DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia

CHIP REPORT | REPORT #21-00280-89 | MARCH 8, 2022

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Figure 1. *Hunter Holmes McGuire VA Medical Center in Richmond, Virginia. Source: https://www.va.gov/richmond-health-care/ (accessed January 31, 2022).*

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Hunter Holmes McGuire VA Medical Center and associated outpatient clinics in Virginia. 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 inspection of the Hunter Holmes McGuire VA Medical Center during the week of May 10, 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 inspection. Although it is difficult to quantify the risk of patient harm, the findings may help this medical center and other Veterans Health

[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)."

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

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued nine 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 inspection, the medical center's leadership team consisted of the Medical Center Director, Chief of Staff, Associate Director for Patient Care Services, Associate Director, and Assistant Director. 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. Leaders monitored patient safety and care through the Quality, Safety, and Value Council, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the medical center's leaders had worked together for 19 months. The Chief of Staff, permanently assigned in September 2015, was the most tenured leader. The Associate Director for Patient Care Services, assigned in September 2019, was the newest member of the leadership team. The Assistant Director was assigned in May 2018, and the Associate Director and Director had served in their positions since October 2018 and March 2019, respectively.

The medical center's fiscal year 2020 annual medical care budget of $943,808,539 increased by nearly 26 percent compared to the previous year's budget, and the executive leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.[2] During an interview with the OIG, the Director indicated the fiscal year 2020 budget increase helped the medical center expand services by funding the construction of a new women's health building, enabling leaders to hire additional nurses and medical support assistants, and supporting pandemic efforts.

For the selected employee survey leadership questions, scores for the Director, Assistant Director, and Associate Director were generally similar to or more favorable than VHA averages. The OIG found the averages for the medical center, Chief of Staff, and Associate Director for Patient Care Services were generally similar to or lower than VHA averages. Opportunities appeared to exist for the Chief of Staff and Associate Director for Patient Care

[2] VHA Support Service Center.

Services to improve employee attitudes toward leaders and the workplace, and for the Director to reduce employee feelings of moral distress at work.[3] Further, the scores highlighted opportunities for the Chief of Staff and Associate Director for Patient Care Services to create an environment where staff feel respected and safe, and discrimination is not tolerated.

Inpatient survey results indicated opportunities for leaders to improve patient experiences. For selected patient satisfaction in outpatient settings, overall survey respondents generally rated patient-centered medical home experiences higher than VHA averages. However, survey results revealed opportunities for leaders to improve female patients' specialty care experiences.

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 factors contributing to poor performance on specific SAIL and Community Living Center SAIL measures.[6] The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify substantial organizational risk factors.[7] In individual interviews, the executive leaders were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and patient experiences.

[3] "2020 VA All Employee Survey (AES): Questions by Organizational Health Framework," VA Workforce Surveys Portal, VHA Support Service Center, accessed July 29, 2021, http://aes.vssc.med.va.gov/SurveyInstruments/_layouts/15/DocIdRedir.aspx?ID=QQVSJ65U5ZMQ-229890423-174. (This is an internal website not publicly accessible.) The 2020 All Employee Survey defines moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing."

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

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

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

[7] 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."

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 medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions. However, the OIG identified areas for improvement in the Systems Redesign and Improvement Program, protected peer review, and the Surgical Work Group's processes.[8]

Medication Management

The OIG team observed compliance with many elements of expected performance, including staff availability to receive remdesivir shipments, completion of required testing prior to remdesivir administration, and reporting of adverse events. However, the OIG found deficiencies with the provision of patient/caregiver education prior to remdesivir administration.

Care Coordination

The medical center met expectations for nurse-to-nurse communication between sending and receiving facilities. However, the OIG identified concerns with the existence of an inter-facility transfer policy, monitoring and evaluation of inter-facility transfers, completion of the VA *Inter-Facility Transfer Form* or facility-defined equivalent, and transmission of patients' active medication lists and advance directives to receiving facilities.[9]

[8] 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.

[9] VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017. (This directive was rescinded and replaced by VHA Directive 1094, *Inter-Facility Transfer,* January 20, 2022. The two documents contain similar language regarding the risks of patient transfers, but VHA removed the requirement for facilities to have a written policy.) 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.

High-Risk Processes

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

Conclusion

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

VA 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 62–63, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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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 Hunter Holmes McGuire VA Medical Center and related community-based 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 inspection, 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)

[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)."

4. Registered nurse credentialing
5. Medication management (targeting remdesivir use)
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8. High-risk processes (examining the management of disruptive and violent behavior)

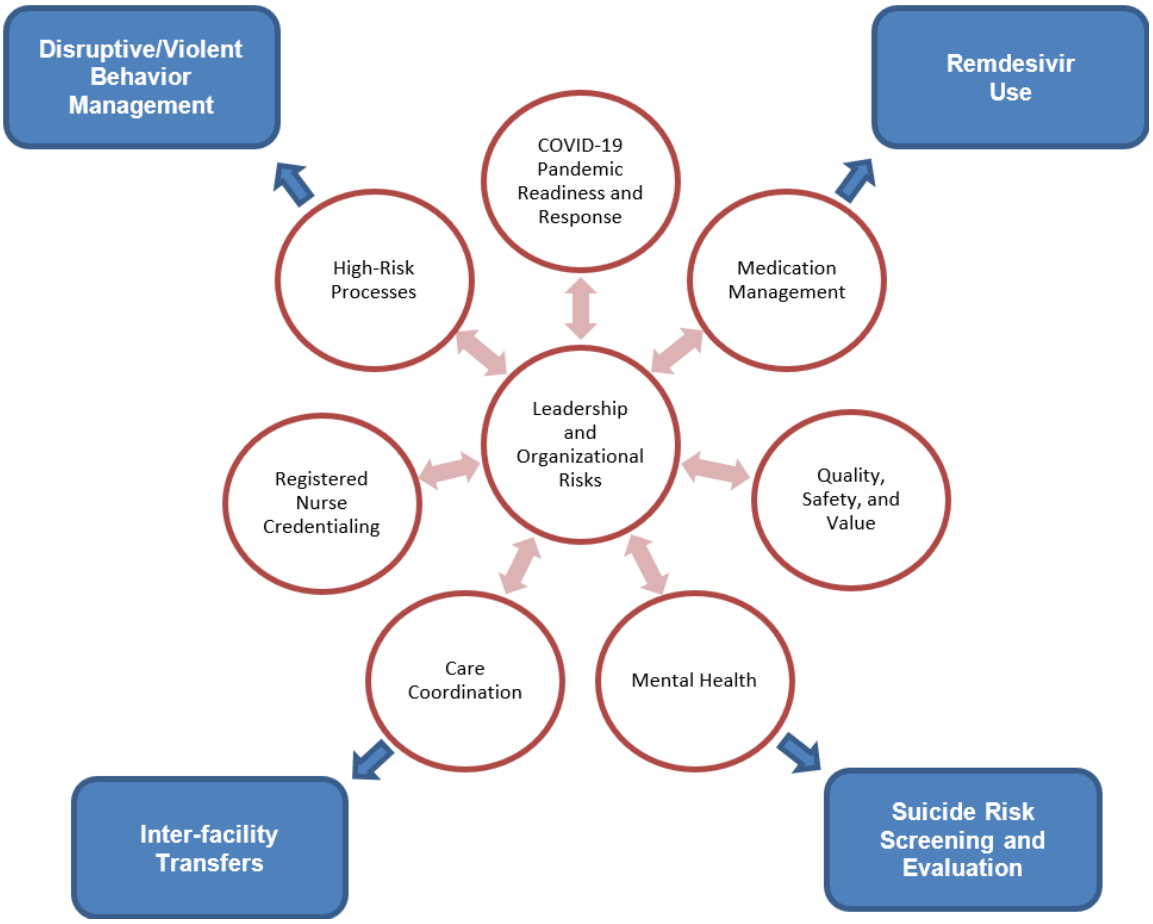


Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services. Source: VA OIG.*

Methodology

The Hunter Holmes McGuire VA Medical Center also provides care through multiple outpatient clinics in Virginia. 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 January 12, 2019, through May 14, 2021, the last day of the unannounced multiday evaluation.[7] During the virtual site visit, 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 Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that the 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 medical center. Leadership and organizational risks can affect a medical center'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), Associate Director, and Assistant Director. The Chief of Staff and ADPCS oversaw patient care, which required managing service directors and chiefs of programs and practices.

