DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

CHIP REPORT | REPORT #21-00277-41 | DECEMBER 9, 2021

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Figure 1. *Fayetteville VA Coastal Health Care System in North Carolina. Source: https://vaww.va.gov/directory/guide/* (*accessed April 19, 2021*).

Abbreviations

ADPCS	Associate Director of Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
FDA	Food and Drug Administration
FY	fiscal year
OIG	Office of Inspector General
QSV	quality, safety, and value
RN	registered nurse
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
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 Fayetteville VA Coastal Health Care System, which includes the Fayetteville VA Medical Center 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 Fayetteville VA Coastal 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 seven recommendations to the Director, Chief of Staff, and Associate Director of Patient Care Services. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

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

When the team conducted this inspection, the healthcare system's leaders had worked together for over one year, although two were assigned to their positions in 2019. The Associate Director of Patient Care Services, who was permanently assigned in May 2016, was the most tenured leader. The Chief of Staff, assigned in February 2020, was the newest member of the leadership team.

The Chief of Staff had opportunities to improve staff attitudes toward the workplace, including feelings of moral distress at work.[2] The executive leaders' servant leadership scores were similar to or lower than the VHA average, except for the Associate Director, whose score was significantly higher.[3] Selected patient experience survey scores generally reflected lower care ratings than the VHA averages. Patients appeared less satisfied with the care provided than VHA patients nationally. During individual interviews, leaders attributed lower satisfaction scores to limited specialty care provider access and staffing shortages.

[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] "2020 VA All Employee Survey (AES): Questions by Organizational Health Framework." The 2020 All Employee Survey defines the Servant Leader Index as a summary measure based on respondents' assessments of their supervisors' listening, respect, trust, favoritism, and response to concerns.

The inspection team reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[4]

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."[5] 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.[6]

The Director and Chief of Staff were knowledgeable within their scope of responsibilities about VHA data and healthcare system-level factors contributing to poor performance on specific SAIL measures. In individual interviews, the Director; Chief of Staff; Associate Director of Patient Care Services; and Associate Director 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.

Quality, Safety, and Value

Generally, the healthcare system met expectations for a quality, safety, and value oversight committee; the Systems Redesign and Improvement Program; and protected peer review.[7] However, the OIG identified weaknesses with the Surgical Workgroup's processes.

Medication Management

The OIG team observed compliance with many elements of expected performance, including the availability of staff to receive remdesivir shipments, provision of required testing prior to

[4] 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."

[5] "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.)

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

[7] VHA Directive 1190. 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.

remdesivir administration, and reporting of adverse events. However, the OIG noted concerns with patient and caregiver education.

Care Coordination

Generally, the healthcare system met expectations for an inter-facility transfer policy, as well as monitoring and evaluation of inter-facility transfers.[8] However, the OIG noted concerns with identification of the physician at the receiving facility, transmission of all pertinent medical records, and communication between nurses at sending and receiving facilities.

High-Risk Processes

The healthcare system met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with Disruptive Behavior Committee meeting attendance and staff training.

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued seven recommendations for improvement to the Director, Chief of Staff, and Associate Director of Patient Care Services. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this healthcare system. The intent is for 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.

[8] 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.

Comments

The Veterans Integrated Service Network Director and System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 62–63, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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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 Fayetteville VA Coastal 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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7. Care coordination (spotlighting inter-facility transfers)
8. High-risk processes (examining the management of disruptive and violent behavior)

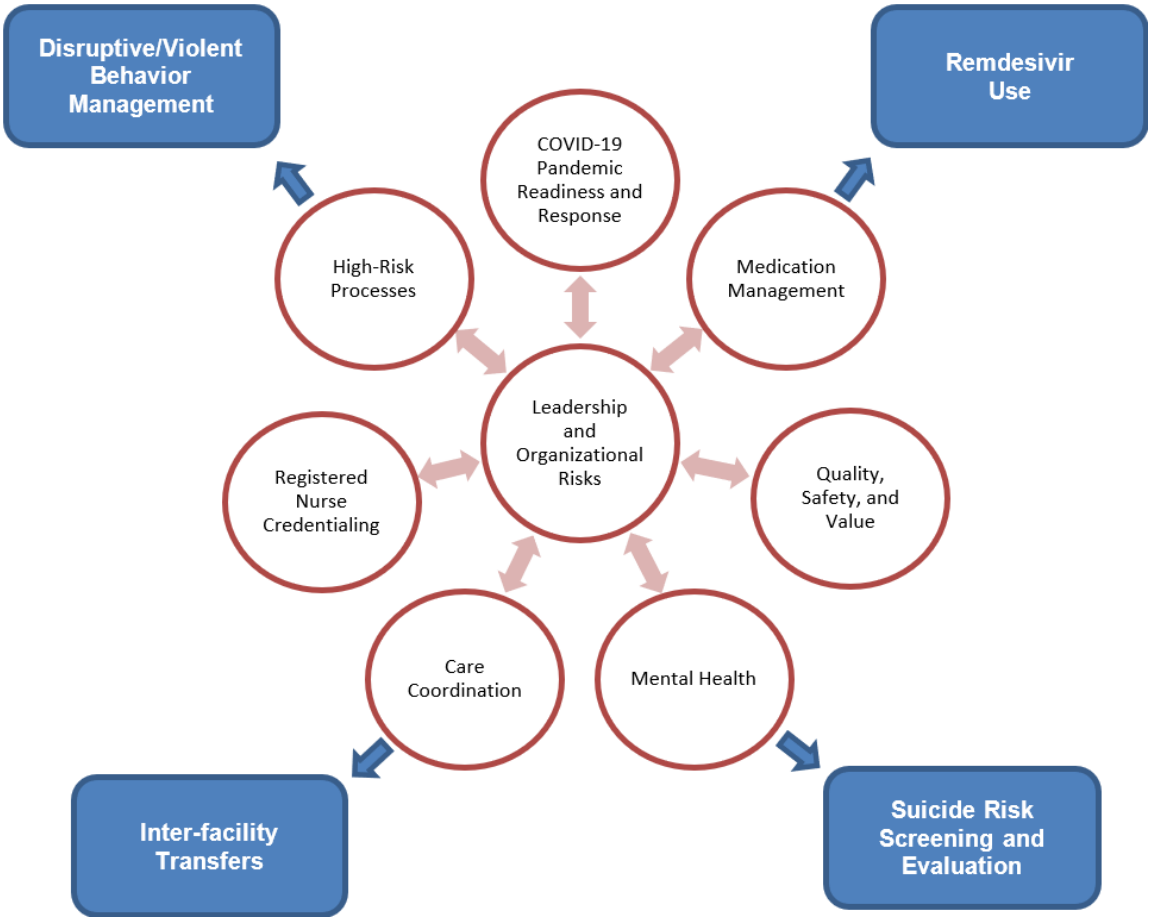


Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services. Source: VA OIG.*

Methodology

The Fayetteville VA Coastal Health Care System includes the Fayetteville 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 August 18, 2017, 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 Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that healthcare 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 Director, Chief of Staff, Associate Director of Patient Care Services (ADPCS), Associate Director of Operations (referred to as the Associate Director), and Assistant Director. The Chief of Staff and ADPCS oversaw patient care, which required managing service directors and chiefs of programs and practices.

[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.

