DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Hampton VA Medical Center in Virginia

CHIP REPORT | REPORT #21-00278-23 | DECEMBER 14, 2021

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Figure 1. *Hampton VA Medical Center in Virginia.*
Source: https://vaww.va.gov/directory/guide/ (accessed April 27, 2021).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
C-SSRS	Columbia-Suicide Severity Rating Scale
ED	emergency department
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
UCC	urgent care center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Hampton VA Medical Center and associated outpatient clinics in Virginia and 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 Hampton VA Medical Center 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 medical center'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 medical center and other Veterans Health Administration (VHA) facilities

[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)."

identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

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

Leadership and Organizational Risks

At the time of the OIG's virtual review, the medical center's leadership team consisted of the Medical Center Director, Chief of Staff, Associate Director for Patient Care Services, and acting Associate Director for Operations. The Director served as the chairperson of the Executive Leadership Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board oversaw various working groups, including the Administrative, Patient Services, and Medical Executive councils. These leaders monitored patient safety and care through the Quality, Safety & Value Council, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Leadership Board.

When the team conducted this inspection, the executive leaders had worked together in their roles for about four months. The Medical Center Director, who was assigned in January 2021, previously served as the Associate Director for Operations for almost three years. The acting Associate Director for Operations, who was also assigned in January 2021, was the newest member of the leadership team. The Associate Director for Patient Care Services, assigned in August 2016, had served on the team the longest. The Chief of Staff, who was permanently assigned in May 2020, also served as the acting Medical Center Director from October 2020 until January 2021.

The OIG found the medical center averages for the selected All Employee Survey leadership questions were similar to or worse than the VHA averages. Survey scores for the executive leaders were generally higher than the VHA and medical center averages, but also suggested opportunities for the Associate Director for Patient Care Services to improve servant leadership and the Chief of Staff to reduce employee feelings of moral distress at work.[2] The OIG reviewed

[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 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, and moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing."

responses to survey questions that reflected patients' attitudes toward their healthcare experiences. This medical center's overall patient satisfaction survey results reflected lower care ratings than the VHA averages. Survey data indicated that patients appeared less satisfied with their inpatient and outpatient care than VHA patients nationally.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[3]

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

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific Strategic Analytics for Improvement and Learning measures.

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The OIG found the medical center complied with most of the requirements for quality, safety, and value oversight functions, the Systems Redesign and Improvement Program, protected peer reviews of clinical care, and the medical center's surgical program.[6] However, the OIG identified a deficiency with required member attendance at Surgical Workgroup meetings.

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

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

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

[6] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a "critical review of care, performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements.

Registered Nurse Credentialing

The OIG found that registered nurses hired between July 1, 2020, through April 4, 2021, were free from potentially disqualifying licensure actions. However, the OIG identified a deficiency with the primary source verification process.

Medication Management

The medical center addressed many of the indicators of expected performance, including staff availability to receive remdesivir shipments, proper naming for medication orders, satisfaction of patient inclusion criteria for medication administration, and completion of required testing. However, the OIG found a deficiency with patient and caregiver education.

Mental Health

The medical center generally complied with requirements related to documentation of all required elements of the Columbia-Suicide Severity Rating Scale and suicide safety plans. However, the OIG identified deficiencies with the initiation of the Columbia-Suicide Severity Rating Scale during emergency department encounters and staff training.

Care Coordination

The OIG observed general compliance with requirements for an inter-facility transfer policy, monitoring and evaluation of inter-facility transfers, transmission of patients' active medication lists to receiving facilities, and nurse-to-nurse communication between facilities. However, the OIG noted deficiencies with completion of the VA *Inter-Facility Transfer Form* or facility-defined equivalent by the appropriate providers involved with patient transfers and transmission of patients' advance directives to receiving facilities.[7]

High-Risk Processes

The OIG determined that the medical center met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with attendance at Disruptive Behavior Committee meetings and completion of required trainings.

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

Conclusion

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

Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 61–62, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
for Healthcare Inspections

Contents

Purpose and Scope

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

[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)
6. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
7. Care coordination (spotlighting inter-facility transfers)
8. High-risk processes (examining the management of disruptive and violent behavior)

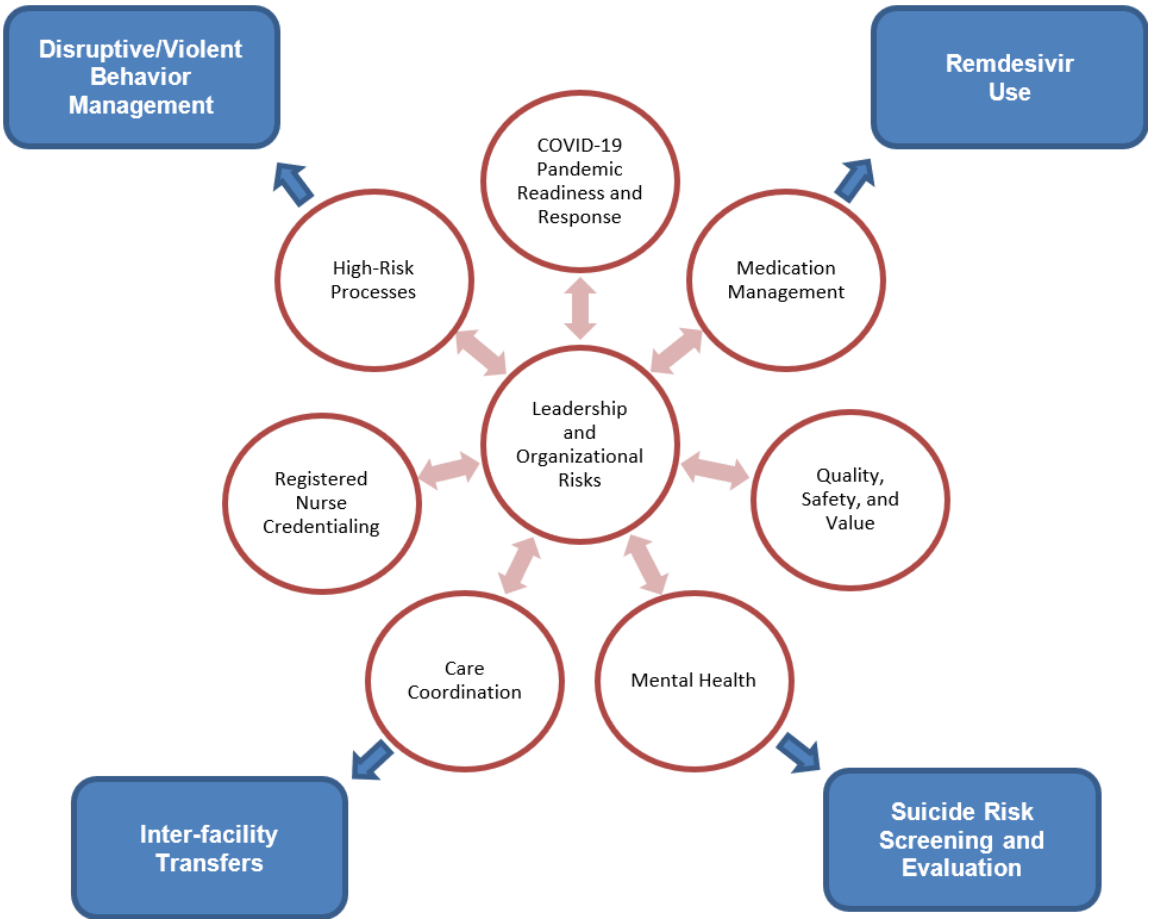

Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services. Source: VA OIG.*

Methodology

The Hampton VA Medical Center also provides care through outpatient clinics in Virginia and one in North Carolina. Additional details about the types of care provided by the medical center can be found in appendixes B and C.