[9] Laura Botwinick, Maureen Bisognano, and Carol Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare Improvement, Innovation Series White Paper, 2006.
[10] VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers*, June 1, 2017. CLCs, previously known as nursing home care units, provide a skilled nursing environment and a variety of interdisciplinary programs for persons needing short- and long-stay services.

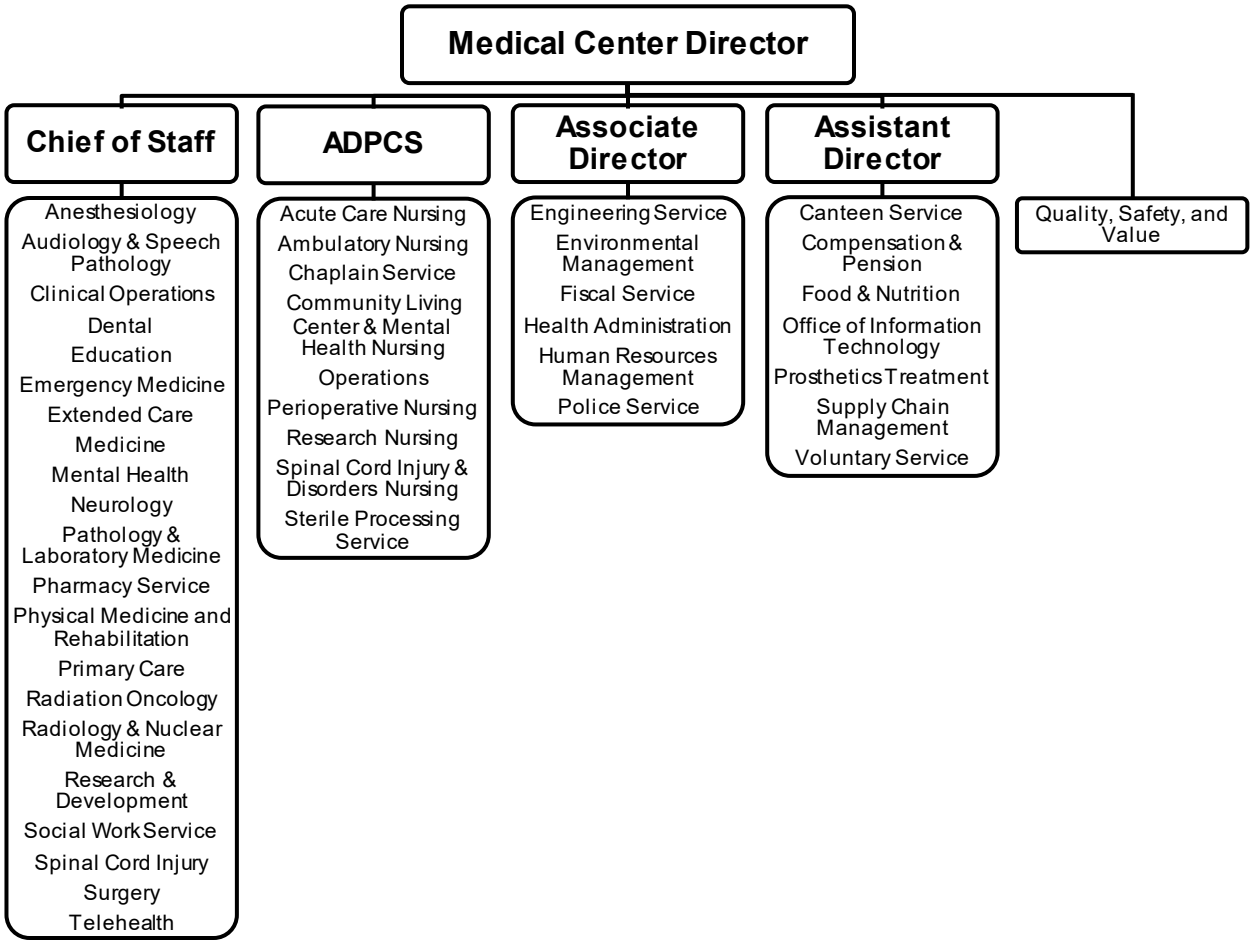


Figure 3. *Medical center organizational chart.*

Source: Hunter Holmes McGuire VA Medical Center (received May 10, 2021).

At the time of the OIG inspection, the executive team had worked together for 19 months, although the Chief of Staff had been in the role since 2015 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	March 3, 2019
Chief of Staff	September 6, 2015
Associate Director for Patient Care Services	September 15, 2019
Associate Director	October 28, 2018
Assistant Director	May 13, 2018

Source: VISN Senior Strategic Business Partner (received May 10, 2021).

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 such as the Medical Executive; QSV; and Patient Service Executive Councils. Medical center leaders monitored patient safety and care through the QSV Council, which was responsible for tracking and trending quality of care and patient outcomes (see figure 4).

