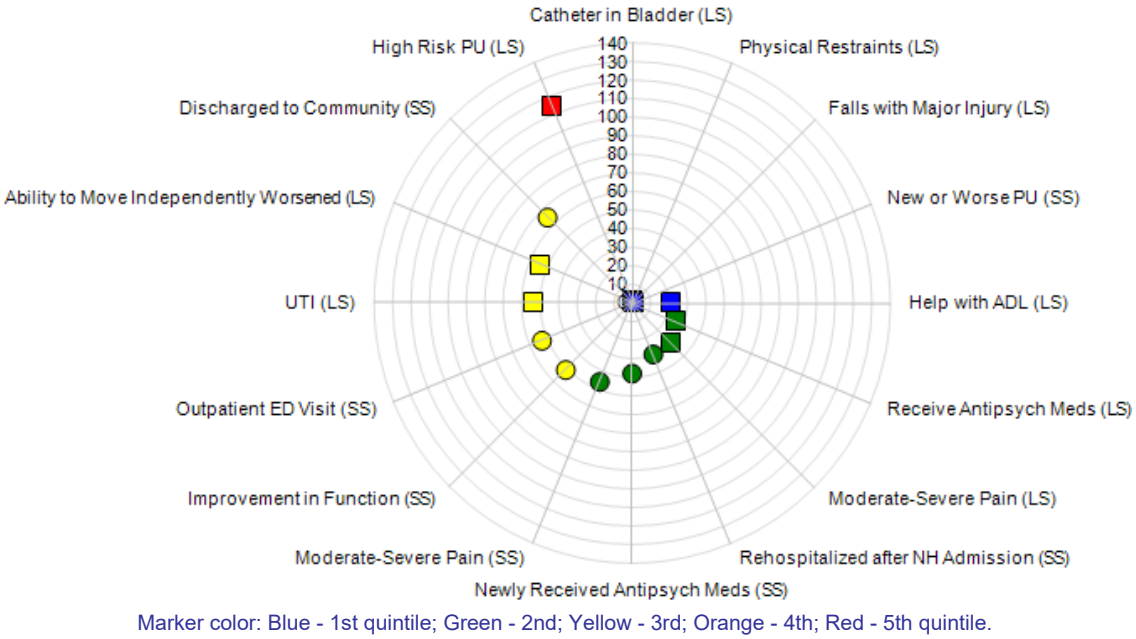


Figure 6. *Durham CLC quality measure rankings for FY 2020 quarter 4 (as of September 30, 2020).*

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

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

The healthcare system's executive leadership team appeared stable with all the positions permanently assigned, except for the new assistant director (healthcare system) position. The healthcare system received approval for the second assistant director (healthcare system) in April 2021. At the time of the virtual review, the system had started recruitment efforts for the position. The healthcare system's FY 2020 annual medical care budget of $896,345,182 increased by approximately 15 percent compared to the previous year's budget of $782,823,537; executive leaders were able to discuss clinical and nonclinical occupational shortages and recruiting strategies.

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

During an interview with the OIG, the Executive Director indicated the FY 2020 budget increase helped the healthcare system hire additional staff, construct a new clinic and a building for the oncology center for excellence program, and expand operating room space.

Selected employee survey responses revealed general satisfaction with leadership and a workplace where staff felt respected, and discrimination was not tolerated. However, survey results highlighted opportunities for leaders to reduce employees' feelings of moral distress at work. Patient experience survey data generally implied lower care ratings than the VHA average, and leaders have opportunities to improve patient satisfaction in the inpatient and outpatient settings for both male and female veterans.

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 leaders were generally knowledgeable within their scopes of responsibility about healthcare system and CLC SAIL measures but should continue to take actions to improve performance.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[40] 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.[41]

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."[42] "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."[43]

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

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

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

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

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[40] "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.

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

[42] 38 U.S.C. § 1785(a); 38 C.F.R. § 17.86(b). VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the 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."

[43] 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.[44] 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.[45] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as TJC), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[46]

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

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

The OIG reviewers also assessed the healthcare system's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[47] 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."[48] 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

[44] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[45] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.
[46] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.
[47] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.
[48] VHA Directive 1026.01.

Next, the OIG assessed the healthcare system's processes for conducting protected peer reviews of clinical care.[49] 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."[50] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[51] 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[52]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[53]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the healthcare system's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[54] The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) Operational oversight of surgical services and quality improvement activities; (2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select

[49] 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."

[50] VHA Directive 1190.

[51] VHA Directive 1190.

[52] VHA Directive 1190.