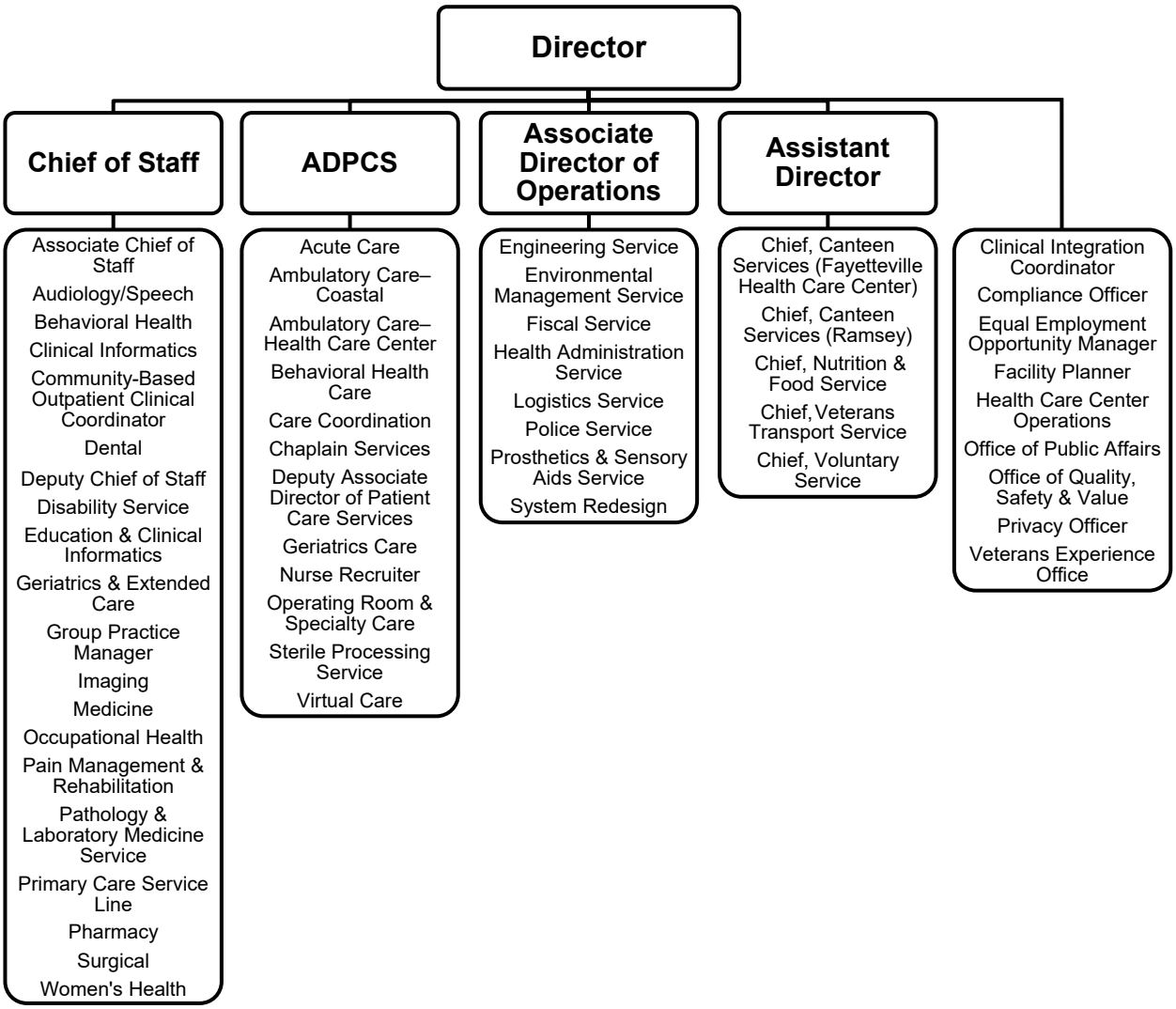


Figure 3. *Healthcare system organizational chart.*

Source: Fayetteville VA Coastal Health Care System (received May 3 and June 21–22, 2021).

At the time of the OIG inspection, executive leaders had worked together for over one year. The ADPCS, permanently assigned in May 2016, was the most tenured leader. The Chief of Staff, assigned in February 2020, was the newest member of the leadership team (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Director	June 23, 2019
Chief of Staff	February 20, 2020
Associate Director of Patient Care Services	May 1, 2016
Associate Director	January 5, 2020
Assistant Director	January 6, 2019

Source: Fayetteville VA Coastal Health Care System Human Resources Specialist (received May 5, 2021).

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

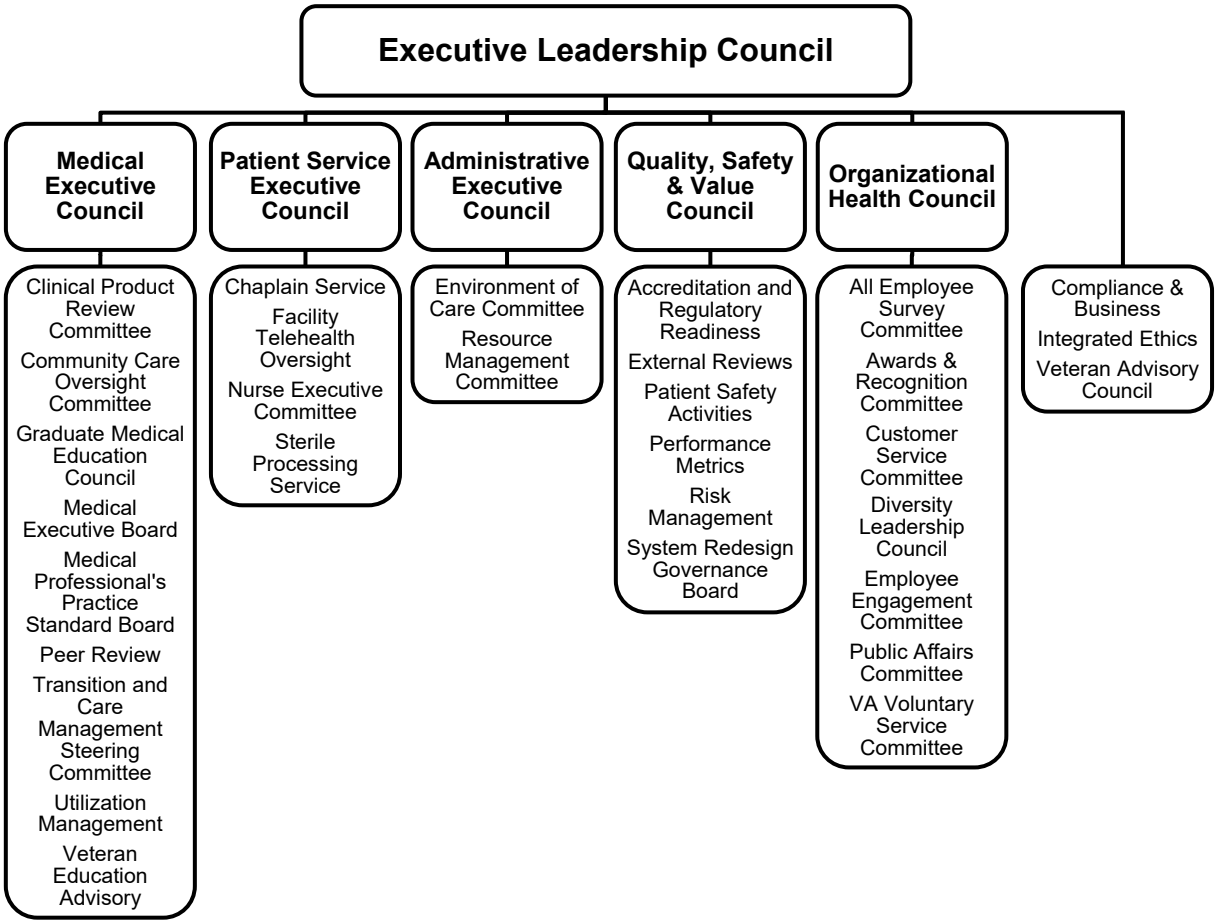


Figure 4. *Healthcare system committee reporting structure.*
Source: Fayetteville VA Coastal Health Care System (received May 3, 2021).