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

The inspection examined operations from July 10, 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 medical center 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 medical center leaders complete corrective actions. The Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that medical center 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 medical center'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 medical center response
8. VHA performance data (medical center)
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 medical center's reported organizational structure. The medical center had a leadership team consisting of the Medical Center Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and acting Associate Director for Operations. The Chief of Staff and ADPCS oversaw patient care, which required managing service directors and chiefs of programs.

[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.

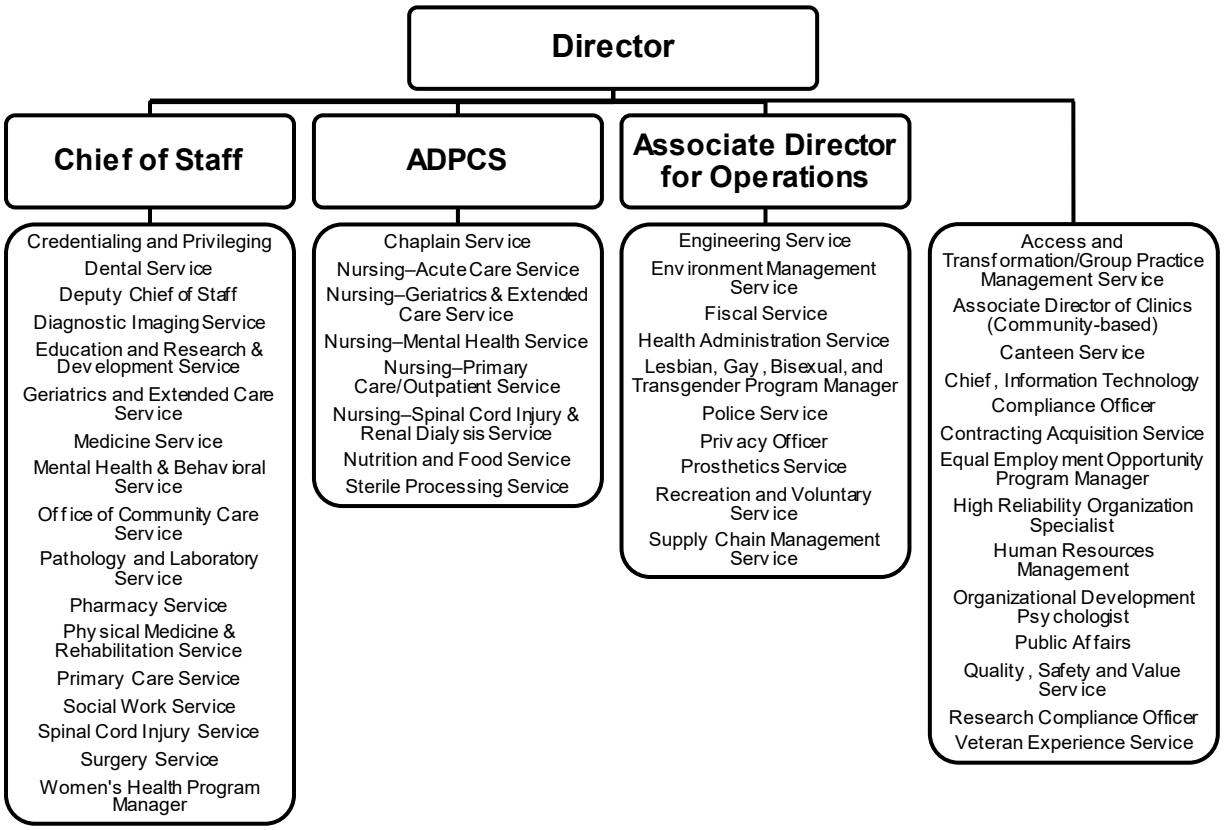

Figure 3. *Medical center organizational chart.*

Source: Hampton VA Medical Center (received May 3, 2021).

At the time of the OIG inspection, the executive team had worked together in their roles for about four months. The Medical Center Director, who was assigned in January 2021, previously served as the Associate Director for Operations for almost three years. The acting Associate Director for Operations, also assigned in January 2021, was the newest member of the leadership team. The ADPCS had served on the team the longest. The Chief of Staff, who was permanently assigned in May 2020, served as the acting Medical Center Director from October 2020 until January 2021 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	January 17, 2021
Chief of Staff	November 18, 2019 (acting); May 24, 2020 (permanent)
Associate Director for Patient Care Services	August 7, 2016
Associate Director for Operations	January 20, 2021 (acting)

Source: Hampton VA Medical Center Senior Strategic Business Partner (received May 3, 2021).

To help assess the medical center executive leaders' engagement, the OIG interviewed the Medical Center Director, Chief of Staff, ADPCS, and acting Associate Director for Operations regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

