



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the
Washington DC VA Medical
Center



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Figure 1. Washington DC VA Medical Center.

Source: <https://www.va.gov/washington-dc-health-care/locations/> (accessed April 29, 2021).

Abbreviations

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
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 Washington DC VA Medical Center, which includes the main campus and multiple outpatient clinics in Maryland; Virginia; and Washington, DC. 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 response¹
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 Washington DC VA Medical Center during the week of August 23, 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 Administration (VHA) facilities identify

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](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)."

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 Executive Director; Associate Director, Clinical Services; and Associate Director, Patient Care Services. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual inspection, the medical center had a leadership team consisting of the Executive Director; Deputy Executive Director; Associate Director, Clinical Services; and Associate Director, Patient Care Services. The executive team had worked together for over three months, after the new deputy executive director position was filled in May 2021. The Associate Director, Clinical Services; Associate Director, Patient Care Services; and Executive Director had served in their roles since 2016, 2017, and 2018, respectively.

Organizational communications and accountability were managed through a committee reporting structure, with Executive Leadership Board oversight of several working groups. The Executive 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 Executive Council, which was responsible for tracking and trending quality of care and patient outcomes.

The medical center's fiscal year 2020 annual medical care budget increased 15 percent compared to the previous year's budget, and the Executive Director discussed using the funds to reopen the community living center, which had been under renovation.² The leaders were also able to discuss interim strategies to address nonclinical occupational shortages.

The OIG reviewed employee satisfaction survey results and concluded that the scores for the executive leaders were generally better than those for VHA. Selected patient experience survey scores generally reflected lower care ratings than the VHA averages, which highlighted opportunities for leaders to improve inpatient and outpatient care experiences.

² VHA Support Service Center.

The inspection team also reviewed accreditation findings, sentinel events, and disclosures of adverse patient events and identified vulnerabilities for organizational risks.³ Specifically, the OIG identified concerns related to sentinel event and institutional disclosure reporting processes.

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 The executive leaders were generally knowledgeable, based on their tenure and scope of responsibilities, about VHA data and/or factors contributing to poor performance on specific SAIL measures. In individual interviews, the executive leadership team members were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

COVID-19 Pandemic Readiness and Response

The OIG reported 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.⁵

Quality, Safety, and Value

The medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions; protected peer reviews; and surgical work group processes.⁶ However, the OIG identified a weakness in the Systems Redesign and Improvement Program.

Registered Nurse Credentialing

The OIG found that registered nurses hired from July 1, 2020, through July 25, 2021, were free from potentially disqualifying licensure actions. However, staff did not consistently complete primary source verification of each registered nurse license prior to the appointment.

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

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

⁵ VA OIG, *Comprehensive Healthcare Inspection of Facilities’ COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

⁶ VHA Directive 1190. A peer review is a “critical review of care, performed by a peer,” to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements.

Medication Management

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

Mental Health

The medical center complied with requirements related to suicide prevention screening within emergency departments and urgent care centers. However, the OIG found that staff responsible for suicide safety plan development had not consistently completed the required training.

Care Coordination

Generally, the medical center met expectations with requirements for an inter-facility transfer policy, completion of the required VA *Inter-Facility Transfer Form* or facility-defined equivalent, and transmission of patients' active medication lists to receiving facilities.⁷ However, the OIG identified deficiencies with the monitoring and evaluation of inter-facility transfers, transmission of patients' advance directives to receiving facilities, and communication between nurses at sending and receiving facilities.

High-Risk Processes

The medical center generally complied with the establishment of a local policy for reporting and tracking disruptive behavior, implementation of a disruptive behavior committee, use of the Disruptive Behavior Reporting System, and completion of the Workplace Behavioral Risk Assessment. However, the OIG identified deficiencies with the Employee Threat Assessment Team, members' consistent attendance at Disruptive Behavior Committee meetings, and staff completion of required trainings.