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

[54] "NSO Reporting, Resources, & Tools," VA Surgical Quality Improvement Program, accessed November 21, 2020, https://dvagov.sharepoint.com/sites/VHANSOVASQIP/SitePages/Default.aspx. (This is an internal VA website not publicly accessible.)

specialty programs."[55] The healthcare system's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (registered nurse)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events[56]

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.[57]

Quality, Safety, and Value Findings and Recommendations

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

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

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

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

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[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 reviewing relevant documents for 55 RNs hired from July 1, 2020, through April 4, 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.

[58] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. VHA Directive 2012-030 was replaced on September 15, 2021, by VHA Directive 1100.20, *Credentialing of Health Care Providers*. The two documents contain similar language regarding credentialing procedures.

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

[60] VHA Directive 2012-030, replaced by VHA Directive 1100.20. The two documents contain similar language regarding RN licenses. "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, replaced by VHA Directive 1100.20. The two documents contain similar language regarding adverse licensure actions.

[63] VHA Directive 2012-030, replaced by VHA Directive 1100.20. The two documents contain similar language regarding previously held licenses.

The OIG team interviewed key managers and reviewed the credentialing files for 30 of the 55 RNs to determine whether healthcare system staff completed primary source verification prior to the appointment.

Registered Nurse Credentialing Findings and Recommendations

The OIG determined that all 55 RNs reviewed were free from potentially disqualifying licensure actions. However, the OIG identified a deficiency with primary source verification.

VHA requires the healthcare system director to ensure all current and previously held licenses are verified from primary sources prior to an individual's initial appointment or transfer from another medical facility.[64] The OIG found that for 6 of 30 RNs, credentialing staff did not complete primary source verification for each license held prior to appointment. This could lead to inappropriate hiring of nurses and subsequently affect the provision of quality care. The Credentialing Coordinator stated a misunderstanding of the requirement and a belief that verifying active RN licenses was sufficient to meet the standard.

Recommendation 1

1. The Executive 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.

[64] VHA Directive 2012-030.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Executive Director reviewed and determined that there were no additional reasons for noncompliance. The Credentialing and Privileging (C&P) staff and Nursing staff met to evaluate the current process and to identify opportunities for improvement. Currently the C&P service line has a dedicated staff assigned to complete audit of nursing licenses. Verification of new Registered Nurse (RN) hires are being completed through NURSYS prior to being appointed. The C&P Supervisor provided education of the new process to all C&P staff with instructions to utilize the NURSYS system to verify all nurse licensure.

The C&P Supervisor or designee conducts monthly audits to ensure each license for all newly selected Registered Nurses (RNs) were verified and have appropriate NURSYS verification uploaded. This metric is tracked as follows: the numerator is the total number of Registered Nurses with initial appointments during the month reviewed that had all licensure verified through NURSYS. The denominator is the total number of Registered Nurses with initial appointments during the month reviewed.

The target is 90 percent compliance for two consecutive quarters. Compliance data will be reported by the C&P Supervisor or designee monthly to the Quality, Safety, Value Council.

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 27 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
  - Potential pregnancy
  - Kidney assessment (estimated glomerular filtration rate)[71]
  - 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 OIG found the healthcare system generally met the requirements listed above. However, the OIG identified deficiencies with patient/caregiver education prior to remdesivir administration.

Under the Emergency Use Authorization, the VA Pharmacy Benefits Management Services required healthcare providers to provide the *Fact Sheet for Patients and Parents/Caregivers*, to inform patients and/or caregivers that remdesivir was not an FDA-approved medication, provide the option to refuse the medication, and advise patients or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[73]

Of the 27 patients who received remdesivir, the OIG determined that healthcare providers did not

- provide 93 percent of patients and/or caregivers with the *Fact Sheet for Patients and Parents/Caregivers*,
- inform 19 percent of patients and/or caregivers that remdesivir was not an FDA-approved medication,
- advise 11 percent of patients and/or caregivers of the option to refuse remdesivir,
- notify 30 percent of patients and/or caregivers of the significant known and potential risks and benefits prior to administration, and

[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.

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

- advise 100 percent of patients and/or caregivers of alternatives to receiving remdesivir prior to administration.

This could have resulted in the patient or caregiver lacking information needed to make a fully informed decision to receive the medication. The Deputy Chief of Medicine stated that the lack of standardized patient education for remdesivir resulted in inconsistent documentation.

Given the FDA's approval of remdesivir for use in adult patients hospitalized with COVID-19, the OIG made no recommendations related to the Emergency Use Authorization requirements.[74]

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

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.[75] The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.[76] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[77]

VHA 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.[78] 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.[79] The healthcare system was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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

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

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

[78] 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.