To help assess the healthcare system executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance. These are discussed in greater detail below.

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of $594,368,001 increased by approximately 22 percent compared to the previous year's budget of $485,459,942.[11] When asked about the effect of this change on the healthcare system's operations, the Director indicated that the increased budget allowed leaders to conduct strategic hiring initiatives for staff vacancies. In addition, the Director reported the increased budget allowed the conversion of the Urgent Care Center to an Emergency Department, the combined COVID-intensive care unit back

[11] VHA Support Service Center.

to an intensive care unit, and patient care rooms to single occupancy rooms. The increase was also used to add an inpatient dialysis unit. However, the Chief of Staff expressed concerns that the budget was inadequate to support the recent expansion in care and services.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[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 occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[15] Executive leaders did not report any nonclinical occupational shortages. The leaders confirmed that occupations listed in table 2 remained the top clinical shortages at the time of the OIG inspection. However, the Chief of Staff indicated that pain management, urology, dental, and orthopedics should be added to the list. The Chief of Staff reported implementing interim strategies to address access such as purchasing care in the community, using local military hospitals, and consulting with other VA medical centers. The Chief of Staff also discussed a robust hiring effort to fill vacancies but shared concerns regarding the slow selection process at the VISN level, which led to missed opportunities to appoint new providers.

[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 Shortages

Top Clinical Staffing Shortages
1. Psychiatry
2. Pulmonary Diseases
3. Dermatology
4. Radiology-Diagnostic
5. Otolaryngology

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. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The executive leaders' Servant Leader Index Composite scores were mostly similar to or lower than the VHA average, although the Associate Director's score was significantly higher.[19] The scores for the remaining selected survey questions for the

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

[17] "AES Survey History."

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

[19] "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. The 2020 All Employee Survey defines the Servant Leader Index as a summary measure based on respondents' assessments of their supervisors' listening, respect, trust, favoritism, and response to concerns.

Director, Chief of Staff, and ADPCS were similar to or higher than the VHA averages, while the Associate Director's scores were significantly higher.[20]

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

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	72.7	70.8	72.7	68.8	98.8
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.4	3.5	3.7	4.0	4.6
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.6	3.6	3.7	3.9	4.3
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.7	3.7	4.0	4.3	4.6

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

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

[20] The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only. The All Employee Survey results are not fully reflective of employee satisfaction with the Chief of Staff or Associate Director, who were not in their roles for the full survey review period. No data were available for the Assistant Director.

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 generally similar to or lower than VHA averages; however, the Associate Director scores were significantly better. Opportunities appeared to exist for the Chief of Staff to improve staff attitudes toward the workplace, including feelings of moral distress (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	Director Average	Chief of Staff Average	ADPCS Average	Assoc. 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	3.7	3.9	3.3	4.0	4.8
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	3.7	3.9	3.6	3.8	4.9

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

[22] The All Employee Survey results are not fully reflective of employee satisfaction with the Chief of Staff or Associate Director, who were not in their roles for the full survey review period. No data were available for the Assistant Director.

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. 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	1.4	1.7	1.4	1.2

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 Director reported being deliberate with efforts to manage harassment by implementing a Diversity Leadership Council and providing civility and respect training.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The scores for the Director, Chief of Staff, and ADPCS were similar to or lower than the VHA averages. However, the Associate Director's scores were consistently higher than the VHA averages. Leaders appeared to maintain an environment where staff felt respected and safe, and discrimination was not tolerated.[25]

[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] The All Employee Survey results are not fully reflective of employee satisfaction with the Chief of Staff or Associate Director, who were not in their roles for the full survey review period. No data were available for the Assistant Director.

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

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

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. Patients appeared less satisfied than VHA patients nationally with the care provided.

During the interview, the Director mentioned factors that may have negatively affected patients' experiences, which included the healthcare system's aging infrastructure, shared patient rooms,

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

and limited services due to the unavailability of some providers. The Director also discussed actions taken to improve patient experiences, such as converting inpatient rooms to single occupancy spaces, upgrading the Urgent Care Center to an Emergency Department, increasing hiring efforts for specialty care providers, and conducting sensitivity training for providers.

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	58.0
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	77.4
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 Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2020).

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[27] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

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

The OIG noted that both males and females in the inpatient setting were less likely to recommend the hospital to friends and family than VHA patients nationally. The results

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

indicated opportunities to improve patient perceptions of doctors treating them with courtesy and respect. However, higher percentages of males and females indicated that nurses treated them with courtesy and respect than VHA averages.

Patient-centered medical home survey results were significantly lower for both genders when compared to the corresponding VHA averages. Specialty care survey results related to females obtaining needed clinic appointments were significantly lower than those for female VHA patients nationally. Despite these results, female respondents at the healthcare system rated their specialty care providers similar to other female respondents nationally. The specialty care survey results for males were generally similar to the corresponding VHA averages. Leaders appeared to have opportunities to improve inpatient and patient-centered medical home experiences for both genders and specialty care experiences for female patients. Leaders reported educating providers on the specific needs of women veterans and adding an additional Women's Health Patient Aligned Care Team to improve care.[28]

[28] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014. A Patient Aligned Care Team (PACT) is a team-based model of care "to provide Veterans with primary care that is patient-centered, data driven, continuously improving, team-based, accessible, timely, comprehensive, coordinated, and provides continuity over time."

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	59.0	50.2
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	81.3	81.2
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	90.4	88.5

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

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

The healthcare system averages are based on 287–290 male and 20 or 21 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	37.3	36.7
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	46.9	45.5
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	65.8	63.1

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

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

The healthcare system averages are based on 556–1,627 male and 71–150 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	47.4	27.4
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	59.1	46.0
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	77.1	72.3

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 418–1,261 male and 32–115 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 other 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 system had closed all but three recommendations for improvement issued since the previous CHIP site visit conducted in August 2017. The Chief, Quality, Safety and Value reported working with system managers to address the three open recommendations from a prior focused OIG report published in 2020.[31]

The OIG team also noted the system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[32] Additional results included the Long Term Care Institute's inspection of the system's CLC and the Paralyzed Veterans of America's inspection of the spinal cord injury/disease unit and related services.[33]

[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] VA OIG, *Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center, North Carolina*, Report No. 19-08256-124, May 19, 2020.

[32] 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.

[33] "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." The Paralyzed Veterans of America inspection took place on February 26, 2019. This veterans service organization review does not result in accreditation status.