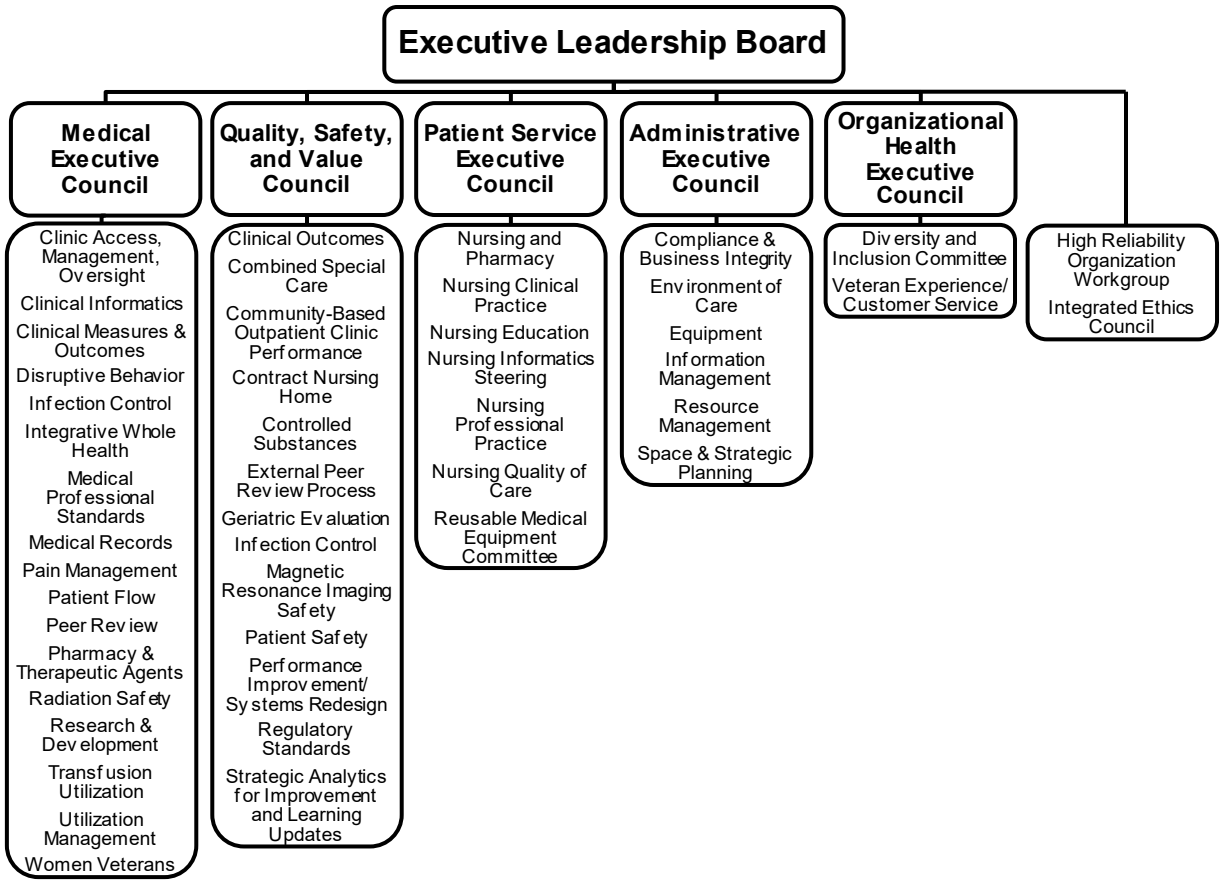


Figure 4. *Medical center committee reporting structure.*
Source: Hunter Holmes McGuire VA Medical Center (received May 10, 2021).

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

Budget and Operations

The medical center's FY 2020 annual medical care budget of $943,808,539 increased by nearly 26 percent compared to the previous year's budget of $749,267,054.[11] When asked about the effect of this change on medical center operations, the Director indicated that the budget increase helped the medical center expand services by funding the construction of a new women's health building, enabling leaders to hire additional nurses and medical support assistants, and supporting pandemic efforts. Additional pandemic-related activities supported by the increased budget included purchasing testing equipment, creating a drive-through clinic for screening and treatment, and establishing an infectious disease surveillance clinic to ensure adequate follow-up care.

Staffing

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

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[15] The executive leaders confirmed that the occupations listed in table 2, except for custodial workers, remained the top clinical and nonclinical shortages at the time of the OIG inspection. During interviews with the executive team, the Associate Director asserted that the medical center had a sufficient number of custodial workers. Leaders reported ongoing challenges recruiting and retaining specialty care providers (including psychiatrists, psychologists, and hematology/oncology specialists), registered nurses, and licensed practical nurses. The Chief of Staff attributed challenges with recruiting hematology/oncology specialists to the medical center's inability to compete with the private sector's higher salaries. To recruit specialty care providers, the Chief of Staff reported collaborating with the local university 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.*

offer dual faculty appointments to providers who were willing to work part-time at the medical center. The Chief of Staff also reported paying bonuses over a three- or four-year period for recruitment and retention to address specialty care provider shortages. Regarding nursing shortages, the ADPCS stated that the nurse recruiter implemented strategies such as participating in career fairs and hiring student nurses after graduation.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Psychiatry	1. Medical Support Assistance
2. Psychology	2. Custodial Worker
3. Hematology/Oncology	3. –
4. Social Work	4. –

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. Scores for the Director, Assistant Director, and Associate Director were generally similar to or more favorable than VHA averages. Results for the selected survey leadership questions for the medical center, Chief of Staff, and ADPCS were generally similar to or lower than VHA averages.[19]

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

[17] "AES Survey History."

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

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

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	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	71.0	87.5	73.0	70.3	–†	76.7
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	3.9	3.3	3.3	3.3	3.7
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	4.2	3.6	3.4	4.0	3.8
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.6	4.2	3.6	3.5	3.8	3.8

Source: VA All Employee Survey (accessed April 12, 2021).

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

†All Employee Survey results did not include a score for the Associate Director related to the Servant Leader Index Composite.

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[20] The Associate Director and Assistant Director averages for selected survey questions were similar to or better than the VHA averages. The medical center averages for the

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

survey questions were slightly less favorable than the VHA averages. The Chief of Staff and ADPCS reported increasing their physical presence in clinical areas, enhancing staff communication, and participating in townhalls. Additionally, the survey results identified opportunities for the Director to reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing). The Director attributed the less favorable score to general healthcare challenges. Leaders discussed routinely visiting each work area to improve staff engagement.

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	Asst. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.6	4.5	3.7	3.6	4.7	4.0
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.6	3.8	3.7	3.6	4.0	4.1
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	1.5	1.6	1.4	1.4	1.4	1.4

Source: VA All Employee Survey (accessed April 12, 2021).

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

To demonstrate commitment to a culture of safety, the Director described implementing a campaign that included hanging educational posters in highly visible areas and incorporating the expectation of zero tolerance for discrimination into the *Daily Buzz* (the medical center's electronic newsletter).

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses.[23] Averages for the selected survey questions for the Director, Associate Director, and Assistant Director were consistently higher than the medical center and VHA averages. Scores for the Chief of Staff and ADPCS were slightly lower than VHA averages, which indicated an opportunity for those leaders to develop an environment where staff feel respected and safe, and discrimination is not tolerated. The Director explained that medical center leaders created an administrative support position to help the Equal Employment Opportunity Manager be more visible and available to employees.

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	Asst. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.7	4.0	3.8	3.7	4.8	4.2
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)–5 (Strongly Agree)	4.1	3.9	4.2	4.0	3.8	4.4	4.4

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

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

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director	Asst. Director Average
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.7	4.1	3.7	3.6	4.6	4.3

Source: VA All Employee Survey (accessed April 12, 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 (PCMH), and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides survey results for VHA and the medical center.[24] For this medical center, patients scored their overall inpatient experience lower than the VHA average. Leaders attributed this to an aging facility infrastructure with some remaining semi-private rooms and a high noise level. The executive team reported ongoing construction of single-patient rooms and installing noise level monitors (lights warning staff of high noise levels on the patient care units). Survey respondents rated PCMH and specialty care slightly higher than the VHA average, indicating general satisfaction with outpatient care. The Director attributed overall satisfaction to the executive team's timely review and prompt response to patient feedback. For example, the Chief of Staff discussed streamlining the process for scheduling appointments in the eye clinic to address patient complaints. Additionally, the Director spoke about "priming the pump" for positivity by displaying patients' positive comments throughout the organization.

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

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	63.1
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	82.9
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	85.4

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

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[25] 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, PCMH, and Specialty Care surveys (see tables 7–9). The inpatient survey results revealed that male and female patients were less likely to recommend the hospital when compared to VHA patients nationally. The Chief of Staff attributed the lower scores to the old infrastructure and lack of an aesthetically pleasing environment. Leaders reported creating focus groups to identify opportunities for improvement as well as starting new construction with design upgrades (painting, hanging artwork, and purchasing new furniture for waiting rooms). While female respondents perceived that nurses treated them with courtesy and respect, the survey results indicated that leaders have an

[25] "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.

opportunity to improve male patients' perceptions. The executive team attributed the lower male scores to a reluctance to share private information with a mostly female nursing population. Leaders shared plans to obtain more specific information from patient focus group sessions.

In outpatient settings, patient survey results revealed generally favorable PCMH experiences for both genders when compared to VHA averages. However, the results indicated opportunities for leaders to improve female patients' experiences in specialty care clinics. The Chief of Staff attributed the lower scores to the lack of gender-specific specialty care. Leaders reported that efforts were underway to address the lower scores with the construction of a 14,000-square-foot women's health center, which will offer gynecology, mammography, mental health, and other services.

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	64.2	52.2
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	88.6	86.4
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	82.8	91.7

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 457–467 male and 42 or 43 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	59.7	56.7
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	58.3	56.7
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	75.5	76.0

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 394–1,102 male and 53–119 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	57.9	26.6
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	58.4	36.5
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	74.2	60.1

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

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

† The medical center averages are based on 657–1,919 male and 64–168 female respondents, depending on the question.