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

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

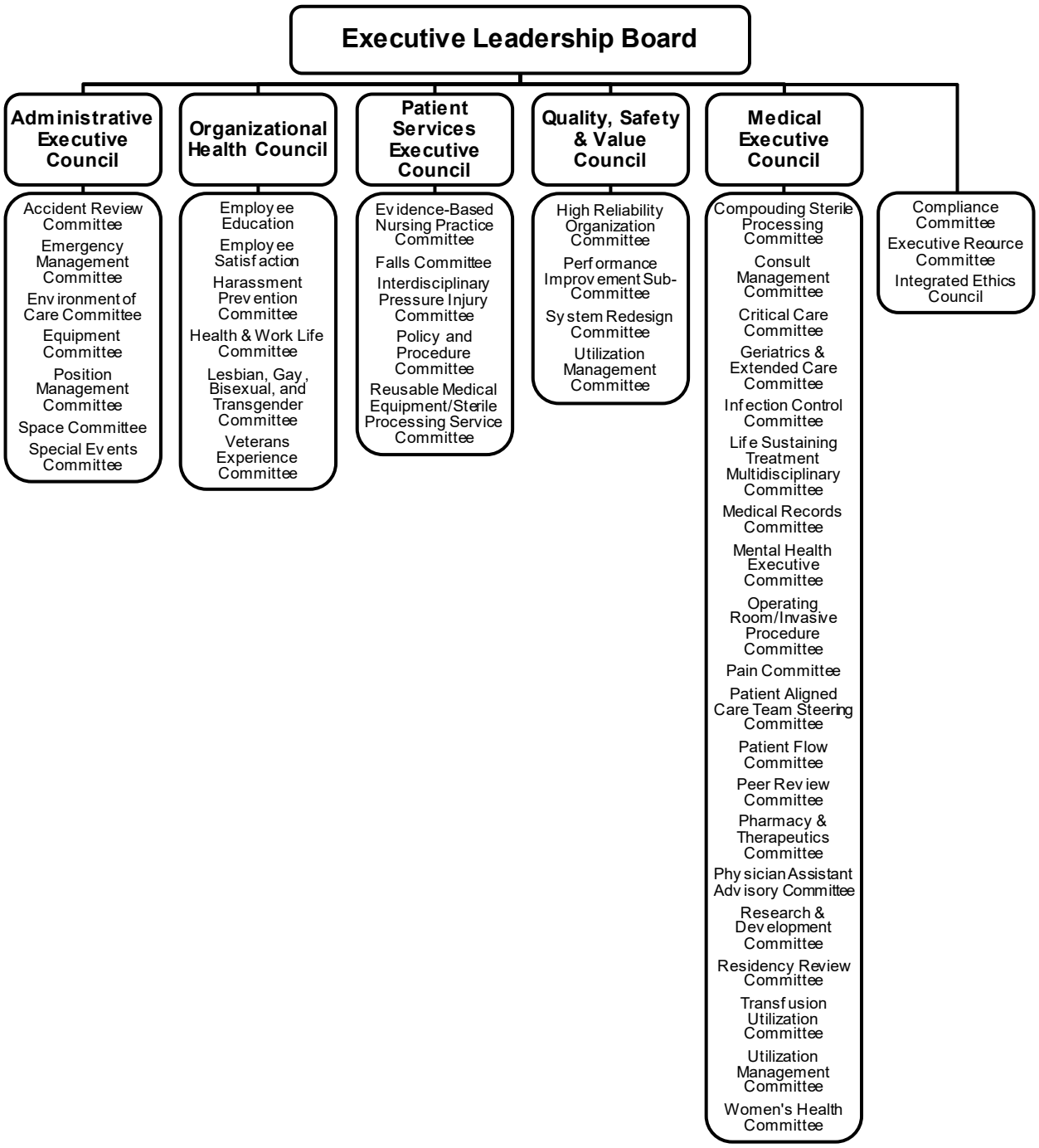

Figure 4. *Medical center committee reporting structure.*
Source: Hampton VA Medical Center (received May 3, 2021).

Budget and Operations

The medical center's FY 2020 annual medical care budget of $461,811,653 increased approximately 18 percent compared to the previous year's budget of $392,242,428.[11] When asked about the effect of this change on the medical center's operations, the Director indicated that the increase in funds helped provide supplies for the pandemic, hire more staff, and allow for work on construction projects. Specifically, the Director reported expanding services at the Virginia Beach and Chesapeake VA clinics and opening the Portsmouth VA Clinic to address primary care and mental health access.

Staffing

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

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[15] To address occupational shortages, the executive leadership team described working with Human Resources to fill vacancies and implementing strategies to improve recruitment and retention. The executive team described ongoing efforts to address occupational shortages that included considering market pay adjustments and offering available incentives (such as the Education Debt Reduction Plan).

The Chief of Staff described interim strategies implemented to alleviate stress caused by the provider occupational staffing shortages, including telehealth visits and contracts with affiliates to provide care. The acting Associate Director for Operations spoke of using contract staff for clinical positions and quickly hiring pharmacists and housekeeping staff. The acting Associate Director for Operations also explained that nationally implemented changes were expected to

[11] VHA Support Service Center.

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

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

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

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

improve the ability to hire VA police. The Director described reaching out to a local college to potentially provide onsite physician support.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. RN Staff – Inpatient Mental Health	1. Police
2. Gastroenterology	2. Medical Records Technician
3. Psychiatry	3. General Engineering
4. Psychology	4. Custodial Worker
5. Pharmacist	5. Food Service Worker

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 medical center leaders.

To assess employee attitudes toward medical center 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 medical center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center averages for the selected survey leadership questions were similar to or lower than the VHA averages.[19] The All Employee Survey scores for the executive leaders were generally higher than the VHA and medical center averages. However, the scores highlighted an opportunity for the ADPCS to improve servant leadership.[20]

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

[17] "AES Survey History."

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

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

[20] The 2020 All Employee Survey results are not reflective of employee satisfaction with the current Director or acting Associate Director for Operations, who assumed their roles after the survey was administered.

The executive leadership team identified communication, accountability, and growth as priorities based on the All Employee Survey. They reported implementing strategies to address these priorities, including holding listening tours with services chiefs; starting leadership forums; and presenting on the topics of communication for leaders, psychological safety, growth, accountability, diversity, and fostering fairness in the workplace. The Director stated that these presentations were replicated at employee town hall sessions, which reached maximum capacity (about 500 people) on the calls.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center 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	68.6	89.0	88.0	70.6	93.2
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.5	3.3	4.4	4.1	3.6	4.6
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.5	4.3	4.3	3.8	4.7
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.7	3.6	4.5	4.4	3.8	4.8

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.*

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[21] The medical center averages for the selected survey questions were less favorable than the VHA averages. Scores for the executive leaders were generally better than those for VHA and the medical center. However, opportunities appeared to exist for the Chief of Staff to reduce employee feelings of moral distress at work. The Chief of Staff reported addressing staff's feelings of moral distress through increased communication with clinical services leaders, fireside chats, and purposeful rounding. The executive leaders appeared actively engaged with employees and were working to sustain and improve employee engagement and satisfaction.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center 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	3.6	4.2	4.5	3.9	4.7
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	3.5	4.6	4.5	3.9	4.8

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center 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	1.6	1.4	1.7	1.5	0.9

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."[22] 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.[23]

Executive leaders reported taking actions toward the commitment to a harassment-free environment. These actions included introducing the zero-tolerance expectation during new employee orientation, developing an anonymous submission system for concerns, and discussing diversity at town halls. The Director reported developing a Diversity and Inclusion Committee and intending to serve as the chair.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The medical center averages for the selected survey questions were lower than the VHA averages. The scores for the leaders were generally similar to or higher than medical center averages. Leaders appeared to maintain an environment where staff felt respected and safe.

[22] "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.

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

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center 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	3.7	4.7	4.6	4.1	4.5
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree) –5 (Strongly Agree)	4.1	3.8	4.5	4.8	3.8	4.7
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.6	4.6	4.6	3.9	4.6

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

Patient Experience

To assess patient experiences with the medical center, 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 medical center.[24] For this medical center, the overall patient satisfaction survey results reflected lower care ratings than the VHA

[24] Ratings are based on responses by patients who received care at this medical center.

averages. Patient experience survey data indicated that patients appeared less satisfied with their inpatient and outpatient care than VHA patients nationally.

The Chief of Staff reported that veterans complained about communication, cleanliness, and food choices while in the hospital. To address these concerns, leaders reportedly hired an additional pharmacist to discuss medications with patients before discharge, increased fresh food options, and had dietitians provide nutrition education. Additionally, the Chief of Staff reported that medical center leaders had implemented the GetWellNetwork within the previous two years, which enabled veterans to notify staff if a room was not cleaned or the temperature was uncomfortable.[25]

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

Questions	Scoring	VHA Average	Medical Center 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	57.8
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	73.6
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	76.4

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans

[25] "GetWellNetwork," Get Well, accessed October 7, 2021, https://www.getwellnetwork.com/. The GetWellNetwork is a digital interactive patient engagement program.

by 2048.[26] 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). Survey data indicated that patients appeared less than satisfied with the care provided. Selected survey results for male and female respondents were generally less favorable than those for VHA patients nationally, except for the inpatient question related to physicians treating patients with courtesy and respect, on which male respondents scored higher than VHA patients nationally.

The Chief of Staff reported that veterans had difficulty reaching staff because phone calls did not transfer properly. Additionally, the ADPCS reported that call volume increased to about 1,900 calls per day when the COVID-19 vaccine became available. As a result, the medical center reportedly established a dedicated COVID-19 call line to assist veterans and encouraged them to use MyHealtheVet and VEText while the medical center worked to resolve the phone issue.[27]

Leaders reported that some specialty areas had only one provider. The Chief of Staff explained that hiring more providers decreased the number of rescheduled appointments and improved inpatient access.