Table 10. Office of Inspector General Inspections/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 Fayetteville VA Medical Center, Fayetteville, North Carolina*, Report No. 17-01856-135, March 28, 2018)	August 2017	10	0
OIG (*Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center, North Carolina*, Report No. 19-08256-124, May 19, 2020)	July and October 2019	12	3*
TJC Hospital Accreditation	January 2020	29	0
TJC Behavioral Health Care Accreditation		5	0
TJC Home Care Accreditation		2	0

Source: OIG and TJC (inspection/survey results received from the Performance Measures Specialist on May 5, 2021).

**As of November 2021, one recommendation remained open.*

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 August 18, 2017 (the prior OIG CHIP site visit), through May 3, 2021.[34]

Table 11. Summary of Selected Organizational Risk Factors (August 18, 2017, through May 3, 2021)

Factor	Number of Occurrences
Sentinel Events	4
Institutional Disclosures	8
Large-Scale Disclosures	0

Source: Fayetteville VA Coastal Health Care System Patient Safety Manager, Risk Manager, and High Reliability Organization Coordinator (received May 4–5, 2021).

The Director spoke knowledgeably about being notified of serious adverse events through daily reports from the Patient Safety Manager and ADPCS. The Director also reported that institutional disclosure determinations are decided with collaboration from the Chief of Staff; Risk Manager; and Chief, Quality, Safety and Value. Further, the Director stated that the healthcare system has follow-up procedures for adverse events that included managers conducting multidisciplinary root cause analysis processes and reporting to executive leaders.

The OIG's review of the healthcare system's sentinel events and disclosures did not identify any substantial organizational risk factors. The OIG confirmed that for all sentinel events and institutional disclosures, program managers conducted required investigations, such as root cause analyses and peer reviews, and took corrective actions by developing and improving processes and monitoring.

[34] 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 Fayetteville VA Coastal Health Care System is a mid-high complexity (1c) affiliated system as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

Veterans Health Administration Performance Data for the 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."[35] 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.[36]

Figure 5 illustrates the healthcare system's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 30, 2020. Figure 5 shows the system's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of ischemic heart disease (IHD90_ec), stress discussed, care transition, and emergency department (ED) throughput). 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, influenza immunization (FLU90_ec), specialty care (SC) care coordination, and mental health (MH) continuity [of] care).[37]

The Director and Chief of Staff were knowledgeable within their scope of responsibilities about VHA data and system-level factors contributing to specific poorly performing SAIL measures. However, the ADPCS and Associate Director revealed opportunities to increase their knowledge of contributing factors.

[35] 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.)

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

[37] For information on the acronyms in the SAIL metrics, please see appendix E.

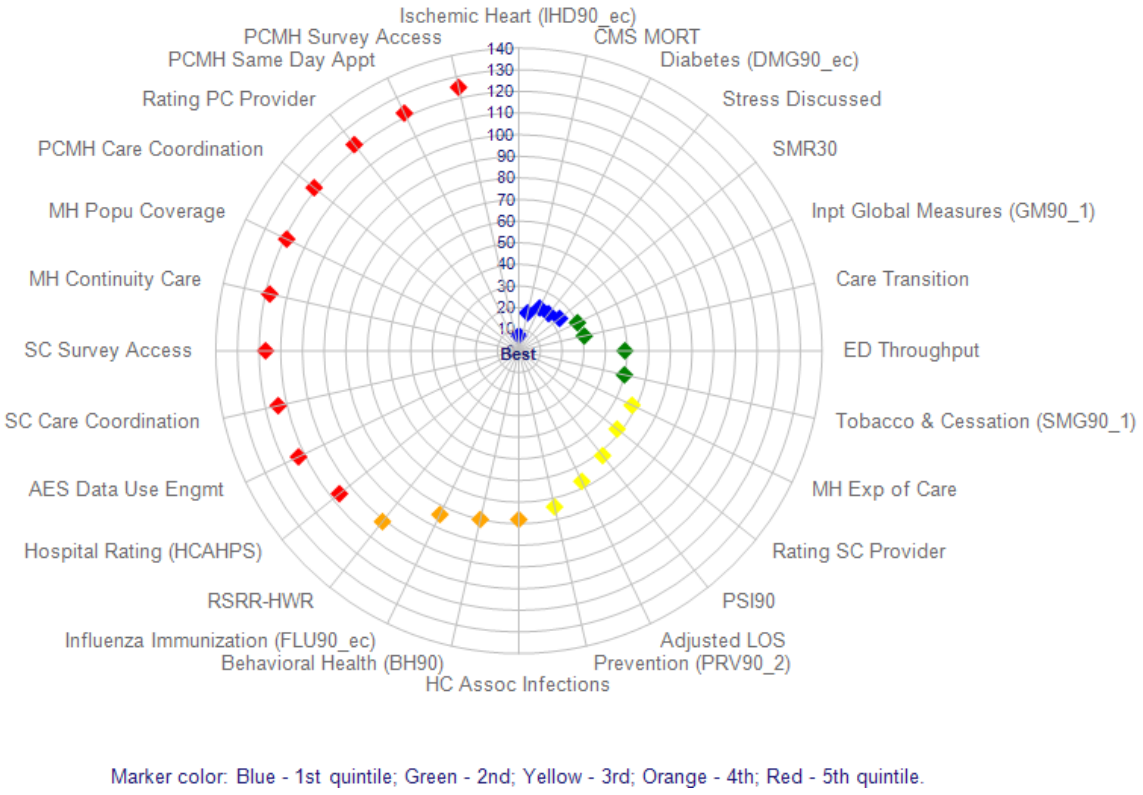


Figure 5. *System quality of care and efficiency metric rankings for fiscal year 2021 quarter 1 (as of December 30, 2020).*

Source: VHA Support Service Center.

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

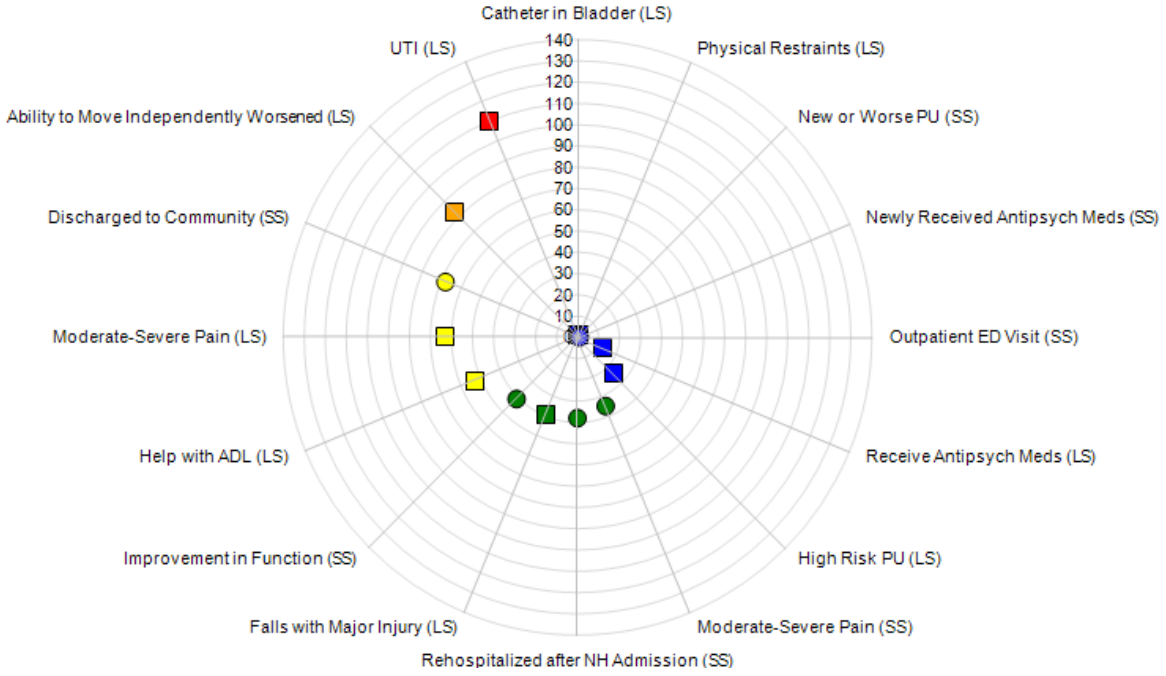
Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA."[38] 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."[39]

[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,* July 16, 2021.