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

- the electronic health records of 47 randomly selected patients who were seen in the emergency department/urgent care center from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

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

VHA requires staff to complete suicide safety plan training prior to developing suicide prevention safety plans with patients.[80] The OIG reviewed the training records for 21 staff responsible for suicide safety plan development and found that four records (19 percent) did not contain evidence that they completed the mandatory training. Lack of training could prevent staff from providing optimal treatment to veterans who are at risk for suicide. The Associate Chief of Staff for Mental and Behavioral Health Services and the Director, Psychiatry Emergency Care cited a lack of oversight when fee-basis staff did not respond to reminders to complete the required training.[81]

Recommendation 2

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

[80] 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*.

[81] "VA Technical Reference Model v 21.7," Department of Veterans Affairs, accessed August 31, 2021, https://www.oit.va.gov/Services/TRM/ToolPage.aspx?tid=8604. "The VA Fee Basis medical program provides payment authorization for eligible Veterans to obtain routine medical treatment services through non-VA health care providers."

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Chief of Staff evaluated reasons for noncompliance and determined no additional reasons. The Associate Chief of Staff for Mental and Behavioral Health Services and the Director, Psychiatry Emergency Care (PEC) reviewed and developed a process for suicide safety plan training completion. The Director of PEC will ensure that applicable PEC staff are assigned the required Talent Management System (TMS) training and complete the mandatory safety plan training prior to developing suicide safety plans. A monthly TMS report to identify all PEC employees due for the safety plan training will be reviewed by the Director of PEC or designee for compliance. This new process has been communicated through emails and staff meetings. The Director of PEC will track and monitor the following metrics: the numerator is the total number of applicable PEC staff who completed the mandatory safety plan training prior to developing suicide safety plans. The denominator is the total number of applicable PEC staff required to complete mandatory safety plan training prior to developing suicide safety plans.

Reporting Committee: Compliance for monitoring the completion of the mandatory safety plan training prior to developing suicide safety plans will be reported monthly by the Director of PEC or designee to the Quality, Safety, Value Council.

Frequency of Monitoring: Monthly until 90% compliance is maintained for six consecutive months.

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.[82]

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."[83] 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.[84]

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

- Existence of a facility policy for inter-facility transfers
- Monitoring and evaluation of inter-facility transfers
- Completion of all required elements of the *Inter-Facility Transfer Form* or facility-defined equivalent by the appropriate provider(s) prior to patient transfer
- Transmission of patient's active medication list and advance directive to the receiving facility
- Communication between nurses at sending and receiving facilities

To determine whether the healthcare system complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 41 patients who were transferred from the healthcare system due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The healthcare system met expectations for maintaining a current inter-facility transfer policy and conducting nurse-to-nurse communication between sending and receiving facilities. However, the OIG identified deficiencies with monitoring and evaluation of inter-facility transfers, completion of the required VA *Inter-Facility Transfer Form* or facility-defined

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

[83] VHA Directive 1094.

[84] 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.

equivalent, documentation of patients' stability for transfer, and transmission of patients' active medication lists and advance directives to receiving facilities.

VHA requires the Chief of Staff and ADPCS to ensure "all transfers are monitored and evaluated as part of VHA's Quality Management Program."[85] The OIG reviewed the healthcare system's data collection worksheets from May 2020 through April 2021 and did not find evidence that staff monitored and evaluated inter-facility patient transfers. Failure to monitor patient transfer data could prevent the identification of system-level deficiencies that put patients at risk. The Chief, Hospital Medicine was unaware of the requirement and cited a lack of oversight of the transfer process.

Recommendation 3

3. The Chief of Staff and Associate Director Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure that inter-facility transfers are monitored and evaluated.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Chief of Staff and Associate Director Patient Care Services evaluated reasons for noncompliance and determined no additional reasons. A multi-disciplinary workgroup (representatives from Medicine, Mental Health, Emergency Department, Surgery, Nursing, Health Administration, and Quality, Safety, Value) was organized and established a standard process of monitoring the inter-facility patient transfers. The inter-facility transfer data are discussed by a multi-disciplinary workgroup for feedback and communication and then reported monthly by the Registered Nurse Quality Improvement Care in the Community or designee to the Community Care Oversight Committee (CCOC).[86] The chair of the CCOC or designee will track and monitor the following metrics: the numerator is the number of CCOC meeting minutes demonstrating discussion of inter-facility patient transfer data was discussed and reported. The denominator is the number of CCOC meeting minutes for six consecutive months. The chair of CCOC or designee reports monthly to the Nursing Executive Coordinating Council.

Frequency of Monitoring: Monthly until 90% compliance is maintained for six consecutive months.

[85] VHA Directive 1094.

[86] The Community Care Oversight Committee reports to the Nursing Executive Coordinating Council. It was established after the CHIP virtual review, and therefore is not listed in figure 4.