Leaders also reported that patients' access to providers had been limited due to insufficient space to provide care. The acting Associate Director for Operations stated that the medical center was the second-fastest growing VA medical facility and had limited ability to expand at the main campus site. Leaders discussed expanding space in the Portsmouth, Virginia Beach, and Chesapeake VA clinic locations to improve veterans' access to care.

The Chief of Staff described measures to ensure a secure and safe environment for women veterans. The Chief of Staff reported, for example, that staff were reminded to knock prior to entering women veterans' rooms and to respect privacy.

The executive leaders appeared actively engaged with employees and patients and were working to sustain and further improve employee and patient engagement and satisfaction.

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[26] "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.

[27] "About My HealtheVet: How to Use My HealtheVet," Department of Veterans Affairs, accessed October 7, 2021, https://www.myhealth.va.gov/mhv-portal-web/web/myhealthevet/faqs - My HealtheVet. "In the Spotlight: Text Messages and VA Appointments," Department of Veterans Affairs, accessed October 7, 2021, https://www.myhealth.va.gov/mhv-portal-web/ss20180907-text-messages-available-for-va-appointments. MyHealtheVet and VEText are services provided by VA. MyHealtheVet is a secure online personal health portal allowing for 24 hours a day/7 days a week access to medical records information, prescription refills, secure messaging, and information. VEText allows veterans to receive appointment reminders on their mobile devices and reschedule their appointment for an earlier available appointment.

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

Questions	Scoring	VHA*		Medical Center†	
		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	59.2	46.7
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	86.8	83.0
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	84.4	74.1

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

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

† The medical center averages are based on 275–277 male and 41 or 42 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*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	45.4	34.0
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	45.5	31.4
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	70.0	64.5

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

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

† The medical center averages are based on 199–745 male and 43–115 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*		Medical Center†	
		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	50.3	18.4
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	53.2	51.4
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	74.8	59.6

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

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

† The medical center averages are based on 295–987 male and 53–157 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.[28] Table 10 summarizes the relevant medical center inspections most recently performed by the OIG and The

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

Joint Commission (TJC).[29] At the time of the OIG review, the medical center had closed all recommendations for improvement issued since the previous CHIP site visit conducted in July 2017.

The OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[30] Additional results included the Long Term Care Institute's inspection of the medical center's CLC and the Paralyzed Veterans of America's inspection of the spinal cord injury/disease unit and related services.[31]

[29] 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."

[30] 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.

[31] "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 inspections took place March 22–23, 2018, and April 23–24, 2019. This veterans service organization review does not result in accreditation status.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the Hampton VA Medical Center, Hampton, Virginia*, Report No. 17-01758-104, February 28, 2018)	July 2017	19	0
TJC Hospital Accreditation	December 2020	27	0
TJC Behavioral Health Care Accreditation		7	0
TJC Home Care Accreditation		5	0
TJC Hospital Accreditation	July 2017	21	0
TJC Behavioral Health Care Accreditation		3	0
TJC Home Care Accreditation		4	0

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

Identified Factors Related to Possible Lapses in Care and Medical Center Responses

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

Table 11 lists the reported patient safety events from July 10, 2017 (the prior OIG CHIP site visit), to May 3, 2021.[32]

Table 11. Summary of Selected Organizational Risk Factors (July 10, 2017, to May 3, 2021)

Factor	Number of Occurrences
Sentinel Events	11
Institutional Disclosures	13
Large-Scale Disclosures	0

Source: Hampton VA Medical Center's Patient Safety Manager and Risk Manager (received May 4, 2021).

The Director reported being informed of serious adverse patient events through morning reports and monitoring events as the co-chair of the Quality, Safety & Value Council. The Director also reported collaborating with staff, assessing all elements, and following VHA policy to determine when an institutional disclosure was warranted.

Veterans Health Administration Performance Data for the Medical Center

The VA Office of Operational Analytics and Reporting developed the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[33] Despite noted limitations for identifying all areas

[32] 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 Hampton VA Medical Center 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."

[33] "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.)

of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[34]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 30, 2020. Figure 5 shows the Hampton VA Medical Center'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 acute care 30-day standardized mortality ratio (SMR30), patient safety index (PSI) 90, and stress discussed). 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, specialty care (SC) coordination, hospital rating (HCAHPS), and patient-centered medical home (PCMH) same day appointment (appt)).[35]

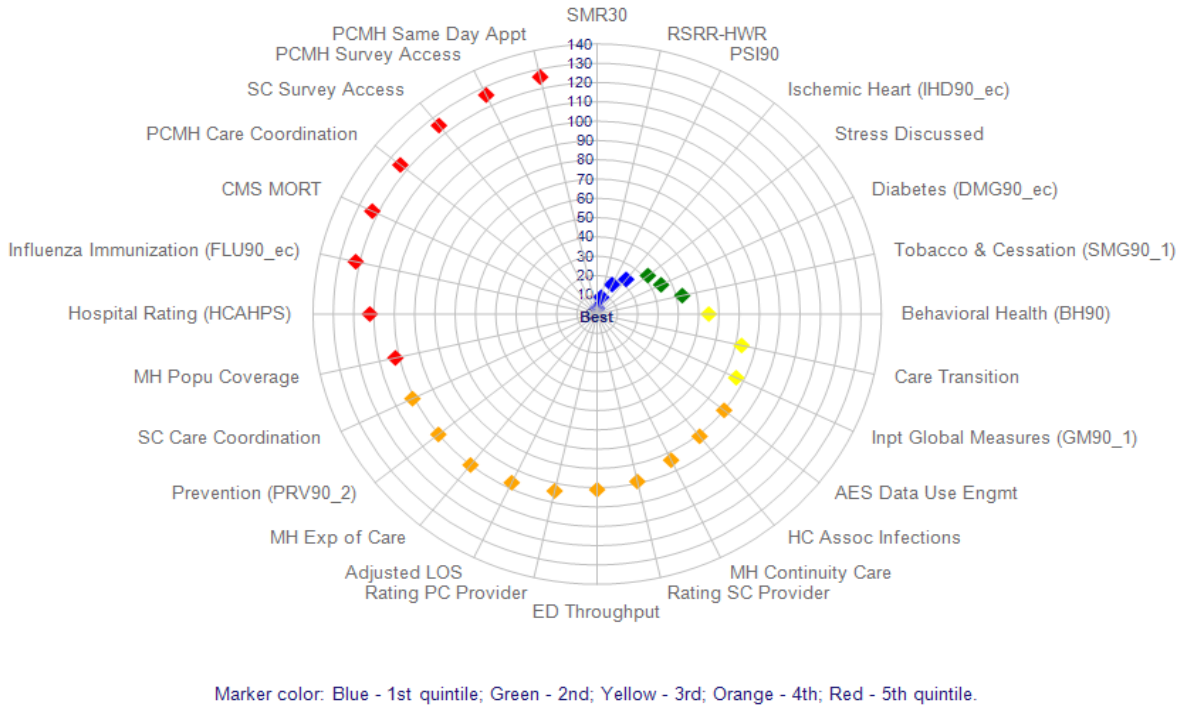


Figure 5. *System quality of care and efficiency metric rankings for FY 2021 quarter 1 (as of December 30, 2020).*

Source: VHA Support Service Center.