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 Executive Director; Associate Director, Clinical Services; and Associate Director, Patient Care Services. The number of recommendations should not be used as a gauge for the overall quality of care

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

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



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

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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 Washington DC VA Medical Center and related outpatient clinics examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so that informed decisions can be made to improve care.¹

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

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual 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 response⁵
3. Quality, safety, and value (QSV)
4. Registered nurse (RN) credentialing

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

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

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

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

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

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

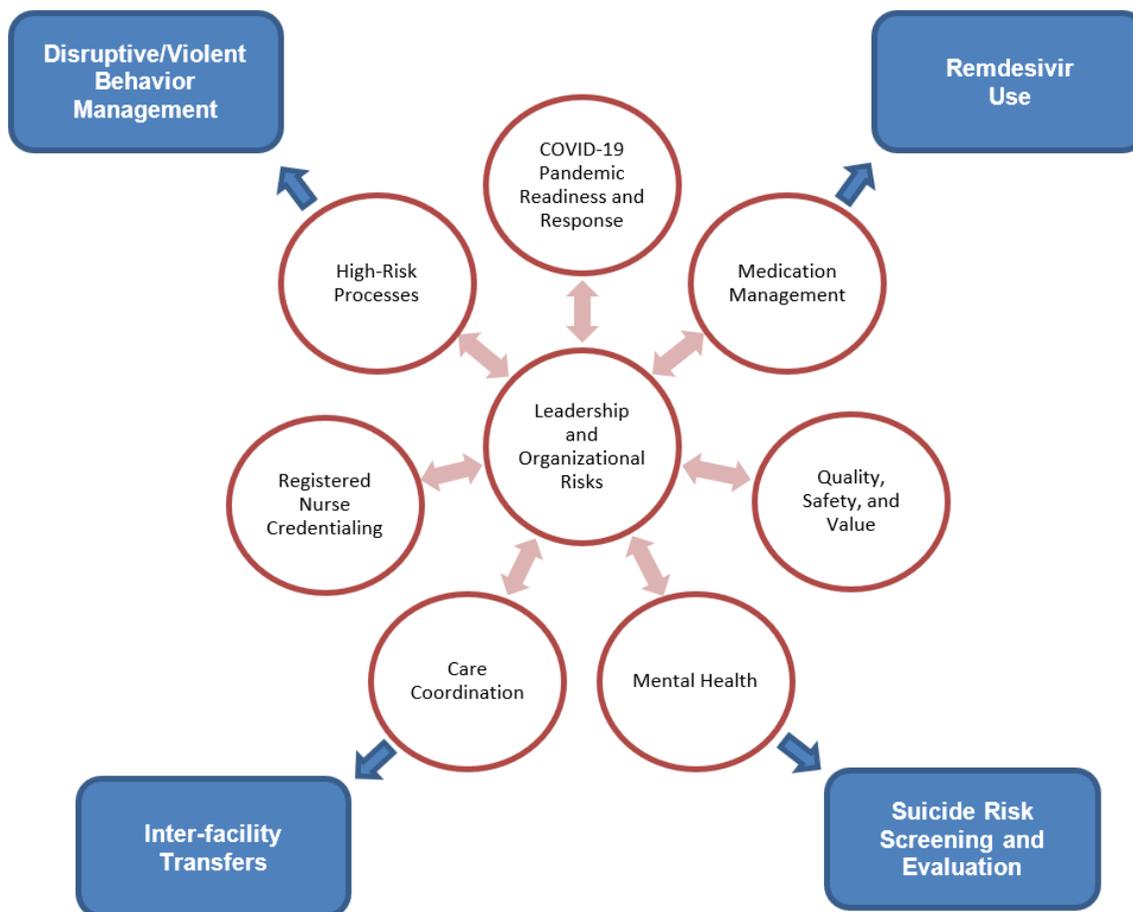


Figure 2. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.
 Source: VA OIG.

Methodology

The Washington DC VA Medical Center also provides care through multiple outpatient clinics in Maryland; Virginia; and Washington, DC. 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 May 21, 2018, through August 27, 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 this inspection.