VHA requires appropriately privileged providers to complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note and record specific elements such as patients' medical and behavioral stability prior to patient transfers.[87] The OIG estimated that 39 percent of patient transfers did not include completion of the VA *Inter-Facility Transfer Form* or an equivalent note and 24 percent of transfer documentation did not include patients' stability for transfer.[88] These deficiencies could result in the unsafe transfer of patients. The Chief, ED reported that providers did not document required elements for transfer because the community care consult template, the tool the system used to document patient transfer information, did not mirror the VA *Inter-Facility Transfer Form*.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that appropriately privileged providers complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note, and document all required elements prior to patient transfers.

[87] VHA Directive 1094.

[88] For provider completion of a transfer note, the OIG estimated that 95 percent of the time, the true compliance rate is between 45.7 and 75.6 percent. For documentation of patient's stability for transfer, the OIG estimated that 95 percent of the time, the true compliance rate is between 61.9 and 88.1 percent. These are statistically significantly below the 90 percent benchmark.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Chief of Staff evaluated reasons for noncompliance and determined no additional reasons. A multi-disciplinary workgroup (representatives from Medicine, Mental Health, Emergency Department, Surgery, Nursing, Health Administration, and Quality, Safety, Value) was organized and established a standard process of monitoring the inter-facility patient transfers. The Emergency Department (ED) checklist, inpatient standard operating procedures (SOP), and interfacility transfer template have been reviewed and revised. The ED checklist and inpatient SOP were updated to include the elements of the VA Inter-Facility Transfer Form 10-2649A and embedded in template format to the medical record notes. Appropriately privileged providers were educated to utilize the ED checklist, inpatient SOP and complete the embedded template in the medical record notes. A process was established for the Care in the Community (CITC) department team to audit and ensure compliance of the VA Inter-Facility Transfer Form requirements. The Registered Nurse Quality Improvement CITC or designee will track and monitor the following metrics: the numerator is the number of VA Inter-Facility Transfer Form or a facility-defined equivalent note completed and documented by privileged providers during the reviewed month. The denominator is the total number of patients transferred from the facility to a VA or non-VA facility during the reviewed month.

Reporting Committee: Compliance for monitoring documentation of the VA Inter-Facility Transfer Form or a facility-defined equivalent note are reported monthly by the Registered Nurse Quality Improvement CITC or designee to Community Care Oversight Committee (CCOC). The chair of CCOC or designee reports monthly to the Nursing Executive Coordinating Council.

Frequency of Monitoring: Monthly until 90% compliance is maintained for six consecutive months.

VHA requires transferring providers to "send all pertinent medical records available, including an active patient medication list and…documentation of the patient's advance directive" to the receiving facility during inter-facility transfers.[89] The OIG estimated that 61 percent of electronic health records lacked evidence that transferring providers sent the active medication list to the receiving facility.[90] Additionally, the OIG determined that providers did not send a copy of the advance directive to the receiving facility for four of the five applicable patients. This could result in incorrect treatment decisions compromising patient safety and self-determination. The Chief, ED stated the medication list was sent but not documented because the community care consult template did not include all elements of the VA *Inter-Facility Transfer Form*. In

[89] VHA Directive 1094.

[90] The OIG estimated that 95 percent of the time, the true compliance rate is between 24.3 and 55.3, which is statistically significantly below the 90 percent benchmark.

addition, Chiefs for ED and Hospital Medicine reported advance directives were not sent because providers did not verify if patients had advance directives and staff were unaware of how to access copies of the directives in the medical record. Due to the small number of patients identified, the OIG made no recommendation for the advance directive requirement.

Recommendation 5

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

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Chief of Staff and Associate Director Patient Care Services evaluated reasons for noncompliance and determined no additional reasons. A multi-disciplinary workgroup (representatives from Medicine, Mental Health, Emergency Department, Surgery, Nursing, Health Administration and Quality, Safety, Value) was organized and established a standard process of monitoring the inter-facility patient transfers. The Emergency Department checklist, inpatient standard operating procedures, and inter-facility transfer equivalent note template have been reviewed and revised to meet the requirements of the VA Inter-Facility Transfer Form including sending an active patient medication list to the receiving facility. A process was established for the Care in the Community (CITC) department team to audit and ensure compliance of the VA Inter-Facility Transfer Form requirements. The Registered Nurse Quality Improvement CITC or designee will track and monitor the following metrics: the numerator is the number of documented active patient medication lists sent to the receiving facility. The denominator is the total number of patients with active medications transferred from the facility to a VA or non-VA facility during the review month.

Reporting Committee: Compliance for monitoring documentation of the interfacility transfer form, including sending an active patient medication list to the receiving facility, are reported monthly by the Registered Nurse Quality Improvement CITC or designee to Community Care Oversight Committee (CCOC). The chair of CCOC or designee reports monthly to the Nursing Executive Coordinating Council.