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

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

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

Veterans Health Administration Performance Data for the Community Living Center

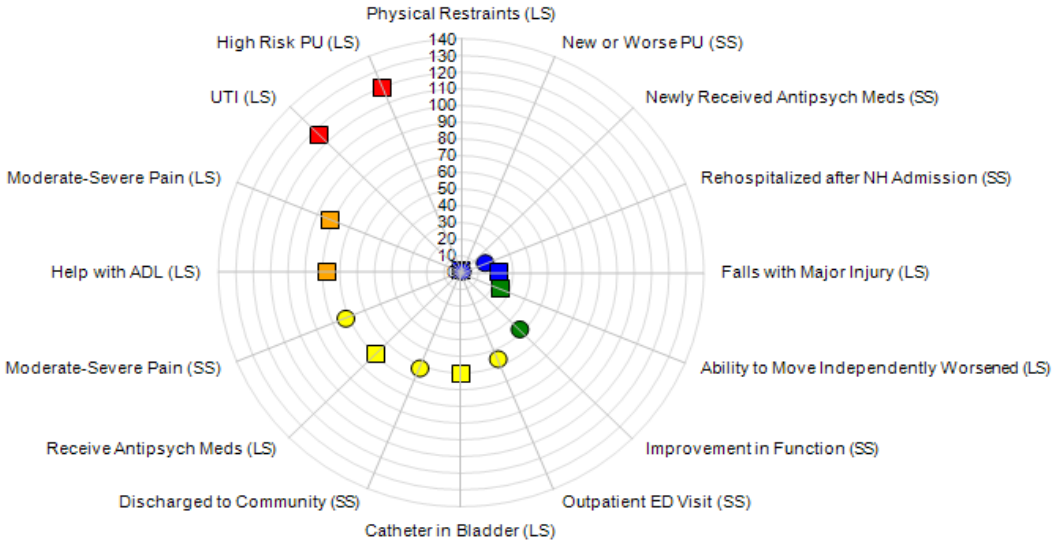
The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA."[36] The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection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

Figures 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. Figure 6 displays the Hampton VA Medical Center'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), rehospitalized after nursing home (NH) admission–short-stay (SS), and improvement in function (SS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, moderate-severe pain (LS), urinary tract infection (UTI) (LS), and high risk pressure ulcer (PU) (LS)).[38]

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

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

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



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

Figure 6. *Hampton CLC quality measure rankings for FY 2020 quarter 3 (as of June 30, 2020).*
LS = Long-Stay Measure. *SS = Short-Stay Measure.*
Source: VHA Support Service Center.
Note: The OIG did not assess VA's data for accuracy or completeness.

The executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the medical center and CLC SAIL models. In April 2021, the Center for Improvement Coordination communicated to medical center leaders that "Hampton [data] reflects a 71% meaningful improvement across SAIL measures from one year prior…[and] made great strides improving the quality of care delivered to Veterans."[39]

Leadership and Organizational Risks Findings and Recommendations

The executive team had worked together in their roles for about four months. The Medical Center Director, who was assigned in January 2021, previously served as the Associate Director for Operations for almost three years. The acting Associate Director for Operations, who was also assigned in January 2021, was the newest member of the leadership team. The ADPCS, who was assigned in August 2016, had served on the team the longest. The Medical Center Director served as the chairperson of the Executive Leadership Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational

[39] "Center for Improvement Coordination," VHA Office of Quality and Patient Safety, accessed May 17, 2021, https://vaww.qps.med.va.gov/divisions/qm/cic/cicDefault.aspx. (This is an internal VA website not publicly accessible.) "The Center for Improvement Coordination (CIC) partners collaboratively with VHA Senior Leaders, VHA Program Offices and VISN Leadership teams and VA Medical Centers (VAMC) on quality improvement initiatives."

management and strategic planning. These leaders monitored patient safety and care through the Quality, Safety & Value Council.

The All Employee Survey scores for the executive leaders were generally higher than VHA and medical center averages. However, the scores suggest opportunities for the ADPCS to improve servant leadership and the Chief of Staff to reduce employee feelings of moral distress at work. The leaders appeared to maintain an environment where staff felt respected and safe.

For this medical center, the overall patient satisfaction survey results generally reflected lower care ratings than the VHA averages. Patient experience survey data indicated that patients appeared less satisfied with the inpatient and outpatient care provided than VHA patients nationally. The executive leaders appeared actively involved with employees and patients and were working to sustain and improve employee and patient engagement and satisfaction.

The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors.

The executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the medical center and CLC SAIL models. Additionally, the Center for Improvement Coordination communicated that the medical center had "made great strides improving the quality of care delivered to Veterans."

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[40] VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.[41]

During this time, VA continued providing care to veterans and engaged its fourth mission, the "provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have VA eligibility for such care and services."[42] "In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans."[43]

Due to VHA's mission-critical work in supporting both veteran and civilian populations during the pandemic, the OIG conducted an evaluation of the pandemic's effect on the medical center 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 medical center 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 medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.

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

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

[42] 38 U.S.C. § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the provision of hospital care and medical services during certain disasters and emergencies: "During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[44] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[45] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as TJC), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[46]

To determine whether VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the medical center'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 medical center's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization."[47] Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[48] The OIG team examined various requirements related to systems redesign and improvement:

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

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

Next, the OIG assessed the medical center's processes for conducting protected peer reviews of clinical care.[49] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[50] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[51] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[52]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[53]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the medical center's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[54] The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) Operational oversight of surgical services and quality improvement activities,

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

[50] VHA Directive 1190.

[51] VHA Directive 1190.

[52] VHA Directive 1190.

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

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

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[55] The medical center's performance was assessed on several dimensions:

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

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[57]

Quality, Safety, and Value Findings and Recommendations

The OIG found the medical center complied with most of the requirements for QSV oversight functions, the Systems Redesign and Improvement Program, protected peer reviews of clinical care, and the medical center's surgical program. However, the OIG identified a deficiency with required member attendance at Surgical Workgroup meetings.

VHA's National Surgery Office directive requires medical facilities with surgical programs to have a surgical work group that meets at least monthly. This work group must be chaired by the Chief of Surgery and include the Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as required members.[58] The OIG reviewed the medical center's Surgical Workgroup attendance records for meetings held from May 2020 through April 2021 and found that the Chief of Staff did not attend 9 of 11 meetings (82 percent).[59] The lack of the executive leader's involvement resulted in the review and analysis of surgery program data without the perspectives of key staff. The Chief of Staff described not being aware of the Surgical Workgroup membership requirement and competing priorities as reasons for not attending the meetings. The OIG noted that the Chief of Staff also served as the acting Medical Center Director from October 25, 2020, until January 17, 2021.

[55] "NSO Reporting, Resources, & Tools."
[56] VHA Directive 1102.01(1), *National Surgery Office,* April 24, 2019, amended May 22, 2019.
[57] For CHIP visits, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.
[58] VHA Directive 1102.01(1).
[59] The Surgical Workgroup reported to the Operating Room/Invasive Procedure Committee.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that required members regularly attend Surgical Workgroup meetings.

Medical Center concurred.

Target date for completion: January 31, 2022

Medical center response: The Chief of Staff evaluated reasons for noncompliance and implemented the following actions to improve the facility's process for documenting attendance for core committee members. The Surgical Workgroup's charter was rewritten to include attendance for core committee members. Core members are responsible for designating an alternate in their absence. The Chief of Surgery will document attendance for all core members at each committee meeting and the Surgical Quality Nurse will review the monthly attendance log for each meeting.