[39] 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."

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 system's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for example, in the areas of physical restraints–long-stay (LS), new or worse pressure ulcer (PU)–short-stay (SS), high risk PU (LS), and falls with major injury (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, ability to move independently worsened (LS), and urinary tract infection (UTI) (LS)).[40] The Director and Chief of Staff were knowledgeable about CLC SAIL measures.



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

Figure 6. *Fayetteville 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 had worked together for over one year at the time of OIG review. The healthcare system managed organizational communications and accountability through a committee reporting structure, with Executive Leadership Council oversight of various working groups. Leaders monitored patient safety and care through the

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

Quality, Safety and Value Council, which tracked and trended quality of care and patient outcomes.

An approximate 22 percent budget increase in FY 2020 allowed healthcare system leaders to conduct strategic hiring initiatives for staff vacancies. This increase also allowed leaders to convert the Urgent Care Center to an Emergency Department, the combined COVID-intensive care unit back to an intensive care unit, and patient care rooms to single occupancy rooms; and add an inpatient dialysis unit.

The healthcare system averages for the selected survey questions for leaders were generally similar to or lower than the VHA averages, but the Associate Director's scores were significantly higher. Opportunities appeared to exist for the Chief of Staff to improve staff attitudes toward the workplace. Patient experience survey results highlighted opportunities to improve inpatient and patient-centered medical home experiences for both genders and specialty care experiences for female patients.

The OIG's review of the healthcare system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. 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. In addition, the Director and Chief of Staff were knowledgeable within their scope of responsibilities about VHA data and system-level factors contributing to specific poorly performing SAIL and CLC SAIL measures. The ADPCS and Associate Director had opportunities to increase their knowledge of poorly performing SAIL measures. The leaders have opportunities to improve quality of care and efficiency at the healthcare system and should continue to take actions to improve performance.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[41] 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.[42]

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."[43] "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."[44]

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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[41] "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.

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

[43] 38 U.S.C. § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the provision of hospital care and medical services during certain disasters and emergencies: "During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

[44] 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.[45] 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.[46] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[47]

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."[48] 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."[49] 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

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

Next, the OIG assessed the healthcare system's processes for conducting protected peer reviews of clinical care.[50] 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."[51] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[52] 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[53]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[54]
- 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."[55] 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

[50] 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."

[51] VHA Directive 1190.

[52] VHA Directive 1190.

[53] VHA Directive 1190.

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

[55] "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."[56] 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[57]

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.[58]

Quality, Safety, and Value Findings and Recommendations

The healthcare system complied with requirements for a committee responsible for QSV oversight functions, the Systems Redesign and Improvement Program, and protected peer review. However, the OIG identified deficiencies with the Surgical Workgroup's processes.

VHA requires medical facility directors to ensure that facilities with surgery programs have a surgical work group that meets at least monthly and includes the Chief of Surgery, Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.[59] The OIG reviewed the Surgical Workgroup meeting minutes from May 2020 through April 2021 and found that the group conducted only 8 meetings in 12 months. The OIG also found that the Chief of Staff did not attend any of the 8 meetings. Additionally, the Surgical Quality Nurse did not attend 2 of 8 meetings (25 percent), and the Operating Room Nurse Manager did not attend 4 of 8 meetings (50 percent). The lack of monthly meetings and core member attendance resulted in missed opportunities for oversight and review of surgery program activities with key staff. The Deputy Chief of Surgery reported that 4 monthly meetings were cancelled because they were scheduled on or around holidays or did not have enough attendees, and staff failed to assign alternates. The Chief of Staff reported being unaware of the requirement to attend the meetings.

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

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

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

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

Recommendation 1

1. The Director evaluates and determines any additional reasons for noncompliance and makes certain that the Surgical Workgroup meets monthly and core members consistently attend meetings.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Surgical Workgroup continues to meet monthly. The meeting day was adjusted to maximize attendance. Qualified primary and alternate members were identified to ensure back up during unforeseen absences. Attendance is tracked and recorded at each meeting. Oversight compliance is reported to the Medical Executive Board and will be tracked until 90 percent compliance for at least six consecutive months.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[60] Licensure is defined by VHA as "the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration."[61]

VA requires all RNs to hold at least one active, unencumbered license.[62] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[63] When an action has been "taken against [an] applicant's sole license or against any of the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA's licensure requirements," and documented as required.[64] Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA's electronic credentialing system, prior to appointment to a VA medical facility.[65]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 39 RNs who were 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.

The OIG team interviewed key managers and reviewed credentialing files for 30 of the 39 RNs to determine whether healthcare system staff completed primary source verification prior to the appointment.

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

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

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

[63] 38 U.S.C. § 7402.

[64] VHA Directive 2012-030.

[65] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

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

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.[66] 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.[67]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[68] 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.[69]

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."[70] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[71]

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 six 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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[66] 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.

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

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

[69] 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*.

[70] 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.

[71] 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)[72]
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[73]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG found the healthcare system addressed many of the indicators of expected performance, including the availability of staff to receive remdesivir shipments, proper naming of medication orders, provision of required testing prior to remdesivir administration, and reporting of adverse events to the FDA. However, the OIG identified deficiencies with patient and caregiver education.

At the time of the review, under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the *Fact Sheet for Patients and Parents/Caregivers*, inform patients or caregivers that remdesivir was not an FDA-approved medication, provide the option to refuse the medication, and advise patients or caregivers of the known risks, benefits, and alternatives to remdesivir prior to administration.[74]

For the six patients who received remdesivir, the OIG did not find evidence that healthcare providers

- provided any of the patients or caregivers with the *Fact Sheet for Patients and Parents/Caregivers*,

[72] "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."

[73] "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.

[74] VA Pharmacy Benefits Management Services, *Remdesivir Emergency Use Authorization (EUA) Requirements*, May 2020. Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*.

- notified any of the patients or caregivers that remdesivir was not an FDA-approved medication,
- informed any of the patients or caregivers of the option to refuse remdesivir,
- informed 67 percent of patients or caregivers of the known risks and benefits of remdesivir, or
- advised 83 percent of patients or caregivers of alternatives to receiving remdesivir prior to administration.

This could have resulted in patients or caregivers lacking the information needed to make a fully informed decision to receive the medication. The Clinical Pharmacist stated that providers were instructed on the need to counsel patients regarding remdesivir and obtain consent. The Clinical Pharmacist also reported that providers were unaware that they should document details of the required FDA education elements in the electronic health record.

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.[75]

[75] 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.[76] 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.[77] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[78]

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.[79] 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.[80] 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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[76] "Suicide Prevention: Facts About Suicide," Centers for Disease Control and Prevention, accessed October 8, 2021, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.