Frequency of Monitoring: Monthly until 90% compliance is maintained for six consecutive months.

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."[91] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[92] 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[93]
- Establishment of a disruptive behavior committee (DBC) or board that holds consistently attended meetings[94]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[95]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[96]

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

[92] VHA Directive 2012-026.

[93] 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."

[94] 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."

[95] 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."

[96] 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.[97] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[98] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The OIG found the healthcare system met many of the requirements for the management of disruptive and violent behavior. However, the OIG noted concerns with required representatives' attendance at DBC meetings, patient notification of an Order of Behavioral Restriction, and staff training.

VHA requires that the Chief of Staff and Nurse Executive (ADPCS) establish a DBC or board comprised of a senior clinician as the chairperson; administrative support staff; the patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and Union Safety Committee. The DBC is responsible for coordinating with clinicians, recommending amendments to treatment plans that may reduce patients' risk of violence, collecting and analyzing disruptive patient incidents, identifying system problems, and recommending to the Chief of Staff other actions related to the problem of patient violence.[99]

The OIG reviewed DBC attendance for meetings held from April 2020 through March 2021 and found the patient advocate did not attend 3 of 12 meetings (25 percent). This could result in the committee taking a less comprehensive approach when assessing patients' disruptive behavior and carrying out other responsibilities. The Chair of the DBC attributed the lack of attendance to representatives' difficulty in accessing virtual meetings, conflicting priorities, and inaccurate recording of excused absences in meeting minutes.

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

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

[99] VHA Directive 2010-053.

Recommendation 6

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

Healthcare system concurred.

Target date for completion: May 31, 2022

Healthcare system response: The Chief of Staff and Associate Director Patient Care Services reviewed and evaluated additional reasons for noncompliance and did not discover any additional reasons. The Chair of the Disruptive Behavior Committee (DBC) will coordinate meetings to ensure all required members attend meetings. A monitor log was created to capture attendance at the beginning of each committee meeting for each required member. The DBC chair will track the following metrics from the monitor log: the numerator is the number of attendance by required members at DBC meetings. The denominator is the number of DBC meetings for six consecutive months.

Reporting Committee: The compliance for monitoring attendance of required members of the Disruptive Behavior Committee will be reported monthly by the DBC chair to Quality, Safety, Value Council.

Frequency of Monitoring: Monthly until 90% compliance is maintained for six consecutive months.

VHA requires the DBC or board to document the decision to implement an Order of Behavioral Restriction and patient notification in the Disruptive Behavior Reporting System.[100] For three of five patients who were issued an order from April 2020 through March 2021, the OIG did not find evidence of patient notification in the Disruptive Behavior Reporting System. This could result in the issuance of restriction orders without patients' knowledge or opportunity to appeal. The Chair of the DBC believed that a certified mail receipt verifying that a notification was delivered met the requirement.

Recommendation 7

7. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Disruptive Behavior Committee documents patient notification for an Order of Behavioral Restriction in the Disruptive Behavior Reporting System.

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

Healthcare system concurred.

Target date for completion: May 31, 2022

Healthcare system response: The Chief of Staff reviewed and evaluated additional reasons for noncompliance and did not discover any additional reasons. The Chair of the Disruptive Behavior Committee (DBC) ensures the process of documentation of patient notification for an Order of Behavioral Restriction in the Disruptive Behavior Reporting System are completed. A DBC dashboard monitor was created and will be a permanent item in the DBC agenda for the committee to track and address documentation of patient notification for an Order of Behavioral Restriction in the Disruptive Behavior Reporting System. The DBC chair will track and monitor the following metrics: the numerator is the number of documented patient notifications for Orders of Behavioral Restriction in the Disruptive Behavior Reporting System. The denominator is the total number of patient notifications of Order of Behavioral Restriction during the month reviewed.

Reporting Committee: The compliance for monitoring of documentation of patient notification for an Order of Behavioral Restriction in the Disruptive Behavior Reporting System will be reported monthly by the DBC chair to Quality, Safety, Value Council.

Frequency of Monitoring: Monthly until 90% compliance is maintained for six consecutive months.

VHA requires staff to complete prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[101] The OIG found that 20 of 30 selected staff (67 percent) did not complete required trainings based on the risk level for their work area. This could result in staff's lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Prevention and Management of Disruptive Behavior Coordinator reported that staff did not respond to reminders and overlooked scheduled training dates for part 1 and followed facility leaders' guidance to cease face-to-face training to prevent staff exposure to COVID-19 for parts 2 and 3.[102]

Recommendation 8

8. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures staff complete the assigned prevention and management of disruptive behavior training based on the risk level assigned to their work area.