Reporting Committee: The compliance on attendance for the Surgical Work Group meeting will be reported to the Quality, Safety and Value Council (QSVC).

Benchmark: 90%

Frequency of Monitoring: Monitor until 90% compliance is maintained for six (6) 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 59 RNs hired from July 1, 2020, through April 4, 2021. The OIG determined whether

- the RNs were free from potentially disqualifying licensure actions, or
- the Chief, Human Resources Management Service or Regional Counsel determined that the RNs met VA licensure requirements.

The OIG also reviewed the credentialing files for 30 of the 59 RNs to determine whether medical center staff completed primary source verification prior to the appointment.

[60] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012.
[61] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.
[62] VHA Directive 2012-030. "Definition of *Unencumbered license*," Law Insider, accessed December 3, 2020, https://www.lawinsider.com/dictionary/unencumbered-license. An unencumbered license is "a license that is not revoked, suspended, or made probationary or conditional by the licensing or registering authority in the respective jurisdiction as a result of disciplinary action."
[63] 38 U.S.C. § 7402.
[64] VHA Directive 2012-030.
[65] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

The OIG found that RNs hired between July 1, 2020, through April 4, 2021, were free from potentially disqualifying licensure actions. However, the OIG identified a deficiency with the primary source verification process.

VHA requires the Director to ensure that "all licenses including not only current licenses, but all previously held, [are] verified through primary source verification" prior to initial appointment.[66] The OIG found that 4 of 30 RN credentialing files reviewed lacked documentation of primary source verification for each RN license. For the remaining 26 RN files that had documentation of primary source verification, 4 were not verified within the required time frame. This could lead to inappropriate hiring of nurses and subsequently affect the provision of quality care. The Credentialing and Privileging Program Manager reported a lack of formal processes, which resulted in verifications being missed or not completed within the required time frame. Additionally, the Credentialing and Privileging Program Manager stated that staffing vacancies contributed to the reviews not being completed.

Recommendation 2

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

Medical Center concurred.

Target date for completion: January 31, 2022

Medical Center response: The Chief of Staff evaluated reasons for noncompliance and implemented the following actions to improve the facility's primary source verification of all Registered Nurses' licenses prior to initial appointment. The Credentialing and Privileging Program Manager will validate primary source verification for each license held by Registered Nurses prior to initial appointment.

Reporting Committee: The compliance on primary source verification will be monitored and reported to the Quality, Safety and Value Council (QSVC).

Benchmark: 100%

Frequency of Monitoring: Monitor until 100% compliance is maintained for six (6) consecutive months.

[66] VHA Directive 2012-030.

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[67] 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.[68]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[69] 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.[70]

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."[71] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[72]

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 16 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

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

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

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

[70] 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*.

[71] 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.

[72] 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)[73]
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[74]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG found the medical center addressed many of the indicators of expected performance, including staff availability to receive remdesivir shipments, proper naming for medication orders, satisfaction of medication administration criteria, and completion of required testing. However, the OIG found a deficiency with patient and caregiver education.

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 and/or caregivers that remdesivir was not an FDA-approved medication, provide the option to refuse the medication, and advise patients and/or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[75] For the 16 electronic health records reviewed, the OIG determined that

- three (19 percent) lacked evidence that the patient or caregiver was given the *Fact Sheet for Patients and Parents/Caregivers*,
- two (13 percent) lacked evidence that the patient or caregiver was informed that remdesivir was not an FDA-approved drug, and
- two (13 percent) lacked evidence that the patient or caregiver was informed of the risks and benefits.

[73] "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."

[74] "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.

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

This could have resulted in patients or caregivers lacking information needed to make a fully informed decision to receive the medication. One physician, a hospitalist, reported that the information was provided but not documented.

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.[76]

[76] 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.[77] 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.[78] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[79]

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 (EDs) or urgent care centers (UCCs) begins with the secondary screen, the Columbia-Suicide Severity Rating Scale (C-SSRS), and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[80] The OIG examined whether staff initiated the C-SSRS 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 ED or UCC.[81] The medical center 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

[77] "Suicide Prevention: Facts About Suicide," Centers for Disease Control and Prevention, accessed December 9, 2020, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.
[78] Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, November 2020.
[79] Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*.
[80] 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.
[81] 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.

To determine whether VHA facilities complied with selected requirements for suicide risk screening and evaluation within EDs and UCCs, the OIG inspection team interviewed key employees and reviewed

- relevant documents;
- the electronic health records of 48 randomly selected patients who were seen in the ED or UCC from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

The OIG found the medical center generally complied with documentation of all required elements of the C-SSRS and suicide safety plans. However, the OIG identified deficiencies with the initiation of the C-SSRS during ED encounters and staff training.

VHA requires that all veterans who present to EDs or UCCs are screened for suicidality using the C-SSRS.[82] The OIG estimated that 35 percent of patients were not screened for suicidality during their ED visit.[83] Failure to screen for suicide risk could result in missed opportunities to identify veterans at risk for suicide and implement suicide safety plans.

The Chief of Mental Health reportedly became aware of the requirement during the November 14, 2019, Risk ID Technical Assistance Call. The Chief also shared that the C-SSRS screening tool was embedded in an ED note and staff members were trained on its use by mid-January 2020. The OIG confirmed that the electronic health records reviewed from ED visits that occurred between January 15 and August 31, 2020, were compliant. Based on the evidence of sustained compliance, the OIG made no recommendation.

VA requires that staff complete suicide safety plan training prior to developing suicide safety plans.[84] The OIG found that 8 of 30 staff (27 percent) responsible for suicide prevention safety plan development had not completed the mandatory training prior to the OIG virtual review. Lack of staff training could prevent staff from providing optimal treatment to veterans who are at risk for suicide. The Chief of Mental Health reportedly recognized during a national call in March 2021 that staff were completing the wrong training. Subsequently, the medical center assigned staff to complete the required training.

[82] "Risk ID Resources," Suicide Risk Identification and Management, Department of Veterans Affairs, accessed May 10, 2021, https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx. (This is an internal website not publicly accessible.); "VA Suicide Risk Identification Strategy," Technical Assistance Call, November 14, 2019.

[83] The OIG estimated that 95 percent of the time the true compliance rate is between 51.0 and 78.0, which is statistically significantly below the 90 percent benchmark.

[84] *VA Suicide Prevention Safety Plan and Suicide Behavior and Overdose Report (SBOR) Templates: Staff Specific Guidance*, June 18, 2020.

Recommendation 3

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

Medical Center concurred.

Target date for completion: March 31, 2022

Medical Center response: The Chief of Staff evaluated reasons for noncompliance and implemented the following actions to ensure staff completes the mandatory suicide safety plan training prior to developing suicide safety plans. Supervisors will identify employees that need TMS [Talent Management System] training (Course # 36232) and provide this information to the TMS Domain Manager for assignment. The Chief, Mental Health & Behavioral Services (MH&BS), Chief, Social Work, and the Chief, Emergency Department will monitor training for compliance.

Reporting Committee: The compliance for completion on the safety plan training will be monitored and reported to the Quality, Safety and Value Council (QSVC).