The OIG reported 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.⁸

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.⁹ 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 Executive 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 August 2021.

⁸ VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

⁹ Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can affect an ability to provide care in the clinical focus areas.¹⁰ 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))¹¹

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 Executive Director; Deputy Executive Director; Associate Director, Patient Care Services; and Associate Director, Clinical Services. The Associate Director, Clinical Services and Associate Director, Patient Care Services oversaw patient care, which required managing service directors and chiefs of programs.

¹⁰ Laura Botwinick, Maureen Bisognano, and Carol Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare Improvement, Innovation Series White Paper, 2006.

¹¹ 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.

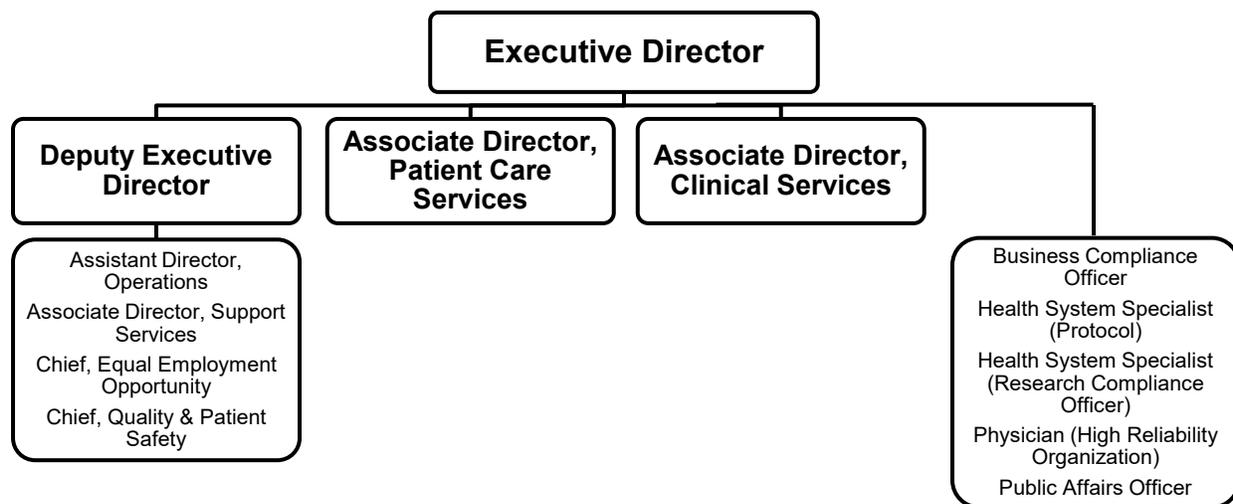


Figure 3. Medical center organizational chart.

Source: Washington DC VA Medical Center (received October 13, 2021).

At the time of the OIG inspection, the executive team had worked together for over three months, after the Deputy Executive Director was hired into this new position at the medical center. The Associate Director, Clinical Services, previously titled Chief of Staff, had served in the role since 2016. The Associate Director, Patient Care Services was assigned in September 2017 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Executive Director	October 14, 2018
Deputy Executive Director	May 10, 2021
Associate Director, Patient Care Services	September 10, 2017
Associate Director, Clinical Services	May 1, 2016

Source: Washington DC VA Medical Center, Assistant Human Resources Officer/Strategic Business Unit (received August 24, 2021).

The Executive 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 the Safety & Health Leadership; Patient Care; Resource & Operations; Quality, Safety and Value; and Medical Executive Councils. These leaders monitored patient safety and care through the Quality, Safety and Value Executive Council, which was responsible for tracking and trending quality of care and patient outcomes (see figure 4).