[101] DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*; DUSHOM Memorandum*, Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements.*

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

Healthcare system concurred.

Target date for completion: November 30, 2022

Healthcare system response: The Chief of Staff reviewed and evaluated additional reasons for noncompliance and did not discover any additional reasons. The Prevention and Management of Disruptive Behavior (PMDB) coordinator will collaborate with all Service Chiefs and Supervisors to ensure all employees complete PMDB trainings based on the risk level for their work area. The PMDB coordinator opened PMDB class offerings and plans to train additional trainers to increase class frequency. The PMDB coordinator will track and monitor the following metrics: the numerator is the number of staff that completed required PMDB trainings. The denominator is the number of staff required to complete PMDB trainings based on the risk level assigned to their work area.

Reporting Committee: The compliance for monitoring completion of required PMDB training will be reported monthly by the PMDB coordinator to the Quality, Safety, Value Committee.

Frequency of Monitoring: Monthly until 90% compliance is maintained for six consecutive months.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines eight 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 Executive Director, Chief of Staff, and ADPCS. The intent is for the leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address system issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

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

Healthcare 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	• None
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	• Staff complete mandatory suicide safety plan training prior to developing suicide safety plans.	• None

Healthcare 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	• Appropriately privileged providers complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note, and document all required elements, prior to patient transfers. • Transferring providers send patients' active medication lists to receiving facilities.	• Inter-facility transfers are monitored and evaluated.
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	• The Disruptive Behavior Committee documents patient notification for an Order of Behavioral Restriction in the Disruptive Behavior Reporting System.	• All required members attend Disruptive Behavior Committee meetings. • Staff complete assigned prevention and management of disruptive behavior training based on the risk level assigned to their work area.

Appendix B: Healthcare System Profile

The table below provides general background information for this highest complexity (1a) affiliated healthcare system reporting to VISN 6.[1]

Table B.1. Profile for Durham VA Health Care System (558) (October 1, 2017, through September 30, 2020)

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019	Healthcare System Data FY 2020‡
Total medical care budget	$719,514,385	$782,823,537	$896,345,182
Number of: • Unique patients	66,900	68,330	68,179
• Outpatient visits	778,319	780,682	741,450
• Unique employees§	3,123	3,242	3,337
Type and number of operating beds: • Community living center	100	100	100
• Medicine	75	75	75
• Mental health	28	28	28
• Surgery	48	48	48
Average daily census: • Community living center	79	48	36
• Domiciliary	0	–	–
• Medicine	89	71	63
• Mental health	27	26	20
• Surgery	27	20	15

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).*

[1] "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing (OPES), accessed August 20, 2021, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (This is an internal website not publicly accessible.) 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." An affiliated medical center is associated with a medical residency program.

Appendix C: VA Outpatient Clinic Profiles

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

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Greenville, NC	558GA	18,252	9,645	Cardio thoracic Cardiology Dermatology Endocrinology Eye Gastroenterology General Surgery GYN Hematology/ Oncology Nephrology Neurology Orthopedics Podiatry	Laboratory & Pathology Radiology	Dental Nutrition Pharmacy Social work Weight management

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Greenville, NC (continued)	558GA			Rehab physician Rheumatology Urology		
Raleigh, NC	558GB	10,638	1,087	Dermatology General surgery Hematology/ Oncology Urology	Laboratory & Pathology	Nutrition Pharmacy Weight management
Morehead City, NC	558GC	5,585	3,267	Dermatology General surgery	Laboratory & Pathology	Nutrition Pharmacy Weight management
Durham, NC	558GD	–	9,917	–	–	–
Durham, NC	558GE	10,547	147	Cardiology Dermatology Endocrinology Gastroenterology Infectious Disease Nephrology Neurology Pulmonary/ Respiratory disease Rheumatology Vascular	Laboratory & Pathology	Nutrition Pharmacy Social work Weight management
Raleigh, NC	558GF	–	11,383	–	Laboratory & Pathology	Pharmacy

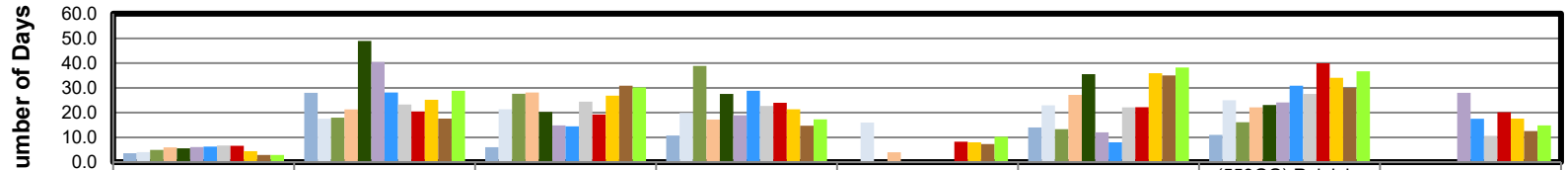
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Raleigh, NC	558GG	8,255	1,016	Cardiology Dermatology Endocrinology Gastroenterology Infectious Disease Nephrology Neurology Rheumatology	–	Nutrition Pharmacy Social work Weight management
Clayton, NC	558GH	45	710	Dermatology Podiatry	–	Pharmacy

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (558QA) Brier Creek, NC as no data were reported.