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.[26] Table 10 summarizes the relevant medical center inspections most recently performed by the OIG and The

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

Joint Commission (TJC).[27] At the time of the virtual OIG inspection, the medical center had closed all but one recommendation for improvement issued since the previous CHIP site visit conducted in January 2019. The Chief, Quality Management discussed the need for additional compliance data to address the remaining recommendation from a focused OIG report published on July 29, 2020, regarding the deficient practice of a pathologist.[28]

The OIG team also learned that the medical center was transitioning its laboratory services accreditation from the College of American Pathologists to TJC. In the interim, VHA's Pathology and Laboratory Medicine Service National Enforcement Office provided enforcement and oversight for the medical center's clinical laboratory, and the OIG noted the results from their latest review.[29]

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

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

[28] VA OIG, *Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia*, Report No. 19-07600-215, July 29, 2020.

[29] Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Clinical Laboratory Improvement Amendments (CLIA) Compliance Inspection During the COVID-19 Pandemic and Accreditation Contract Delayed*, April 6, 2020. "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." In 2020, VHA changed its laboratory accreditation process from the College of American Pathologists to The Joint Commission with an estimated resumption of accreditation inspections in January 2021.

[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."

[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 inspection took place April 25–26, 2019. This veterans service organization review does not result in accreditation status.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia*, Report No. 18-04679-239, September 27, 2019)	January 2019	21	0
OIG (*Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia,* Report No. 19-07600-215, July 29, 2020)	September 2019	10	1*
OIG (*Pharmacy Process Concerns and Improper Staff Communication at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia,* Report No. 20-01102-266, September 24, 2020)	February 2020	5	0
TJC Unannounced Office of Quality and Patient Safety Event	July 2019	0	0
TJC Hospital Accreditation	October 2020	27	0
TJC Behavioral Health Care Accreditation		1	0
TJC Home Care Accreditation		2	0
TJC Methadone Maintenance Program	February 2021	3	0

Source: OIG and TJC (inspection/survey results received from the Chief, Quality Management on May 10, 2021).

**This recommendation was closed on May 27, 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 January 12, 2019 (the prior OIG CHIP site visit), through May 10, 2021.[32] The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify substantial organizational risk factors.

Table 11. Summary of Selected Organizational Risk Factors (January 12, 2019, through May 10, 2021)

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

Source: Hunter Holmes McGuire VA Medical Center's Patient Safety Manager, Risk Manager, and Chief, Quality Management. (The OIG received sentinel events on May 10, 2021, and institutional disclosures on May 12, 2021.)

The Director spoke knowledgeably about serious adverse event reporting and conveyed that all adverse events are discussed during morning meetings. Leaders stated that the Patient Safety Manager monitors serious adverse events and regularly reports updates concerning ongoing investigations, with corresponding action plan implementation and closure, to the Executive Leadership Board. The Director reported personally addressing "zero harm," Just Culture, and psychological safety during new employee orientation.[33] In addition, the Director discussed

[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 Hunter Holmes McGuire VA Medical Center is a highest complexity (1a) affiliated center 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 leader(s) 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] Gary L. Sculli and Robin Hemphill, "Culture of Safety and Just Culture," VHA National Center for Patient Safety, 2013. "In a Just Culture, employees feel safe and protected when voicing concerns about safety and have the freedom to discuss their own actions, or the actions of others in the environment, with regard to an actual or potential adverse event."

embracing high reliability organization concepts and reorganizing the reporting structure to facilitate rapid process improvement.

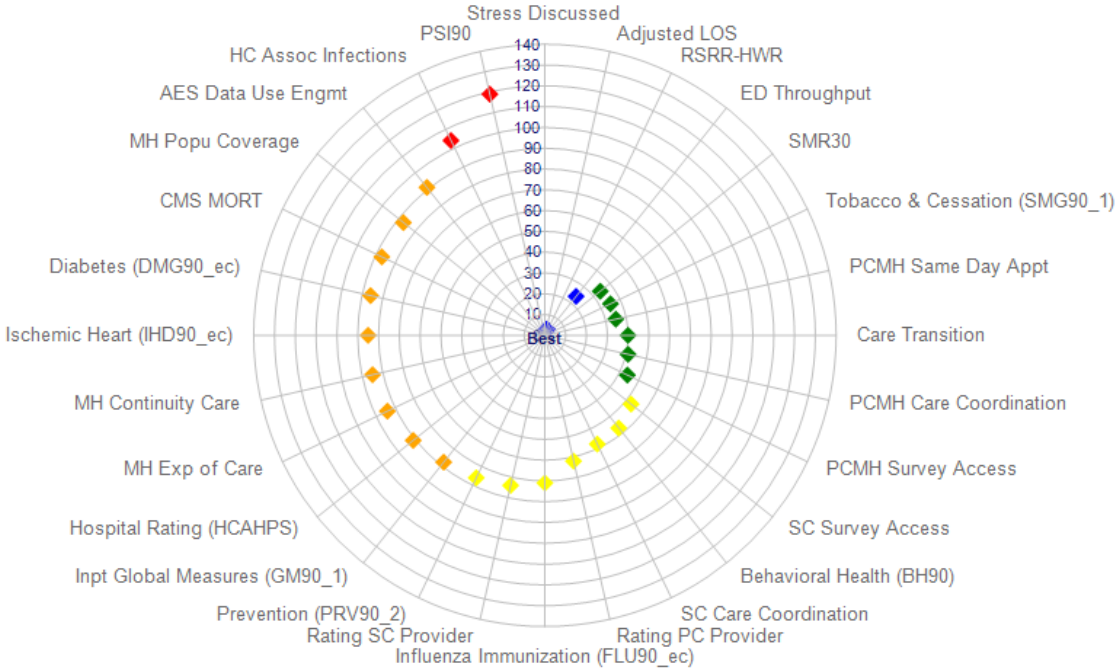
Veterans Health Administration Performance Data for the Medical Center

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[34] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[35]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 5 shows the Hunter Holmes McGuire 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 adjusted length of stay (LOS), emergency department (ED) throughput, and care transition). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, mental health (MH) continuity [of] care, All Employee Survey (AES) data use engagement (engmt), and health care (HC) associated (assoc) infections).[36]

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and factors contributing to poor performance on specific medical center SAIL measures.

[34] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center, accessed March 6, 2020, https://vssc.med.va.gov. (This is an internal website not publicly accessible.)
[35] "Strategic Analytics for Improvement and Learning (SAIL) Value Model."
[36] For information on the acronyms in the SAIL metrics, please see appendix E.



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

Figure 5. *Medical center quality of care and efficiency metric rankings for FY 2021 quarter 1 (as of December 31, 2020).*

Source: VHA Support Service Center.

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

Veterans' Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA."[37] The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[38]

Figures 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2020. Figure 6 displays the Hunter Holmes McGuire VA Medical Center's CLC metrics with high performance (blue and green data points) in the first

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

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

and second quintiles (for example, in the areas of physical restraints–long-stay (LS), ability to move independently worsened (LS), and moderate-severe pain (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, falls with major injury (LS), urinary tract infection (UTI) (LS), and catheter in bladder (LS)).[39]

The executive leaders were knowledgeable within their scope of responsibilities about factors contributing to poor performance on specific CLC SAIL measures.