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

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

[79] 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.

[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*, October 17, 2019.

- the electronic health records of 44 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 the above requirements. The OIG made no recommendations.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[81]

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."[82] 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.[83]

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 48 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 OIG observed general compliance with requirements for an inter-facility transfer policy, as well as monitoring and evaluation of inter-facility transfers. However, the OIG found deficiencies with identification of the physician at the receiving facility, transmission of all pertinent medical records, and communication between nurses at sending and receiving facilities.

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

[82] VHA Directive 1094.

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

VHA requires the referring physician to record "the date and time the transfer will occur, documentation of the patient's (or legally responsible person acting on the patient's behalf) informed consent, medical and/or behavioral stability of the patient for transfer, the mode of transportation and equipment needed…[and] identification of the transferring and receiving physicians" on the VA *Inter-Facility Transfer Form* or an equivalent note prior to the transfer.[84] The OIG estimated that referring physicians did not identify or document the receiving physician on 50 percent of inter-facility transfer forms reviewed.[85] This deficiency could result in the unsafe transfer of patients and an incomplete medical record. The Chief Nurse, CLC and Geriatric Extended Care, whose duties included transfer coordination, indicated that Emergency Department physicians were unaware that the receiving physician must be identified in the electronic health record. Failure to document all required inter-facility transfer elements is a repeat finding from the previous comprehensive healthcare inspection.[86]

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that the referring physician records all required elements, including the identification of the receiving physician, on the VA *Inter-Facility Transfer Form* or an equivalent note prior to patient transfers.

Healthcare system concurred.

Target date for completion: June 30, 2022

Healthcare system response: A patient transfer and movement tracker was developed to monitor documentation of all required elements for transfer to include information related to documenting the name of the receiving physician. Education has been provided to staff associated with the inter-facility transfer process and documentation templates have been reviewed for accuracy with documentation requirements. Compliance and oversight of this process will be reported to the Medical Executive Board. The process will continue to be monitored until at least 90 percent compliance is achieved 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.[87] The OIG estimated that transferring providers

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

[85] The OIG estimated that 95 percent of the time the true compliance rate is between 35.6 and 64.0, which is statistically significantly below the 90 percent benchmark.

[86] VA OIG, *Comprehensive Healthcare Inspection Program Review of the Fayetteville, VA Medical Center, Fayetteville, North Carolina,* Report No. 17-01856-135, March 28, 2018.

[87] VHA Directive 1094.

did not send an active medication list to the receiving facility for 23 percent of patient transfers.[88] Further, the OIG found that for 12 of 14 patients who had an advanced directive, staff did not send a copy to the receiving facility. This may result in suboptimal treatment decisions that compromise patient safety. The Chief Nurse, CLC and Geriatric Extended Care indicated that Emergency Department staff were unaware that the patient's active medication list and advance directive must be sent with the patient. Failure to send all available pertinent medical records to the receiving facility is a repeat finding from the previous comprehensive healthcare inspection.[89] Due to the low number of patients who had advance directives, the OIG made no recommendation for this review element.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that transferring providers send patients' active medication lists to the receiving facilities during inter-facility transfers.

Healthcare system concurred.

Target date for completion: June 30, 2022

Healthcare system response: A patient transfer and movement tracker was developed to monitor documentation of all required elements for transfer to include information to include providing accurate active medication lists. Education has been provided to staff associated with the inter-facility transfer process and documentation templates have been reviewed for accuracy with documentation requirements. Compliance and oversight of this process will be reported to the Medical Executive Board. The process will continue to be monitored until at least 90 percent compliance is achieved for six consecutive months.

VHA requires that "the accepting physician, or designee, must speak directly with the referring physician, or designee, regarding the care of the patient. A nurse-to-nurse contact for a patient report is also essential. These verbal communications need to allow for questions and answers from both transferring and receiving facilities."[90] The OIG did not find evidence of nurse-to-nurse communication for 29 percent of patient transfers.[91] This could have resulted in staff at the receiving facility lacking the information needed to care for patients.[92] The Chief, Nurse CLC

[88] For active medication lists, the OIG estimated that 95 percent of the time the true compliance rate is between 63.8 and 87.8, which is statistically significantly below the 90 percent benchmark.

[89] VA OIG, *Comprehensive Healthcare Inspection Program Review of the Fayetteville, VA Medical Center, Fayetteville, NC*, Report No. 17-01856-135, March 28, 2018.

[90] VHA Directive 1094.

[91] The OIG estimated that 95 percent of the time the true compliance rate is between 57.5 and 83.3, which is statistically significantly below the 90 percent benchmark.

[92] VHA Directive 1094.

and Geriatric Extended Care indicated that Emergency Department staff were unaware that nurse-to-nurse communication must be documented in the electronic health record.

Recommendation 4

4. The Associate Director of Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures nurse-to-nurse communication occurs between sending and receiving facilities.

Healthcare system concurred.

Target date for completion: June 30, 2022

Healthcare system response: A patient transfer and movement tracker was developed to monitor documentation of all required elements for transfer to include information related to documenting that nurse-to-nurse communication takes place and is documented prior to inter-facility patient transfer. Education has been provided to staff associated with the inter-facility transfer process and documentation templates have been reviewed for accuracy with documentation requirements. Compliance and oversight of this process will be reported to the Medical Executive Board. The process will continue to be monitored until at least 90 percent compliance is achieved 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."[93] 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."[94] 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[95]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[96]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[97]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[98]

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

[94] VHA Directive 2012-026.

[95] 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."

[96] 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."

[97] 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."

[98] 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.[99] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[100] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The OIG determined that the healthcare system complied with many of the requirements for the management of disruptive and violent behavior. However, the OIG found deficiencies with Disruptive Behavior Committee meeting attendance and staff training.

VHA requires that the Chief of Staff and Nurse Executive (ADPCS) be responsible for establishing a disruptive behavior committee or board that includes 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 the Union Safety Committee.[101]

The OIG found that for Disruptive Behavior Committee meetings held from March 2020 through March 2021, the VA police and Patient Advocate did not attend 3 of 12 meetings (25 percent). This could have resulted in a potential lack of knowledge and expertise when assessing patients' disruptive behavior. The Chief, Behavioral Health Service Line reported being unaware of the requirement for assigning alternates to attend committee meetings.

Recommendation 5

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

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

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

[101] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: The Disruptive Behavior Committee has implemented a new attendance tracker and reporting process in their monthly meetings, all of which will educate, reinforce, and track required attendance at the monthly meetings. The new full processes went live on October 1, 2021, are being reported monthly to the Chief of the Behavioral Health Service Line (BHSL) and reported quarterly to the Medical Executive Board; compliance will be monitored for 90 percent or greater attendance for at least six consecutive months.

VHA requires that staff be assigned the prevention and management of disruptive behavior part 1 training at hire and "additional levels of PMDB [prevention and management of disruptive behavior] training based on the risk for exposure to disruptive behaviors as determined in the facility Workplace Behavioral Risk Assessment."[102] The OIG found that 21 of 30 selected staff (70 percent) did not complete the required training. This may result in staff's lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Prevention and Management of Disruptive Behavior Program Coordinator reported following national guidance to cancel face-to-face training due to social distancing restrictions to prevent staff exposure to COVID-19.