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days



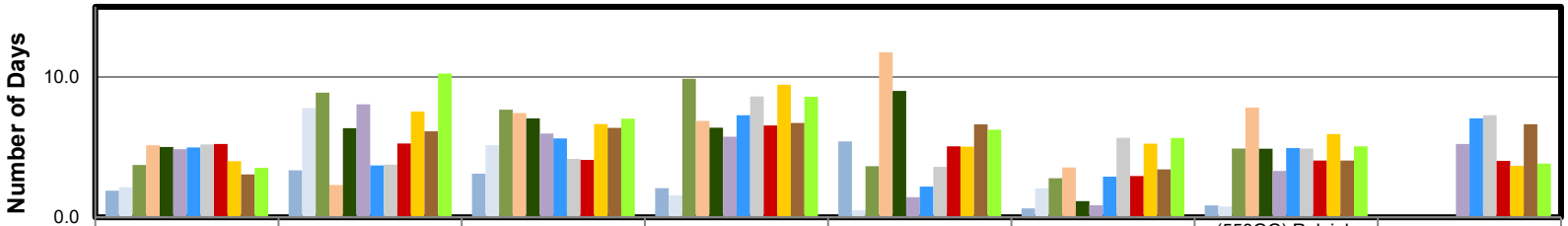
	All VHA	(558) Durham, NC	(558GA) Greenville, NC	(558GB) Raleigh, NC	(558GC) Morehead City, NC	(558GE) Hillandale Road, NC	(558GG) Raleigh-Atlantic Avenue, NC	(558GH) Clayton-East Raleigh, NC
APR-FY20	3.6	28.0	6.0	10.8	n/a	14.0	11.0	n/a
MAY-FY20	4.0	17.5	21.4	19.9	16.0	23.0	25.0	n/a
JUN-FY20	4.9	18.0	27.6	38.8	n/a	13.3	16.1	n/a
JUL-FY20	5.9	21.3	28.2	17.2	4.0	27.2	22.1	n/a
AUG-FY20	5.6	49.0	20.3	27.5	0.0	35.6	23.1	n/a
SEP-FY20	6.1	40.4	14.9	18.9	n/a	12.0	24.1	28.0
OCT-FY21	6.3	28.1	14.5	28.9	n/a	8.0	30.9	17.5
NOV-FY21	6.7	23.3	24.4	22.7	0.0	22.1	27.5	10.6
DEC-FY21	6.6	20.5	19.3	24.0	8.3	22.2	40.0	20.1
JAN-FY21	4.4	25.2	26.9	21.4	8.0	36.0	34.1	17.6
FEB-FY21	2.9	17.6	30.9	14.7	7.3	35.0	30.0	12.6
MAR-FY21	2.9	28.9	30.2	17.3	10.3	38.2	36.7	14.9

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the healthcare system's explanation for the increased wait times for the Durham VA Health Care System and VA clinics in (558GB) Raleigh, NC; (558GE) Hillandale Road, NC; and (558GG) Raleigh-Atlantic Avenue, NC. The OIG omitted (558GD) Durham, NC; (558GF) Wake County, NC; and (558QA) Brier Creek, NC 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



	All VHA	(558) Durham, NC	(558GA) Greenville, NC	(558GB) Raleigh, NC	(558GC) Morehead City, NC	(558GE) Hillandale Road, NC	(558GG) Raleigh-Atlantic Avenue, NC	(558GH) Clayton-East Raleigh, NC
APR-FY20	1.9	3.3	3.1	2.1	5.4	0.6	0.9	n/a
MAY-FY20	2.1	7.8	5.2	1.6	0.5	2.1	0.8	n/a
JUN-FY20	3.7	8.9	7.7	9.9	3.6	2.8	4.9	n/a
JUL-FY20	5.1	2.3	7.4	6.9	11.7	3.6	7.8	n/a
AUG-FY20	5.0	6.4	7.0	6.4	9.0	1.2	4.9	n/a
SEP-FY20	4.9	8.1	6.0	5.7	1.4	0.9	3.3	5.2
OCT-FY21	5.0	3.7	5.6	7.3	2.2	2.9	4.9	7.1
NOV-FY21	5.2	3.8	4.2	8.6	3.6	5.7	4.9	7.3
DEC-FY21	5.2	5.3	4.1	6.5	5.1	2.9	4.0	4.0
JAN-FY21	4.0	7.5	6.6	9.4	5.0	5.2	5.9	3.7
FEB-FY21	3.1	6.1	6.4	6.7	6.6	3.4	4.0	6.6
MAR-FY21	3.5	10.2	7.0	8.6	6.2	5.7	5.1	3.8