Benchmark: 90%

Frequency of Monitoring: Monitor until 90% compliance is maintained for six (6) consecutive months.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[85]

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."[86] 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.[87]

The medical center 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 medical center complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed managers and key employees. The team also reviewed the electronic health records of 49 patients who were transferred from the medical center 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, monitoring and evaluation of inter-facility transfers, transmission of patients' active medication lists to receiving facilities, and nurse-to-nurse communication between facilities. However, the OIG noted deficiencies with completion of the VA *Inter-Facility Transfer Form* or facility-

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

[86] VHA Directive 1094.

[87] 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.

defined equivalent by the appropriate providers involved with patient transfers and transmission of patients' advance directives to receiving facilities.

VHA requires providers to complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record prior to the patient transfer. VHA also requires appropriately privileged providers to co-sign transfer forms or notes that are completed by non-physician designees.[88] The OIG estimated that 22 percent of patient transfer forms were not co-signed by an appropriately privileged provider.[89] This lack of oversight could have resulted in unsafe patient transfers. Prior to December 2020, the Assistant Chief of Medicine Service/ED Medical Director reported being unaware that the notes completed by other staff needed to be co-signed by an appropriately privileged provider. In December 2020, the Assistant Chief of Medicine Service/ED Medical Director, after being asked by staff within the QSV Service to conduct an audit of transfers (prompted as a result of OIG findings at other facilities), became aware of co-signer requirements and implemented improvement actions.

Recommendation 4

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

[88] VHA Directive 1094.

[89] The OIG estimated that 95 percent of the time the true compliance rate is between 65.3 and 88.0 , which is statistically significantly below the 90 percent benchmark.

Medical Center concurred.

Target date for completion: September 30, 2022

Medical Center response: The Chief of Staff evaluated reasons for noncompliance and implemented the following actions to ensure compliance for completion of VA Form 10-2649A. Chief, Medicine Services and the Nurse Manager of the Flow Department collaborated to create a transfer checklist. The Emergency Department Medical Director re-trained the staff on the newly designed checklist to ensure accurate documentation for VA Form 10-2649A. Audits will be conducted on fifteen (15) transfers per month and if less than 15 transfers, 100% of transfers will be reviewed and monitored by the Patient Flow Committee and Quality, Safety, and Value Council.

Reporting Committee: Compliance on the completion of VA Form 10-2649A will be reported to the Patient Flow Committee and the Quality, Safety and Value Council (QSVC).

Benchmark: 90%

Frequency of Monitoring: Monitor until 90% compliance is maintained for six (6) consecutive months.

VHA requires transferring providers to send "all pertinent medical records available, including an active patient medication list and…advance directive" to the receiving facility during inter-facility transfers.[90] The OIG found, for the 10 records where an advance directive was present, 7 lacked evidence that staff sent the advance directives to the receiving facility. As a result, there was no assurance that receiving facility staff could determine patient preferences regarding their health care. The Assistant Chief of Medicine Service/ED Medical Director reported that the process was for providers to review the most recent note referencing advance directives and verify the information or view the actual advance directive. Due to the low number of patients identified for this review element, the OIG made no recommendation.

[90] VHA Directive 1094.

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[91] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[92] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team[93]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[94]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[95]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[96]

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

[92] VHA Directive 2012-026.

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

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

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

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

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[97] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[98] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The OIG determined that the medical center 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.

VHA requires that the Chief of Staff and ADPCS are responsible for establishing a disruptive behavior committee or board that includes a senior clinician as the chairperson, clerical and administrative support staff, patient advocate, and representatives from the Prevention Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and the Union Safety Committee.[99] The OIG found that from May 2020 through April 2021, administrative support staff missed all 12 Disruptive Behavior Committee meetings.[100] Additionally, the Prevention Management of Disruptive Behavior Program representative did not attend 3 of 12 meetings (25 percent), and the VA police representative did not attend 2 of 12 meetings (17 percent). This could result in a lack of knowledge and expertise when assessing patients' disruptive behavior. According to the Disruptive Behavior Committee chair, the administrative support representative role was not filled due to an oversight. Additionally, the Prevention Management of Disruptive Behavior Program representative was unaware of attendance requirements and one of the VA police representative's absences was attributed to a police emergency, which did not allow adequate time to secure an alternate representative to attend.

[97] DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments,* February 24, 2020.
[98] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.
[99] VHA Directive 2012-026; VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.
[100] The Disruptive Behavior Committee reports to the Environment of Care Committee and the Mental Health Executive Committee.

Recommendation 5

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

Medical Center concurred.

Target date for completion: January 31, 2022

Medical Center response: The Chief of Staff evaluated reasons for noncompliance and implemented the following actions to improve the facility's process in documenting attendance for core members. The Chief, MH&BS reviewed and updated the Disruptive Behavior Committee charter according to VHA Directive 2010-053, Patient Record Flags. Administrative support attendance was added. The Chair, Disruptive Behavior Committee will capture attendance at the beginning of each committee meeting for each required member. Members are responsible for designating an alternate in their absence.

Reporting Committee: The compliance on attendance for the Disruptive Behavior Committee meeting with be monitored and reported to the Quality, Safety and Value Council (QSVC).

Benchmark: 90%

Frequency of Monitoring: Monitor until 90% compliance is maintained for six (6) consecutive months.

VHA requires that staff complete prevention and management of disruptive behavior training based on the risk level assigned to their work area.[101] The OIG found 13 of the 30 selected staff (43 percent) had not completed the required trainings. This could result in lack of awareness, preparedness, and precautions needed when responding to disruptive behavior. The Disruptive Behavior Committee chair reported that scheduling in-person training was difficult due to a limited number of trainers and COVID-19 restrictions. The Chief of Mental Health added that employees were responsible for self-scheduling trainings, which may have contributed to noncompliance.

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

Recommendation 6

6. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work area.[102]

Medical Center concurred.

Target date for completion: September 30, 2022

Medical Center response: The Chief of Staff evaluated reasons for noncompliance and will ensure that employees complete the Prevention and Management of Disruptive Behavior (PMDB) training. On-boarding staff are assigned Part I in New Employee Orientation (NEO). Additional trainers have been certified to train employees for Part II and Part III. The Chair of the Disruptive Behavior Committee will distribute a monthly report to the Executive Leadership Team (ELT). The ELT will champion compliance for staff completion of training within their designated areas.

Reporting Committee: Compliance will be monitored and reported to the Quality, Safety and Value Council (QSVC).

Benchmark: 90%

Frequency of Monitoring: Monitor until 90% compliance is maintained for six (6) consecutive months.

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

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 medical center, the OIG conducted a detailed review of eight clinical and administrative areas and provided six recommendations on systemic issues that may adversely affect patients. While the OIG's recommendations are not a comprehensive assessment of the caliber of services delivered at this medical center, they illuminate areas of concern and provide a road map for improvement. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

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 medical center response • VHA performance data (medical center) • 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 medical center 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	• Required members regularly attend Surgical Workgroup meetings.
RN Credentialing	• RN licensure requirements • Primary source verification	• Credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.	• None
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• Staff complete mandatory suicide safety plan training prior to developing suicide safety plans.	• None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• Appropriately privileged transferring providers complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note prior to inter-facility patient transfers.	• 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	• All required members attend Disruptive Behavior Committee meetings. • Staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work area.