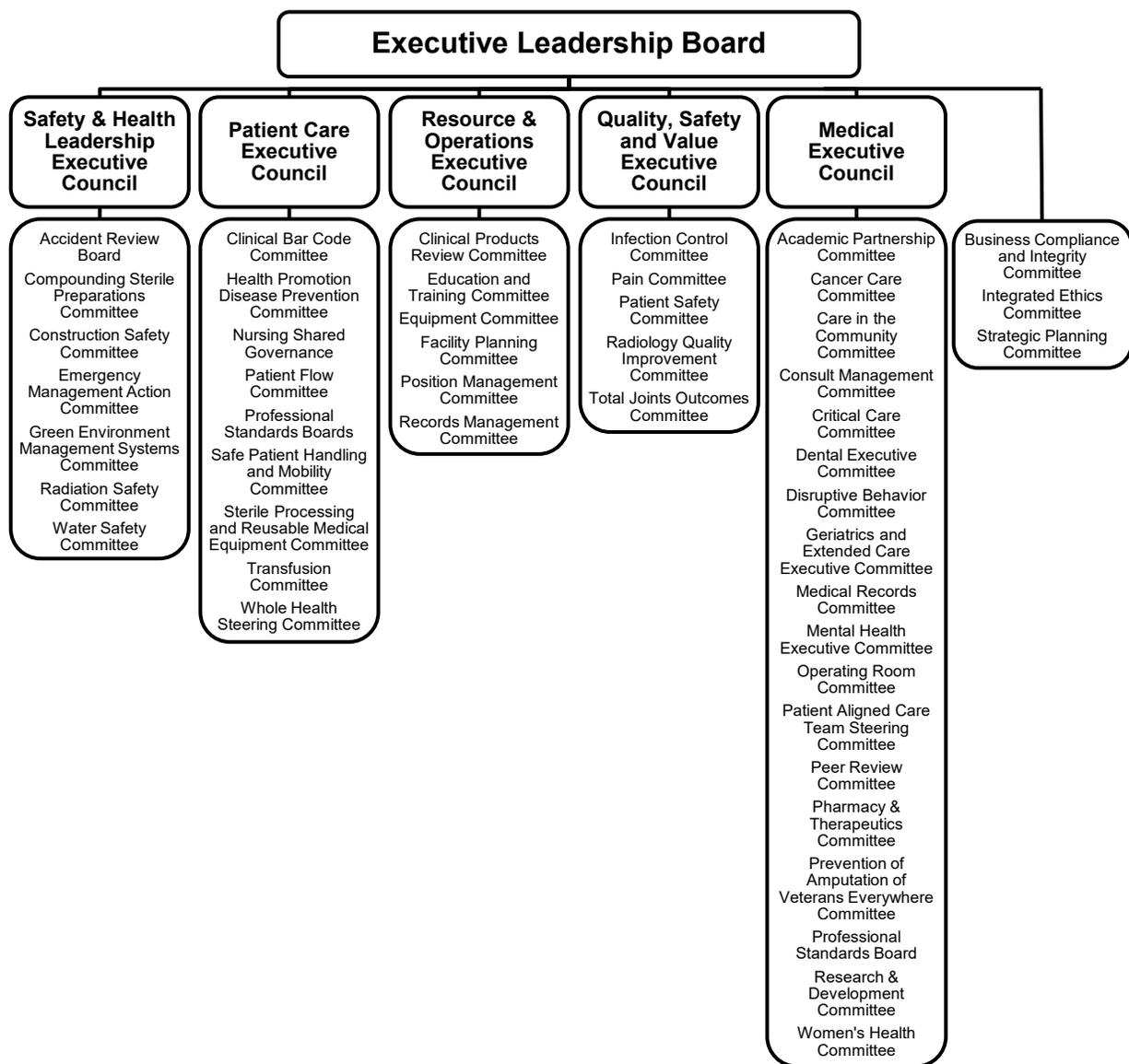


Figure 4. Medical center committee reporting structure.

Source: Washington DC VA Medical Center (received August 23, 2021).