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (558GD) Durham, NC; (558GF) Wake County, NC; and (558QA) Brier Creek, NC 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 engmt	Sharing and use of All Employee Survey (AES) data	A higher value is better than a lower value
Behavioral Health (BH90)	Healthcare Effectiveness Data and Information Set (HEDIS) outpatient performance measure composite related to screening for depression, posttraumatic stress disorder, alcohol misuse, and suicide risk	A higher value is better than a lower value
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
Diabetes (DMG90_ec)	HEDIS outpatient performance measure composite for diabetes care	A higher value is better than a lower value
ED throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Healthcare associated infections	A lower value is better than a higher value
Hospital rating (HCAHPS)	Patient overall rating of hospital (inpatient)	A higher value is better than a lower value
Influenza immunization (FLU90_ec)	HEDIS outpatient performance measure composite for outpatient influenza immunization	A higher value is better than a lower value
Inpt global measures (GM90_1)	ORYX inpatient composite of global measures related to influenza immunization, alcohol and drug use, and tobacco use	A higher value is better than a lower value

Measure	Definition	Desired Direction
Ischemic heart (IHD90_ec)	HEDIS outpatient performance measure composite for ischemic heart disease care	A higher value is better than a lower value
MH continuity care	Mental health continuity of care	A higher value is better than a lower value
MH exp of care	Mental health experience of care	A higher value is better than a lower value
MH popu coverage	Mental health population coverage	A higher value is better than a lower value
PCMH care coordination	Care coordination (PCMH)	A higher value is better than a lower value
PCMH same day appt	Days waited for an appointment for urgent care (PCMH survey)	A higher value is better than a lower value
PCMH survey access	Timeliness in getting appointments, care and information (PCMH survey access composite)	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
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	A higher value is better than a lower value
Rating PC provider	Rating of primary care providers (PCMH survey)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care survey)	A higher value is better than a lower value
RSRR-HWR	All cause hospital-wide readmission rate	A lower value is better than a higher value
SC care coordination	Care coordination (specialty care)	A higher value is better than a lower value
SC survey access	Timeliness in getting specialty care urgent care and routine care appointments (specialty care survey access composite)	A higher value is better than a lower value

Measure	Definition	Desired Direction
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH survey)	A higher value is better than a lower value
Tobacco & Cessation (SMG90_1)	HEDIS outpatient performance measure composite related to tobacco screening and cessation strategies	A lower value is better than a higher value

Source: VHA Support Service Center.

Appendix F: 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: October 25, 2021

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subj: Comprehensive Healthcare Inspection of the Durham VA Health Care System in North Carolina

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

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

1. We appreciate the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Durham VA Health Care System in North Carolina.

2. I have reviewed the recommendations and concur with the responses and actions provided by our team at the Durham VA Health Care System to ensure we continue to deliver excellent care to our Veterans.

(Original signed by:)

Paul S. Crews, MPH, FACHE

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: October 20, 2021

From: Interim Executive Director, Durham VA Health Care System (558/00)

Subj: Comprehensive Healthcare Inspection of the Durham VA Health Care System in North Carolina

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. We appreciate the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Durham VA Health Care System in North Carolina.

2. I have reviewed the recommendations and concur with the responses and actions provided by our team here at the Durham VA Health Care System to ensure we continue to deliver excellent care to our Veterans.

(Original signed by:)

Marri M. Fryar MBA, MHA, BSN, NE-BC, VHA-CM
Interim Executive Director
Durham VA Health Care System

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Martynee Nelson, MSW, LCSW, Team Leader Cynthia Hickel, MSN, CRNA Megan Magee, MSN, RN Robert Ordonez, MPA Simonette Reyes, BSN, RN
Other Contributors	Melinda Alegria, AuD, CCC-A, F-AAA Daisy Arugay-Rittenberg, MT Elizabeth Bullock Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Ashley Fahle Gonzalez, MPH, BS Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN-BC Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Krista Stephenson, MSN, RN Caitlin Sweany-Mendez, MPH Robert Wallace, ScD, MPH Elizabeth K. Whidden, MS, APRN

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