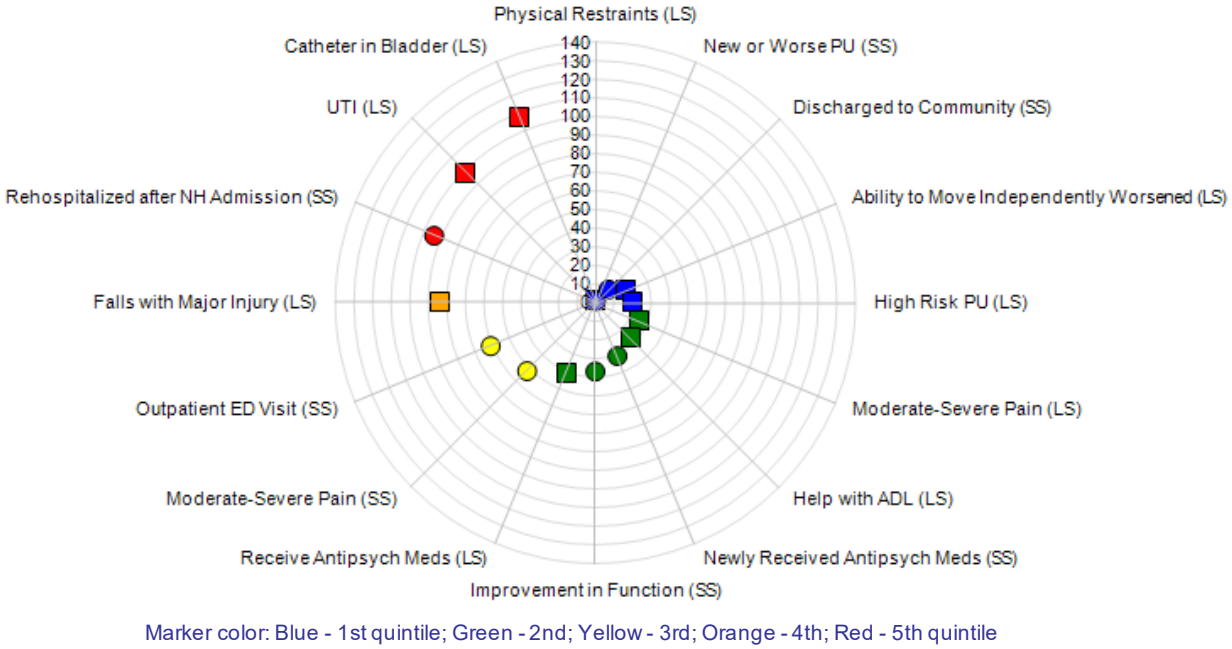


Figure 6. *CLC quality measure rankings for FY 2020 quarter 4 (as of September 30, 2020).*
LS = Long-Stay Measure. *SS = Short-Stay Measure.*
Source: VHA Support Service Center.
Note: The OIG did not assess VA's data for accuracy or completeness.

Leadership and Organizational Risks Findings and Recommendations

During the virtual inspection, the executive leadership team appeared stable and had worked together for 19 months. 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. Leaders supported the medical center's work to become a high reliability organization and implemented interim strategies to address clinical and nonclinical occupational shortages.

[39] For information on the acronyms in the SAIL CLC measures, please see appendix F.

The medical center's FY 2020 annual medical care budget of $943,808,539 increased by nearly 26 percent compared to the previous year's budget.[40] The FY 2020 budget increase helped medical center leaders fund the construction of a new women's health building, hire additional nurses and medical support assistants, and support the needs of the pandemic.

For the selected employee survey leadership questions, the OIG found the medical center averages were generally lower than VHA averages. Opportunities appeared to exist for the Chief of Staff and ADPCS to improve employee attitudes toward leaders and the workplace and create an environment where staff feel respected and safe, and discrimination is not tolerated. Further, the scores highlighted an opportunity for the Director to reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing).

Generally, patient experience data identified opportunities to improve inpatient care. Overall, survey respondents rated PCMH slightly higher than the VHA averages, indicating general satisfaction with outpatient care. However, survey results revealed opportunities for leaders to improve female patients' specialty care experiences.

The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify substantial organizational risk factors. The leadership team was knowledgeable, within their scope of responsibility, about medical center and CLC SAIL measures but should continue efforts to improve performance. In individual interviews, leaders were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and patient experiences.

The OIG made no recommendations.

[40] VHA Support Service Center.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[41] VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.[42]

During this time, VA continued providing care to veterans and engaged its fourth mission, the "provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have VA eligibility for such care and services."[43] "In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans."[44]

Due to VHA's mission-critical work in supporting 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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[41] "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, accessed December 8, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

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

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

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[45] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[46] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as 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."[47]

To determine whether VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the 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."[48] Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[49] The OIG team examined various requirements related to systems redesign and improvement:

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

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

Next, the OIG assessed the medical center's processes for conducting protected peer reviews of clinical care.[50] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[51] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[52] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[53]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[54]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the 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."[55] The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) Operational oversight of surgical services and quality improvement activities;

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

[51] VHA Directive 1190.

[52] VHA Directive 1190.

[53] VHA Directive 1190.

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

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

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[56] 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[57]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[58]

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for QSV oversight functions. However, the OIG identified areas for improvement in the Systems Redesign and Improvement Program, protected peer review, and the Surgical Work Group's processes.

VHA requires the Systems Redesign and Improvement Coordinator to track facility-level improvement capabilities and projects.[59] Based on the information provided by medical center staff, the OIG did not find evidence that the Coordinator tracked improvement capabilities and projects from April 1, 2020, through March 31, 2021. This may have resulted in missed opportunities to identify resources needed to support activities and monitor progress made by improvement teams. The Systems Redesign and Improvement Coordinator stated that projects were facilitated and tracked independently by various venues and committees and believed having access to the groups' databases met the requirement.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures the Systems Redesign and Improvement Coordinator tracks facility-level improvement capabilities and projects.

[56] "NSO Reporting, Resources, & Tools."
[57] VHA Directive 1102.01(1), *National Surgery Office,* April 24, 2019, amended May 22, 2019.
[58] For CHIP visits, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.
[59] VHA Directive 1026.01.

Medical center concurred.

Target date for completion: March 2022

Medical center response: The Medical Center Director evaluated reasons for noncompliance and determined no additional reasons for noncompliance. The Chief of Quality Management and Systems Redesign Coordinator reviewed the process of capturing and documenting facility-level capabilities and projects. To comply with VHA Directive 1026.01, a decision was made to utilize VHA's National Quality Improvement Tracking Tool (QuITT) to track project progress and outcomes more effectively while contributing to nationwide VHA knowledge and sharing. Starting in October 2021, the Systems Redesign Coordinator began tracking approved projects, i.e., Lean Belt projects, service-level projects, etc. ensuring they are tracked and documented in QuITT with 90 percent or greater compliance for at least six consecutive months. This information will be reported to the Quality, Safety, and Value Council.

VHA requires that a final peer review is completed within 120 calendar days from the date it is determined that a peer review is needed, or the facility director approves a written extension request.[60] For final peer reviews conducted from April 2020 through March 2021, the OIG did not find evidence that staff completed 3 of 11 peer reviews within the expected time frame or received written extensions signed by the Director. This likely prevented timely improvements in patient care. The Risk Manager and Peer Review Coordinator cited a lapse in tracking and inadequate documentation as the reasons for noncompliance.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that staff complete a final peer review within 120 calendar days from the date it is determined that a peer review is needed, or the Medical Center Director approves an extension request in writing.

[60] VHA Directive 1190.

Medical center concurred.

Target date for completion: July 2022

Medical center response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The Peer Review Coordinator will monitor all peer reviews that are reported to the Peer Review Committee to ensure they are completed within the 120-day time frame or have a memo requesting extension.

The numerator will be the number of peer reviews completed within the 120-day time frame (or have a written request for extension) that are reported to the Peer Review Committee each month. The denominator will be the total number of peer reviews reported to the Peer Review Committee each month. This will provide the percent of compliance. The Peer Review Coordinator will monitor until 90 percent compliance is met for six (6) consecutive months. The data will be reported to the Medical Executive Council for oversight.

VHA requires the Peer Review Committee to complete a final review of peer review cases and recommend "non-punitive, non-disciplinary actions to improve the quality of health care delivered."[61] The OIG found no evidence that the committee recommended improvement actions for the medical center's two Level 3 peer reviews, which likely prevented improvements in providers' patient care practices. The Peer Review Coordinator stated the committee instructs service chiefs to discuss the cases with the individuals who are the subject of the peer review and believed this met the requirement.