To help assess the medical center executive leaders’ engagement, the OIG interviewed the Executive Director; Deputy Executive Director; Associate Director, Clinical Services; Associate Director, Patient Care Services; and Associate Director, Support Services regarding their knowledge of various performance metrics and involvement and support of actions to improve or sustain performance. In individual interviews, the executive leadership team members were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

Budget and Operations

The medical center's FY 2020 annual medical care budget of \$733,720,701 increased 15 percent compared to the previous year's budget of \$637,118,388.¹² When asked about the effect of this change on the medical center's operations, the Executive Director indicated that the funds went toward reopening the CLC, which had been under renovation for two years. The Executive Director also stated that the FY 2020 budget included funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act and additional funds allocated for community care, COVID-19, and medical service expenses.¹³ However, the Executive Director explained that VISN leaders retained some of those funds.¹⁴

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.¹⁵ 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.¹⁶ In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.¹⁷

Only one facility-reported occupational shortage was noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.¹⁸ The executive leaders confirmed that police remained the top nonclinical occupational shortage at the time of the OIG inspection. The Deputy Executive Director described a high demand for police officers due to the medical center's geographic location and lower starting salaries compared to the local area as factors contributing to the shortage. Executive leaders discussed significant challenges with hiring qualified candidates because of poor communication and prolonged processing delays from human resources staff. Executive leaders added that the modernization of Human Resources Service by transitioning staff from the local level to VISN and national levels had resulted in excessive delays and gaps with timely and efficient hiring processes.

¹² VHA Support Service Center.

¹³ Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136 (2020).

¹⁴ The Executive Director provided additional funding information for FY 2020.

¹⁵ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

¹⁶ 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.

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

¹⁸ VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.

The Associate Director, Clinical Services and Associate Director, Patient Care Services acknowledged that there were no current clinical staffing shortages. However, the Executive Director and Associate Director, Patient Care Services discussed conducting a market pay analysis for nursing staff that resulted in the decision to implement a 5 percent pay increase over the next two years to remain competitive with local area salaries.

The Associate Director, Support Services identified additional nonclinical occupational shortages for environmental management staff, medical support assistants, and biomedical and supply technicians. Executive leaders discussed recruitment and retention challenges, reported difficulty obtaining qualified candidates, and explained that contracted environmental management staff supported the enhanced cleaning needs during the pandemic. Additionally, the Associate Director, Support Services reported approximately 50 vacancies in medical support assistant positions due to noncompetitive salaries. Executive leaders described offering special pay and retention incentives to recruit and retain staff.

Employee Satisfaction

The All Employee Survey “is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential.”¹⁹ Since 2001, the instrument has been refined several times in response to VA leaders’ inquiries on VA culture and organizational health.²⁰ 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, 2020.²¹ Table 2 provides relevant survey results for VHA, the medical center, and selected executive leaders. The OIG found that scores for the Associate Director, Clinical Services; Associate Director, Patient Care Services; and Assistant Director, Operations were reflective of all direct reports, while the results for the Executive Director and Associate Director, Support Services were a composite of all staff in reporting business lines; therefore, the OIG team could not make a comparison regarding direct reports’ scores for all leaders. The All

¹⁹ “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.)

²⁰ “AES Survey History.”

²¹ The medical center’s leaders changed their organizational chart, which was approved June 2021. Leaders’ titles at the time of the FY 2020 All Employee Survey were Medical Center Director (now Executive Director), Chief of Staff (now Associate Director, Clinical Services), Chief Nurse Executive (now Associate Director, Patient Care Services), Associate Director (now Associate Director, Support Services), and Assistant Director (now Assistant Director, Operations). For consistency with the current leadership structure and prior sections of the report, tables reflect the current titles for these leaders.

Employee Survey was initiated in September 2020 and is not reflective of the leadership provided by the Deputy Executive Director, who was assigned in May 2021. Overall scores for the executive leaders generally reflected higher averages than VHA.²²

The Executive Director described the current executive team as strong leaders who are transparent and visible within the organization. The Executive Director explained how during the pandemic, leaders increased communication through virtual platforms such as Microsoft Teams. The Executive Director also discussed how a medical center employee died in April 2021, and the Critical Incident/Stress Management Care Team assisted staff through this transition. The executive leaders spoke about the strategies taken to create a work environment that fosters open communication, servant leadership, and transparency by including open office hours and conducting frequent leadership rounds after normal business hours. Leaders added that examples of their servant leadership included working at the bedside with frontline staff, working weekends, administering vaccines, performing housekeeping duties such as making beds, and participating in meetings with the Patient Advocate.