Recommendation 6

6. The Director evaluates and determines any additional reasons for noncompliance and ensures staff complete the required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[103]

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

[103] 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: June 30, 2022

Healthcare system response: The PMDB Coordinator in partnership with the Chief of BHSL is implementing a new tracking and reporting process for monitoring new employee compliance with completion of Level 1 PMDB within 90 days of employment, which will be reported to the Service Chiefs monthly and to Medical Executive Board on a quarterly basis. With the implementation of PMDB Level 2 virtually in February 2021, the new process will also track and report on required PMDB Level 2 completion rates. PMDB Level 3 remains suspended per Facility policy during the COVID-19 pandemic response. Once the facility lifts restrictions, the tracking and reporting process will also include PMDB Level 3 compliance. Compliance will be monitored for 90 percent or greater compliance per service for six consecutive months.

VHA requires the chair and members of the Employee Threat Assessment Team to complete specific workplace violence prevention program training.[104] The OIG found that 5 of 11 Employee Threat Assessment Team members (45 percent) did not complete the required training. This could result in ineffective de-escalation of employees' disruptive behaviors in times of crisis. The Chair of the Employee Threat Assessment Team stated that gaps in training completion were due to lack of oversight.

Recommendation 7

7. The Director evaluates and determines any additional reasons for noncompliance and makes certain that Employee Threat Assessment Team members complete required training.

Healthcare system concurred.

Target date for completion: March 31, 2022

Healthcare system response: Employee Threat Assessment Team (ETAT) members have been made aware of the required training. Members with deficient training requirements have been contacted and provided a deadline for completion. Training requirements for members and any alternates will be reviewed for compliance quarterly. Oversight and compliance will be reported to the Medical Executive Board on a quarterly basis until 90 percent or greater is achieved for at least two consecutive quarters.

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

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

Table A.1. Summary Table of Recommendations

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Leadership and Organizational Risks	• 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	• The Surgical Workgroup meets monthly and core members consistently attend meetings.
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None

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	• Referring physicians record all required elements, including the identification of the receiving physician, on the VA *Inter-Facility Transfer Form* or an equivalent note prior to patient transfers. • Transferring providers send patients' active medication lists to the receiving facilities during inter-facility transfers. • Nurse-to-nurse communication occurs between sending and receiving facilities.	• None
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• None	• Required members attend Disruptive Behavior Committee meetings. • Staff complete required prevention and management of disruptive behavior training based on the risk level assigned to their work areas. • Employee Threat Assessment Team members complete required training.

Appendix B: Healthcare System Profile

The table below provides general background information for this mid-high complexity (1c) affiliated healthcare system reporting to VISN 6.[1]

Table B.1. Profile for Fayetteville VA Coastal Health Care System (565) (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	$450,293,462	$485,459,942	$594,368,001
Number of:			
• Unique patients	75,112	78,721	80,022
• Outpatient visits	788,322	877,484	812,961
• Unique employees§	1,978	1,979	2,035
Type and number of operating beds:			
• Community living center	69	69	69
• Medicine	37	37	37
• Mental health	20	20	20
• Surgery	3	3	3
Average daily census:			
• Community living center	42	43	36
• Domiciliary	0	–	–
• Medicine	13	13	10
• Mental health	15	17	12

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 healthcare systems are classified according to a facility complexity model; a designation of "1c" indicates a facility with "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." An affiliated healthcare system 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
Jacksonville, NC	565GA	9,503	3,465	Dermatology Nephrology	–	Nutrition Pharmacy Weight management

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Wilmington, NC	565GC	14,469	12,714	Cardiology Dermatology Endocrinology Gastroenterology Infectious Disease Nephrology Neurology Poly-Trauma Rehab physician Spinal cord injury	EMG Laboratory & Pathology Radiology	Dental Nutrition Pharmacy Prosthetics Social work Weight management
Hamlet, NC	565GD	2,928	1,683	Nephrology	–	Nutrition Pharmacy Weight management
Pembroke, NC	565GE	4,662	2,008	Dermatology Nephrology	–	Nutrition Pharmacy Weight management
Goldsboro, NC	565GF	5,178	3,246	Dermatology Nephrology	–	Nutrition Pharmacy Weight management
Sanford, NC	565GG	5,914	2,962	Dermatology Endocrinology General surgery Nephrology	–	Nutrition Pharmacy Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Supply, NC	565GH	2,906	767	Dermatology Nephrology	–	Nutrition Pharmacy Weight management
Jacksonville, NC	565GJ	1,914	–	Dermatology	–	Pharmacy
Fayetteville, NC	565GL	52,578	14,050	Anesthesia Cardiology Dermatology Endocrinology Eye Gastroenterology General surgery GYN Infectious Disease Nephrology Neurology Orthopedics Plastic Pulmonary/ Respiratory disease Podiatry Rheumatology Urology	Laboratory & Pathology Radiology	Nutrition Pharmacy Prosthetics Social work Weight management

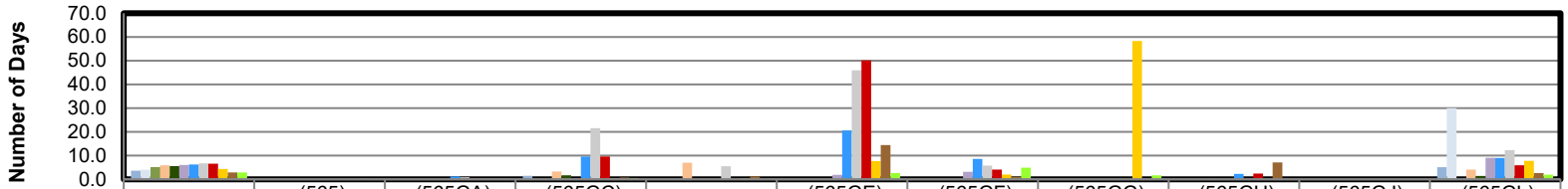
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Jacksonville, NC	565GM	–	3,432	–	–	–

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 (565GN) Jacksonville 4, NC; (565QA) Fayetteville, NC; (565QD) Fayetteville, NC; and (565QE) Fort Bragg, NC, as no data were reported.