Recommendation 3

3. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that the Peer Review Committee recommends improvement actions for Level 3 peer reviews.

[61] VHA Directive 1190.

Medical center concurred.

Target date for completion: July 2022

Medical center response: The Medical Center Director evaluated and determined no additional reasons for noncompliance. The Chief of Staff will ensure all Level 3 peer reviews are discussed by the committee and provide recommended actions. The Peer Review Coordinator will monitor peer reviews that are reported to the Peer Review Committee to ensure the committee recommends improvement actions for Level 3 peer reviews. The numerator will be the number of Level 3 peer reviews with committee recommended actions. The denominator will be the total number of Level 3 peer reviews reported to the Peer Review Committee each month. This will provide the percent of compliance. The Peer Review Coordinator will monitor until 90 percent compliance is met for six (6) consecutive months. The data will be reported to the Medical Executive Council for oversight.

VHA requires medical facilities that have surgery programs to have a surgical work group responsible for

"1. A monthly review of surgical deaths;

2. An analysis of efficiency and utilization metrics;

3. An identification of gaps within current surgical care;

4. A review of NSO [National Surgery Office] surgical quality reports; and

5. An evaluation of critical surgical events."[62]

The OIG reviewed the Surgical Work Group's meeting minutes from April 2020 to March 2021 and did not find evidence that the group reviewed surgical deaths.[63] Failure to review surgical deaths may result in missed opportunities to improve patient safety. The Chief of Surgery stated that the Surgical Work Group reviewed surgical deaths but did not annotate it in the minutes to protect personal identifiable information.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that the Surgical Work Group reviews surgical deaths.

[62] VHA Directive 1102.01(1).

[63] The Chief of Surgery confirmed that the Surgical Work Group, although not listed in the committee reporting structure in figure 4, reports to the Medical Executive Council every six months.

Medical center concurred.

Target date for completion: July 2022

Medical center response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The Surgical Work Group will include discussion of all surgical deaths and ensure evidence is documented in the Surgical Work Group minutes. The Administrative Officer of Surgical Services, or designee, will monitor Surgical Work Group minutes each month to ensure there is documented evidence of discussion of all surgical deaths. Monitoring will continue until 90 percent compliance is met for six (6) consecutive months. The data will be reported to the Medical Executive Council for oversight.

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."[64] 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."[65]

VA requires all RNs to hold at least one active, unencumbered license.[66] 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.[67] 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.[68] 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.[69]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 48 RNs hired from January 1, 2020, through April 11, 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 48 RNs to determine whether medical center staff completed primary source verification prior to the appointment.

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

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

[66] VHA Directive 2012-030, replaced by VHA Directive 1100.20. The two documents contain similar language regarding RN licenses. "Definition of *Unencumbered license,"* Law Insider, accessed December 3, 2020, https://www.lawinsider.com/dictionary/unencumbered-license. An unencumbered license is "a license that is not revoked, suspended, or made probationary or conditional by the licensing or registering authority in the respective jurisdiction as a result of disciplinary action."

[67] 38 U.S.C. § 7402.

[68] VHA Directive 2012-030, replaced by VHA Directive 1100.20.

[69] VHA Directive 2012-030, replaced by VHA Directive 1100.20.

Registered Nurse Credentialing Findings and Recommendations

The medical center generally met the requirements listed above. The OIG made no recommendations.

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[70] 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.[71]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[72] 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.[73]

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."[74] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[75]

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 30 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

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

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

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

[73] 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.*

[74] 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.

[75] 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)[76]
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[77]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The medical center generally met the requirements listed above. However, the OIG identified deficiencies with the provision of patient/caregiver education prior to remdesivir administration.

Under the Emergency Use Authorization, the VA Pharmacy Benefits Management Services required healthcare providers to provide the *Fact Sheet for Patients and Parents/Caregivers*, 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.[78] For the 30 patients who received remdesivir, the OIG determined that healthcare providers did not

- provide 70 percent of patients or caregivers with the *Fact Sheet for Patients and Parents/Caregivers*,
- inform 43 percent of patients or caregivers that remdesivir was not an FDA-approved medication,
- inform 30 percent of patients or caregivers of the option to refuse the medication,
- advise 37 percent of patients or caregivers of the known risks and benefits, or

[76] "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."

[77] "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.

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

- advise any of the patients or caregivers of alternatives to receiving remdesivir prior to administration.

This could have resulted in patients or caregivers lacking the information needed to make a fully informed decision to receive the medication. The Chief of Pulmonary-Critical Care Medicine reported believing that counseling was provided but not adequately 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.[79]

[79] 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.[80] 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.[81] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[82]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[83] The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.[84] 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

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

- relevant documents;

[80] "Suicide Prevention: Facts About Suicide," Centers for Disease Control and Prevention, accessed October 8, 2021, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.
[81] Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, November 2020.
[82] Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*.
[83] 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.
[84] DUSHOM Memorandum, *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives*, October 17, 2019.

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

Mental Health Findings and Recommendations

The medical center met the requirements listed above. The OIG made no recommendations.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[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 key employees. The team also reviewed the electronic health records of 35 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 medical center met expectations for nurse-to-nurse communication between sending and receiving facilities. However, the OIG identified deficiencies with the existence of an inter-

[85] VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017. (This directive was rescinded and replaced by VHA Directive 1094, *Inter-Facility Transfer*, January 20, 2022. The two documents contain similar language regarding the risks of patient transfers.)
[86] VHA Directive 1094. (In the updated directive, VHA removed the requirement for facilities to have a written policy.)
[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. The old and new directives contain similar language describing the documentation elements required at the time of transfer.

facility transfer policy, monitoring and evaluation of inter-facility transfers, completion of the VA *Inter-Facility Transfer Form* or facility-defined equivalent, and transmission of patients' active medication lists and advance directives to receiving facilities.

At the time of the virtual visit, VHA required that each VA facility have a written policy to ensure "the safe, appropriate, orderly, and timely transfer of patients."[88] The OIG did not find evidence of an inter-facility transfer policy. The absence of a policy could result in the lack of coordination between facilities to ensure seamless care for patients during the transfer process. The Clinical Command Center Chief reported believing the use of the VISN 6 inter-facility transfer policy met the requirement. On January 20, 2022, VHA updated its inter-facility transfer directive and removed the requirement for medical facilities to have a written policy; therefore, the OIG did not issue a recommendation.

VHA requires that "all transfers are monitored and evaluated as part of VHA's Quality Management Program."[89] The OIG found that staff had a tracking process for current transfers but did not find evidence they monitored or evaluated all transfer data.[90] Failure to monitor patient transfer data could prevent the identification of system-level deficiencies that may place patients at risk. The Clinical Command Center Chief reported being unaware of the requirement.

Recommendation 5

5. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that staff monitor and evaluate inter-facility transfers.

Medical center concurred.

Target date for completion: July 2022

Medical center response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The Chief of the Clinical Command Center will review all inter-facility transfers to ensure requirements are met and report the findings to the Utilization Management Committee and the Medical Executive Council for oversight. Monitoring will continue until 90 percent compliance is met for six (6) consecutive months. Results will be reported quarterly to the Medical Executive Council.

VHA requires the Chief of Staff and ADPCS to ensure that providers complete the VA *Inter-Facility Transfer Form* or an equivalent note, which includes documentation of the patient's informed consent for transfer and an assessment of the patient's medical and behavioral stability,

[88] VHA Directive 1094. In the updated directive, VHA removed the requirement for facilities to have a written policy.

[89] VHA Directive 1094.