The Associate Director, Clinical Services discussed the importance of using active listening skills, maintaining open communication, and being sensitive to career goals and transitions to assist staff with growth and development. The Associate Director, Patient Care Services described the importance of communication and meeting weekly with chief nurses and biweekly with nurse managers, as well as conducting rounds and monthly town halls. The Associate Director, Support Services reported performing weekly rounds, following up on any identified concerns within the same day, and asking staff for their input on how to resolve issues.

²² 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 2. 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	Executive Director Average	Assoc. Director, Clinical Services Average	Assoc. Director, Patient Care Services Average	Assoc. Director, Support Services Average	Asst. Director, Operations Average
All Employee Survey: <i>Servant Leader Index Composite.*</i>	0–100 where higher scores are more favorable	73.8	73.1	87.0	92.1	90.0	79.4	80.0
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.5	4.3	4.1	4.3	4.2	3.6
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.6	4.0	4.4	4.5	3.8	3.6
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.8	4.1	4.3	4.7	4.1	3.6

Source: VA All Employee Survey (accessed July 21, 2021).

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

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The medical center averages for the selected survey questions were similar to the VHA averages. Scores related to the Executive Director were similar to or better than those for VHA and the medical center.

**Table 3. Survey Results on Employee Attitudes toward the Workplace
(October 1, 2019, through September 30, 2020)**

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Executive Director Average	Assoc. Director, Clinical Services Average	Assoc. Director, Patient Care Services Average	Assoc. Director, Support Services Average	Asst. Director, Operations Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	4.6	4.5	4.3	4.3	4.2
All Employee Survey: <i>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).</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.7	4.3	4.3	4.4	3.4	3.5
All Employee Survey: <i>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)?</i>	0 (Never)– 6 (Every Day)	1.4	1.4	1.4	1.5	1.5	0.6	1.1

Source: VA All Employee Survey (accessed July 21, 2021).

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

Table 4 summarizes employee perceptions related to respect and discrimination based on VHA’s All Employee Survey responses. The executive leadership team averages for the selected survey questions were generally similar to or better than the medical center and VHA averages. Executive leaders reported having a diverse workplace and zero tolerance for hostility, harassment, and discrimination. The Associate Director, Patient Care Services explained that investigations, actions, and follow-ups occur in response to concerns. The Executive Director discussed speaking about harassment and discrimination during town hall meetings. Executive leaders appeared to maintain an environment where staff felt respected and safe, and discrimination was not tolerated.

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Executive Director Average	Assoc. Director, Clinical Services Average	Assoc. Director, Patient Care Services Average	Assoc. Director, Support Services Average	Asst. Director, Operations Average
All Employee Survey: <i>People treat each other with respect in my workgroup.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.9	3.8	4.6	4.4	4.3	4.1	4.3
All Employee Survey: <i>Discrimination is not tolerated at my workplace.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	4.1	4.0	4.4	4.5	4.1	4.0	4.0

²³ “Stand Up to Stop Harassment Now!” Department of Veterans Affairs, accessed December 8, 2020, <https://vaww.insider.va.gov/stand-up-to-stop-harassment-now/>. (This is an internal website not publicly accessible.) Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*, October 23, 2019.

²⁴ “Stand Up to Stop Harassment Now!”

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Executive Director Average	Assoc. Director, Clinical Services Average	Assoc. Director, Patient Care Services Average	Assoc. Director, Support Services Average	Asst. Director, Operations Average
All Employee Survey: <i>Members in my workgroup are able to bring up problems and tough issues.</i>	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	4.4	4.4	4.3	4.1	4.3

Source: VA All Employee Survey (accessed July 21, 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 (primary care), and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients’ attitudes toward their healthcare experiences. Table 5 provides relevant survey results for VHA and the medical center.²⁵ For this medical center, the overall patient satisfaction survey results generally reflected lower care ratings than the VHA averages. Opportunities appeared to exist for leaders to improve patients’ perceptions of their inpatient and outpatient care.