Appendix B: Medical Center Profile

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

Table B.1. Profile for Hampton VA Medical Center (590)
(October 1, 2017, through September 30, 2020)

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019†	Medical Center Data FY 2020‡
Total medical care budget	$410,668,899	$392,242,428	$461,811,653
Number of:			
• Unique patients	53,958	55,611	59,051
• Outpatient visits	561,098	592,236	578,984
• Unique employees§	1,625	1,810	1,937
Type and number of operating beds:			
• Community living center	122	122	122
• Domiciliary	169	169	169
• Medicine	33	33	33
• Mental health	40	40	40
• Residential rehabilitation	21	21	21
• Spinal cord	64	64	64
• Surgery	9	9	9
Average daily census:			
• Community living center	57	76	56
• Domiciliary	123	141	55
• Medicine	19	18	20
• Mental health	29	24	22
• Residential rehabilitation	9	9	6
• Spinal cord	41	53	37

[1] "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing (OPES), accessed August 20, 2021, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (This is an internal website not publicly accessible.) VHA medical centers are classified according to a facility complexity model; a designation of "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.

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019†	Medical Center Data FY 2020‡
• Surgery	3	2	2

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

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

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

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

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

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

Appendix C: VA Outpatient Clinic Profiles

The VA outpatient clinics in communities within the catchment area of the medical center 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
Virginia Beach, VA	590GB	10,822	8,258	Anesthesia Dermatology Endocrinology Eye General surgery Hematology/ Oncology	–	Nutrition Pharmacy Weight management
Elizabeth City, NC	590GC	2,501	2,121	Anesthesia Dermatology General surgery	–	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.

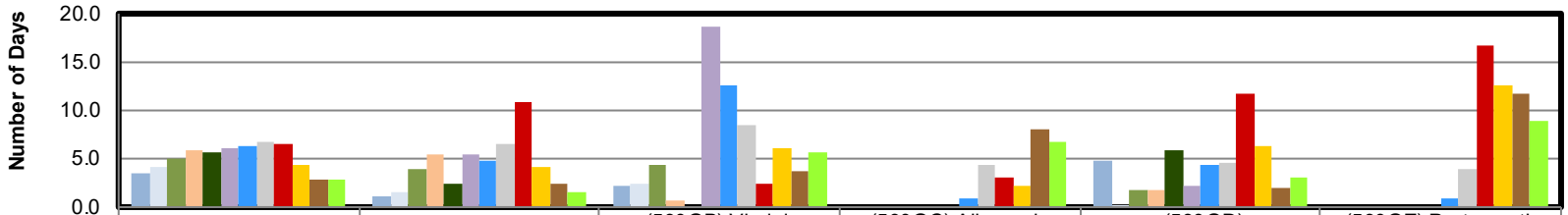
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Chesapeake, VA	590GD	9,291	5,797	Dermatology Endocrinology General surgery	Nuclear med	Nutrition Pharmacy Social work Weight management

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 (590GE) Portsmouth, VA, as it opened in October 2020, and therefore, no data were reported.

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days

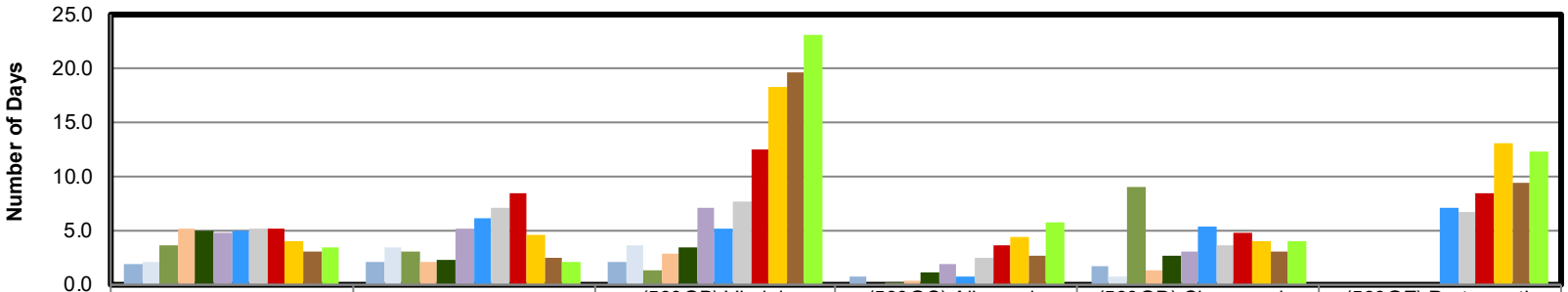


	All VHA	(590) Hampton, VA	(590GB) Virginia Beach, VA	(590GC) Albemarle, NC	(590GD) Chesapeake, VA	(590GE) Portsmouth, VA
APR-FY19	3.6	1.2	2.3	n/a	4.8	n/a
MAY-FY19	4.0	1.5	2.4	0.0	0.2	n/a
JUN-FY19	4.9	3.9	4.4	n/a	1.8	n/a
JUL-FY19	5.9	5.4	0.8	0.0	1.8	n/a
AUG-FY19	5.6	2.4	n/a	n/a	5.9	n/a
SEP-FY19	6.1	5.5	18.8	n/a	2.1	n/a
OCT-FY20	6.3	4.8	12.5	1.0	4.4	1.0
NOV-FY20	6.7	6.6	8.5	4.3	4.6	3.8
DEC-FY20	6.6	10.9	2.4	3.1	11.7	16.8
JAN-FY20	4.4	4.3	6.1	2.1	6.3	12.6
FEB-FY20	2.9	2.5	3.8	8.0	1.9	11.7
MAR-FY20	2.9	1.6	5.7	6.8	3.0	8.9

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

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

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	(590) Hampton, VA	(590GB) Virginia Beach, VA	(590GC) Albemarle, NC	(590GD) Chesapeake, VA	(590GE) Portsmouth, VA
APR-FY19	1.9	2.2	2.2	0.8	1.6	n/a
MAY-FY19	2.1	3.4	3.6	0.0	0.8	n/a
JUN-FY19	3.7	3.0	1.4	0.1	9.1	n/a
JUL-FY19	5.1	2.2	2.9	0.3	1.4	n/a
AUG-FY19	5.0	2.4	3.5	1.2	2.7	n/a
SEP-FY19	4.9	5.3	7.0	2.0	3.2	n/a
OCT-FY20	5.0	6.2	5.1	0.7	5.4	7.2
NOV-FY20	5.2	7.1	7.6	2.5	3.7	6.7
DEC-FY20	5.2	8.4	12.6	3.7	4.8	8.5
JAN-FY20	4.0	4.5	18.4	4.4	4.0	13.1
FEB-FY20	3.1	2.6	19.6	2.7	3.0	9.4
MAR-FY20	3.5	2.1	23.2	5.8	4.0	12.4

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.

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

Subj: Comprehensive Healthcare Inspection of the Hampton VA Medical Center in Virginia

To: Director, Office of Healthcare Inspections (54CH03)

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 Hampton VA Medical Center in Virginia.

2. I have reviewed the recommendations and concur with the responses and actions provided by our team at the Hampton VA Medical Center to ensure we continue to deliver excellent care to our Veterans.

(Original signed by:)

Paul S. Crews, MPH, FACHE

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: October 18, 2021

From: Director, Hampton VA Medical Center (590/00)

Subj: Comprehensive Healthcare Inspection of the Hampton VA Medical Center in Virginia

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Hampton VA Medical Center. This review serves as part of the ongoing process to improve the care provided to our Veterans.

2. I have reviewed and concur with the recommendations. I will ensure the actions to correct the findings are completed and sustained as described in the responses.

   (Original signed by:)

   Taquisa K. Simmons, PhD, LCSW

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