[90] Staff provided a log of patient transfer activities to the OIG on May 12, 2021. The log contained data for current patient transfers but had no historical data.

prior to transfer.[91] The OIG estimated that providers did not complete the VA *Inter-Facility Transfer Form* or an equivalent note for 29 percent of patients who were transferred (95% CI: 14.3 and 44.1 percent), which is statistically significantly above the 10 percent deficiency benchmark. Additionally, an estimated 26 percent of transfer notes (95% CI: 11.8 and 41.2 percent) lacked documentation of the patients' informed consent and an assessment of their medical and behavioral stability, which is statistically significantly above the 10 percent deficiency benchmark. These deficiencies could result in unsafe patient transfers and treatment decisions that compromise patient safety.

The Clinical Command Center Chief explained that the medical center's process was to complete community care consults and discharge summaries in lieu of the VA *Inter-Facility Transfer Form* for community care referrals and reported being unaware that the consults and summaries did not include all required elements. The Clinical Command Center Chief acknowledged that providers did not obtain consent or document the reason consent was not obtained for patients who lacked mental capacity. The Emergency Department Chief stated there were technological issues with the electronic consent system and that staff did not consistently scan paper consents into the electronic health record. The same leaders attributed providers' noncompliance to being unaware of the requirement to use the VA *Inter-Facility Transfer Form* or an equivalent note to record patients' stability for transfer.

Recommendation 6

6. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure transferring providers complete all required elements of the VA *Inter-Facility Transfer Form* or a facility-defined equivalent prior to patient transfers.

Medical center concurred.

Target date for completion: July 2022

Medical center response: The Chief of Staff and Associate Director for Patient Care Services evaluated and determined no additional reasons for noncompliance. The Chief of the Clinical Command Center monitors inter-facility transfers to ensure transferring providers complete all the required elements of the VA Inter-Facility Transfer Form or a facility-defined equivalent, prior to patient transfers. Monitoring will continue until 90 percent compliance is met for six (6) consecutive months. The Chief of the Clinical Command Center will report the data quarterly to the Medical Executive Council.

[91] VHA Directive 1094.

VHA requires that the Chief of Staff and ADPCS ensure staff send all pertinent medical records with the patient during inter-facility transfers. This includes an active patient medication list and advance directive, when applicable.[92] The OIG estimated that 96 percent of electronic health records (95% CI: 86.7 and 100.0 percent) lacked evidence that staff sent an active medication list to the receiving facility, which is statistically significantly above the 10 percent deficiency benchmark. Further, the OIG found that for the five patients who had an advance directive, staff did not send a copy to the receiving facility. As a result, there was no assurance that receiving facility staff had the information needed to properly care for patients or determine patient preferences regarding future health care decisions in the event the patient no longer had decision-making capability. The Emergency Department Chief reported believing that patients' active medication lists were sent but not documented because staff used the community care consult template, which did not include all elements of the VA *Inter-Facility Transfer Form*. The Chief also stated that providers were unaware of how to access advance directive information, and that directives completed in other states could not be transferred to community facilities. Due to the low number of patients identified for the advance directive review element, the OIG made no recommendation.

Recommendation 7

7. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and make certain that staff send pertinent medical records, including an active patient medication list, to the receiving facility during inter-facility transfers.

Medical center concurred.

Target date for completion: July 2022

Medical center response: The Chief of Staff and Associate Director for Patient Care Services evaluated and determined no additional reasons for noncompliance. The Clinical Command Center developed additional responsibilities for the Transfer Coordinator to review and document what was sent to the receiving facility by utilizing the Medical Records Checklist for Transfer template for each inter-facility transfer; inclusive of pertinent medical records, including active patient medication lists to the receiving facility. This data will be monitored until 90 percent compliance has been achieved for six consecutive months. Evidence of compliance has been documented beginning in the January 2022 Utilization Management Committee meeting and will be reported quarterly to the Medical Executive Council.

[92] 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."[93] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[94] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team[95]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[96]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[97]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[98]

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

[94] VHA Directive 2012-026.

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

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

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

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

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high-risk, staff are required to complete parts 1, 2, and 3 of the training.[99] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[100] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

The medical center generally met many of the requirements for the management of disruptive and violent behavior. However, the OIG noted concerns with required representatives attending Disruptive Behavior Committee meetings and staff training.

VHA requires the Chief of Staff and Nurse Executive (ADPCS) to establish a disruptive behavior committee or board comprised of a senior clinician as the chairperson; administrative support staff; a patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and Union Safety Committee.[101] The committee or board is responsible for coordinating with clinicians, recommending amendments to the patients' treatment plans that may reduce the patients' risk of violence, collecting and analyzing disruptive patient incidents, identifying system problems, and recommending to the Chief of Staff other actions related to the problem of patient violence.[102]

The OIG reviewed Disruptive Behavior Committee meeting minutes from April 2020 through March 2021 and found that a VA police representative did not attend 10 of 19 meetings (53 percent).[103] This could result in the committee taking a less comprehensive approach when assessing patients' disruptive behavior and carrying out other responsibilities. The Chief of Police attributed absences to scheduled leave and competing priorities.

[99] DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.
[100] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.
[101] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.
[102] VHA Directive 2010-053.
[103] The Union Safety Committee representative also did not consistently attend but was not included in the finding based on *Executive Order Ensuring Transparency, Accountability, and Efficiency in Taxpayer Funded Union Time Use*, issued May 25, 2018.

Recommendation 8

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

Medical center concurred.

Target date for completion: July 2022

Medical center response: The Chief of Staff and Associate Director for Patient Care Services evaluated and determined no additional reasons for noncompliance. The Chief, Mental Health & Behavioral Health Services, reviewed the Disruptive Behavior Committee charter to ensure it met requirements listed in VHA Directive 2010-053, VHA Directive 2012-026, and VHA Directive 5019.01. The Chair, Disruptive Behavior Committee, will capture attendance at the beginning of each committee meeting for each required member. All core members of the Disruptive Behavior Committee (DBC) have designated at least one alternate representative to be present at all DBC meetings. Committee members have been instructed to alert the DBC Chair and Co-chair of their absence and ensure an alternate representative will be present. The Chair of the Disruptive Behavior Committee, or designee, will monitor Disruptive Behavior Committee minutes each month to ensure there is documented evidence of all required members' participation. Monitoring will continue until 90 percent compliance is met for six (6) consecutive months. The data will be reported to the Medical Executive Council for oversight.

VHA requires that staff are assigned prevention and management of disruptive behavior training part 1 when hired and "additional levels of PMDB [Prevention and Management of Disruptive Behavior] training based on the risk for exposure to disruptive behaviors as determined in the facility Workplace Behavior Risk Assessment."[104] The OIG found that 14 of 30 selected staff (47 percent) did not complete the required training based on their work area's risk level. This could result in staff's lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Prevention and Management of Disruptive Behavior Coordinator reported that face-to-face training was not offered due to social distancing recommendations to prevent exposure to COVID-19.

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

Recommendation 9

9. 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.[105]

Medical center concurred.

Target date for completion: December 2022

Medical center response: The Medical Center Director evaluated reasons for noncompliance and determined no additional reasons for noncompliance. To ensure new employees complete the Prevention and Management of Disruptive Behavior (PMDB) training, onboarding staff are assigned Part I, II, and III in New Employee Orientation (NEO) based on the risk level assigned to their work area. For existing employees, additional trainers are being certified to train employees for Part II and Part III. The Chair, Disruptive Behavior Committee, will monitor staff compliance with completing required levels of PMDB training monthly until 90 percent compliance is maintained for six (6) consecutive months and distribute a report to the Deputy Associate Chief of Staff for Education, who will report compliance quarterly to the Medical Executive Council.