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days

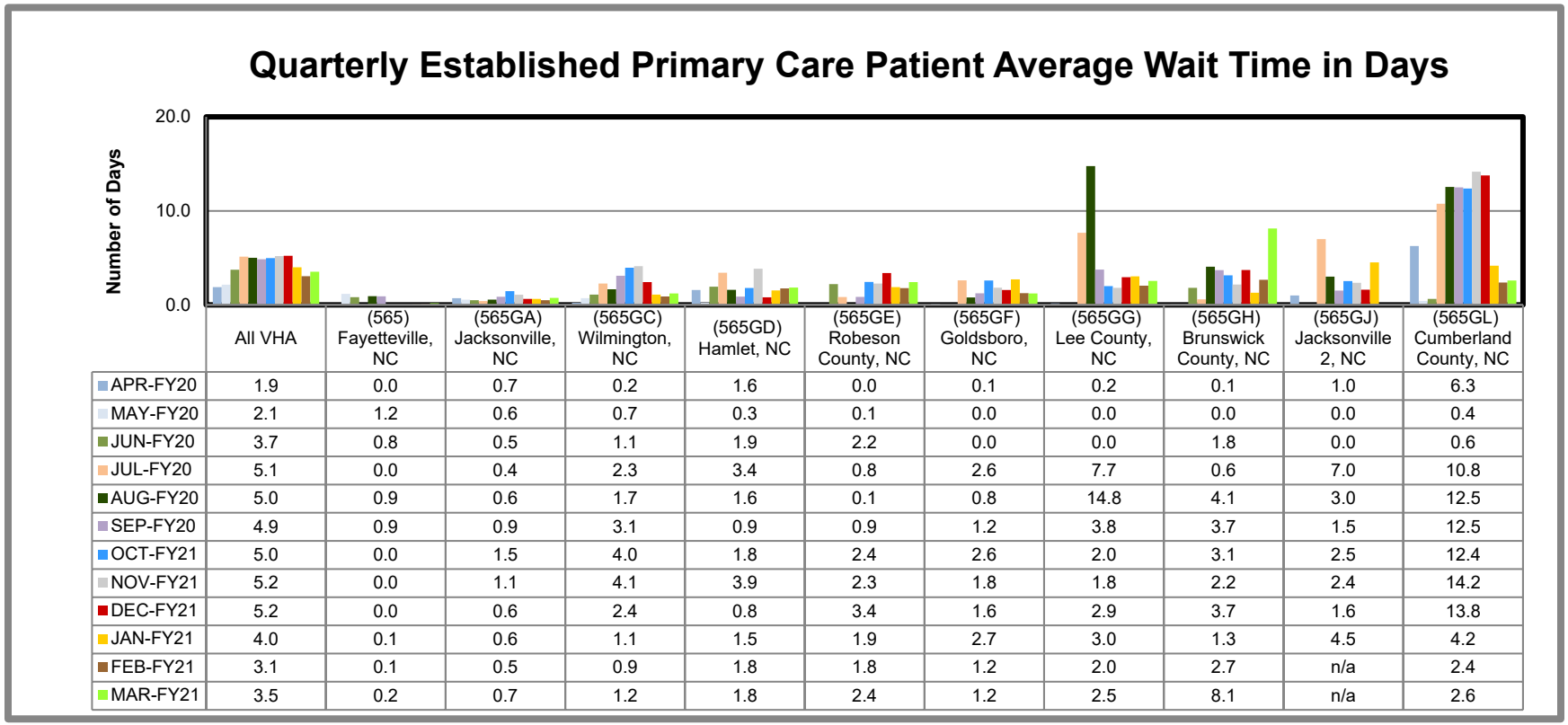


	All VHA	(565) Fayetteville, NC	(565GA) Jacksonville, NC	(565GC) Wilmington, NC	(565GD) Hamlet, NC	(565GE) Robeson County, NC	(565GF) Goldsboro, NC	(565GG) Lee County, NC	(565GH) Brunswick County, NC	(565GJ) Jacksonville 2, NC	(565GL) Cumberland County, NC
APR-FY20	3.6	n/a	n/a	1.5	0.0	0.0	0.0	0.0	0.0	n/a	5.1
MAY-FY20	4.0	n/a	n/a	0.0	n/a	0.0	0.0	n/a	n/a	n/a	30.0
JUN-FY20	4.9	n/a	n/a	0.0	n/a	n/a	0.0	n/a	n/a	n/a	0.0
JUL-FY20	5.9	n/a	n/a	3.3	7.0	0.0	0.1	0.0	0.2	n/a	4.1
AUG-FY20	5.6	n/a	0.0	1.7	0.0	0.0	0.0	n/a	0.0	n/a	1.4
SEP-FY20	6.1	n/a	0.0	0.2	0.0	1.9	3.2	0.0	0.0	0.0	9.1
OCT-FY21	6.3	n/a	1.2	9.6	0.0	20.6	8.6	0.0	2.3	0.0	9.0
NOV-FY21	6.7	n/a	0.9	21.5	5.5	46.0	5.8	0.0	0.0	0.0	12.3
DEC-FY21	6.6	n/a	0.5	9.6	0.0	50.2	4.1	0.0	2.4	0.0	5.9
JAN-FY21	4.4	0.1	0.2	0.5	0.3	7.6	2.0	58.3	0.0	n/a	7.8
FEB-FY21	2.9	0.3	0.4	0.8	1.2	14.4	1.0	0.2	7.1	n/a	2.6
MAR-FY21	2.9	0.1	0.2	0.6	0.0	2.7	4.9	1.7	0.0	n/a	1.9

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 omitted (565GM) Jacksonville 3, NC; (565GN) Jacksonville 4, NC; (565QA) Fayetteville, NC; (565QD) Fayetteville, NC; and (565QE) Fort Bragg, NC, as no data were reported. 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 Lee County and Robeson County community-based outpatient clinics.

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."



	All VHA	(565) Fayetteville, NC	(565GA) Jacksonville, NC	(565GC) Wilmington, NC	(565GD) Hamlet, NC	(565GE) Robeson County, NC	(565GF) Goldsboro, NC	(565GG) Lee County, NC	(565GH) Brunswick County, NC	(565GJ) Jacksonville 2, NC	(565GL) Cumberland County, NC
APR-FY20	1.9	0.0	0.7	0.2	1.6	0.0	0.1	0.2	0.1	1.0	6.3
MAY-FY20	2.1	1.2	0.6	0.7	0.3	0.1	0.0	0.0	0.0	0.0	0.4
JUN-FY20	3.7	0.8	0.5	1.1	1.9	2.2	0.0	0.0	1.8	0.0	0.6
JUL-FY20	5.1	0.0	0.4	2.3	3.4	0.8	2.6	7.7	0.6	7.0	10.8
AUG-FY20	5.0	0.9	0.6	1.7	1.6	0.1	0.8	14.8	4.1	3.0	12.5
SEP-FY20	4.9	0.9	0.9	3.1	0.9	0.9	1.2	3.8	3.7	1.5	12.5
OCT-FY21	5.0	0.0	1.5	4.0	1.8	2.4	2.6	2.0	3.1	2.5	12.4
NOV-FY21	5.2	0.0	1.1	4.1	3.9	2.3	1.8	1.8	2.2	2.4	14.2
DEC-FY21	5.2	0.0	0.6	2.4	0.8	3.4	1.6	2.9	3.7	1.6	13.8
JAN-FY21	4.0	0.1	0.6	1.1	1.5	1.9	2.7	3.0	1.3	4.5	4.2
FEB-FY21	3.1	0.1	0.5	0.9	1.8	1.8	1.2	2.0	2.7	n/a	2.4
MAR-FY21	3.5	0.2	0.7	1.2	1.8	2.4	1.2	2.5	8.1	n/a	2.6

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

Note: The OIG did not assess VA's data for accuracy or completeness. Note: The OIG omitted (565GM) Jacksonville 3, NC; (565GN) Jacksonville 4, NC; (565QA) Fayetteville, NC; (565QD) Fayetteville, NC; and (565QE) Fort Bragg, 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
Prevention (PRV90_2)	HEDIS outpatient performance measure composite related to immunizations and cancer screenings	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating PC provider	Rating of 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, Mid-Atlantic Healthcare Network (10N6)

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

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

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

1. We appreciate for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Fayetteville 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 Fayetteville 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 26, 2021

From: Director, Fayetteville VA Coastal Health Care System (565/00)

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

To: Director, Mid-Atlantic Healthcare Network (10N6)

1. The Executive Director of the Fayetteville NC VA Coastal Health Care System has reviewed the draft report and concurs with the findings.

2. An updated plan for corrective actions to include timeline for completion and sustainment of improvements has been completed. Attached to this memo you will find our action plan for review and concurrence.

   (Original signed by:)

   Daniel L. Dücker, MSS, M Ed

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