[105] 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 inspection of eight clinical and administrative areas and provided nine 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 nine OIG recommendations aimed at improving vulnerabilities that may 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 system issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Budget and operations • Staffing • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Identified factors related to possible lapses in care and 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	• The Peer Review Committee recommends improvement actions for Level 3 peer reviews. • The Surgical Work Group reviews surgical deaths.	• The Systems Redesign and Improvement Coordinator tracks facility-level improvement capabilities and projects. • Staff complete a final peer review within 120 calendar days or the Medical Center Director approves an extension request in writing.
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• Transferring providers complete all required elements of the VA *Inter-Facility Transfer Form* or a facility-defined equivalent prior to patient transfers. • Staff send pertinent medical records, including an active patient medication list, to the receiving facility during inter-facility transfers.	• Staff monitor and evaluate inter-facility transfers.
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• None	• Required representatives 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 highest complexity (1a) affiliated medical center reporting to VISN 6.[1]

Table B.1. Profile for Hunter Holmes McGuire VA Medical Center (652) (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	$768,487,126	$749,267,054	$943,808,539
Number of:			
• Unique patients	62,450	68,621	69,239
• Outpatient visits	766,596	801,525	732,102
• Unique employees§	3,303	3,523	3,393
Type and number of operating beds:			
• Community living center	98	98	98
• Domiciliary	16	16	16
• Medicine	80	80	80
• Mental health	22	22	22
• Rehabilitation medicine	42	42	42
• Spinal cord	100	100	100
• Surgery	44	44	44
Average daily census:			
• Community living center	36	43	34
• Domiciliary	10	8	7
• Medicine	43	44	37
• Mental health	16	16	13
• Neurology	0	0	0
• Rehabilitation medicine	28	26	19
• Spinal cord	49	48	32

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

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019†	Medical Center Data FY 2020‡
• Surgery	25	23	16

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
Fredericksburg, VA	652GA	9,186	6,068	Dermatology Endocrinology Gastroenterology Podiatry	Nuclear medicine	Nutrition Pharmacy Social work Weight management
Fredericksburg, VA	652GB	7,443	4,803	Dermatology Endocrinology Gastroenterology Physical Medicine & Rehabilitation physician	Laboratory & Pathology	Nutrition Pharmacy Social work Weight management

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

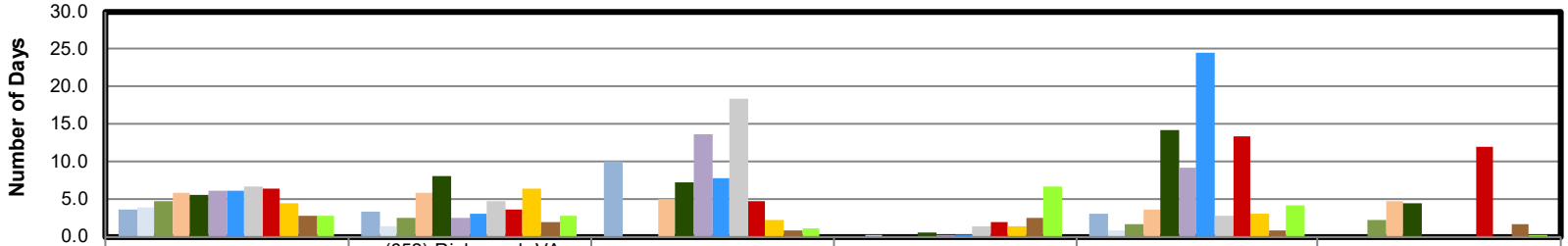
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Charlottesville, VA	652GE	6,991	4,299	Cardiothoracic Dermatology Endocrinology Gastroenterology General surgery Orthopedics Podiatry	Nuclear medicine	Nutrition Pharmacy Social work Weight management
Emporia, VA	652GF	2,997	1,104	Dermatology Endocrinology Podiatry	Laboratory & Pathology Nuclear medicine	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.

Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days

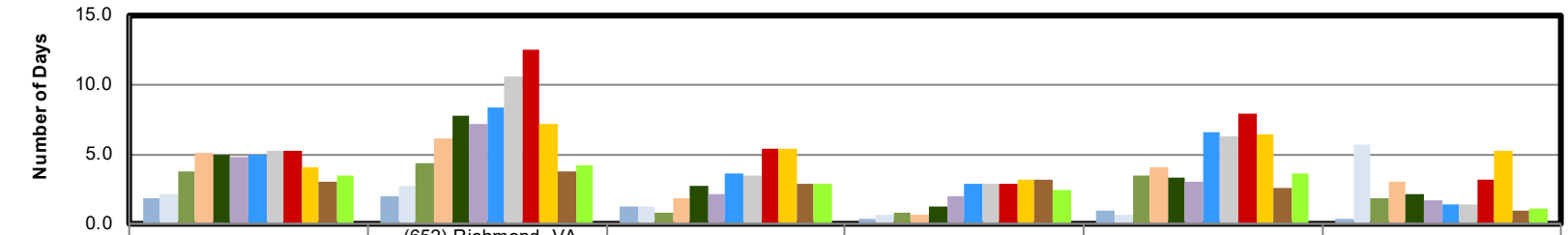


	All VHA	(652) Richmond, VA (Hunter Holmes McGuire)	(652GA) Fredericksburg, VA	(652GB) Fredericksburg 2, VA	(652GE) Charlottesville, VA	(652GF) Emporia, VA
APR-FY20	3.6	3.3	10.2	0.0	3.2	n/a
MAY-FY20	4.0	1.4	0.0	0.1	0.9	0.0
JUN-FY20	4.9	2.4	0.0	0.0	1.8	2.3
JUL-FY20	5.9	5.8	5.0	0.0	3.7	4.8
AUG-FY20	5.6	8.2	7.4	0.6	14.2	4.5
SEP-FY20	6.1	2.5	13.8	0.1	9.3	0.0
OCT-FY21	6.3	3.1	7.8	0.4	24.6	0.0
NOV-FY21	6.7	4.7	18.4	1.5	2.8	n/a
DEC-FY21	6.6	3.8	4.8	1.9	13.5	12.0
JAN-FY21	4.4	6.5	2.2	1.6	3.0	0.0
FEB-FY21	2.9	1.9	1.0	2.4	1.0	1.7
MAR-FY21	2.9	2.7	1.1	6.8	4.2	0.2

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed May 3. 2021.

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 possibly create date. The absence of reported data is indicated by "n/a."



	All VHA	(652) Richmond, VA (Hunter Holmes McGuire)	(652GA) Fredericksburg, VA	(652GB) Fredericksburg 2, VA	(652GE) Charlottesville, VA	(652GF) Emporia, VA
APR-FY20	1.9	2.0	1.3	0.3	0.9	0.4
MAY-FY20	2.1	2.8	1.2	0.7	0.6	5.8
JUN-FY20	3.7	4.3	0.8	0.7	3.5	1.8
JUL-FY20	5.1	6.1	1.8	0.7	4.1	3.0
AUG-FY20	5.0	7.7	2.7	1.3	3.4	2.1
SEP-FY20	4.9	7.2	2.1	1.9	3.0	1.7
OCT-FY21	5.0	8.4	3.7	2.8	6.6	1.4
NOV-FY21	5.2	10.6	3.5	2.8	6.3	1.4
DEC-FY21	5.2	12.6	5.4	3.0	7.9	3.2
JAN-FY21	4.0	7.2	5.3	3.1	6.5	5.2
FEB-FY21	3.1	3.8	2.9	3.2	2.6	1.0
MAR-FY21	3.5	4.2	2.8	2.4	3.6	1.1

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed May 3, 2021.

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."

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 (SC) 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: January 19, 2022

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

Subj: Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia

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

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

1. We appreciate the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Hunter Holmes McGuire Medical Center in Richmond, VA.

2. I have reviewed the recommendations and concur with the responses and submitted actions provided by our team at the Hunter Holmes McGuire 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: January 19, 2022

From: Director, Hunter Holmes McGuire VA Medical Center (652/00)

Subj: Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia.

2. I have reviewed and concur with the recommendations and will ensure the actions to correct the findings are completed and sustained as described in the responses. I appreciated the opportunity for this review as a continuing process to improve the care to our Veterans.

   (Original signed by:)

   J. RONALD JOHNSON, FACHE

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