²⁵ Ratings are based on responses by patients who received care at this medical center.

**Table 5. 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): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	69.5	49.8
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of “Very satisfied” and “Satisfied” responses.	82.5	79.7
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	The response average is the percent of “Very satisfied” and “Satisfied” responses.	84.8	81.2

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 2048.²⁶ For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients’ experiences by gender, including those for Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys (see tables 6–8). For inpatient care, the results for male respondents were lower than the corresponding VHA averages, except for the question regarding doctors treating them with courtesy and respect. The scores for female respondents were also lower when compared to the VHA averages, especially for their willingness to recommend the hospital and perceptions of nurses treating them with respect.

The Associate Director, Clinical Services reported infrastructure concerns as a significant factor contributing to patient dissatisfaction. The Associate Director, Clinical Services provided an example of a patient’s daughter who called regarding the uncomfortably warm temperature in the

²⁶ “Veteran Population,” Table 1L: VetPop2018 Living Veterans by Age Group, Gender, 2018-2048, National Center for Veterans Analysis and Statistics, accessed November 30, 2020, https://www.va.gov/vetdata/Veteran_Population.asp.

patient's room. The Associate Director, Clinical Services reported working with engineering staff to resolve the issue but stated that the age of the building made it extremely challenging to regulate the temperature and humidity. The Deputy Executive Director echoed the same concerns, citing that the building was over 50 years old. The leaders also identified the lack of private rooms with bathrooms as a patient concern. The Associate Director, Patient Care Services explained that facilities management staff made repairs, painted, and installed new white boards in some locations, and patients and families were aware that the medical center is an old building.

The Deputy Executive Director reported that the hospital food also negatively affected patient satisfaction. Additionally, the Executive Director explained that food service carts were old and did not retain heat well. To improve hospital food, the Deputy Executive Director stated that the executive leaders and new Chief of Nutrition requested six food trays so they could sample the food and identify future options.

For Patient-Centered Medical Home care (primary care), the results for male and female respondents were less favorable than the corresponding VHA averages, except for provider ratings among male patients. Overall specialty care survey scores for male and female respondents were lower than the VHA averages, excluding males' score for obtaining non-routine appointments right away. Executive leaders reported that a lack of medical support assistants contributed to the lower patient satisfaction scores. The Executive Director explained that there are fewer medical support assistants to answer phones, so it takes longer for patients to connect with someone who can assist with scheduling appointments. The Associate Director, Clinical Services identified a perceived access issue when patients request same day appointments and stated that while same day appointments were available, patients may have been scheduled to see a different care provider, which could have contributed to their perceived lack of access.

**Table 6. 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
<i>Would you recommend this hospital to your friends and family?</i>	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	52.0	26.0
<i>During this hospital stay, how often did doctors treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	86.5	78.8
<i>During this hospital stay, how often did nurses treat you with courtesy and respect?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	74.1	57.9

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 442–451 male and 28 or 31 female respondents, depending on the question.

Table 7. 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
<i>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?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	49.8	41.0
<i>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?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	47.4	45.9
<i>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?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	78.5	64.5

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

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

†The medical center averages are based on 484–926 male and 89–169 female respondents, depending on the question.

Table 8. 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
<i>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?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	53.7	33.9
<i>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?</i>	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	49.1	40.4
<i>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?</i>	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	65.7	65.5

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

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

†The medical center averages are based on 536–1,172 male and 99–191 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.²⁷ Table 9 summarizes the relevant medical center inspections most recently performed by the OIG and The

²⁷ “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).²⁸ At the time of the OIG inspection, the medical center had seven open recommendations from an OIG focused report, published in February 2021, that QSV staff reported actively working to close.²⁹ All recommendations from the prior comprehensive healthcare inspection conducted in May 2018 and TJC survey performed in March 2020 were closed. The Executive Director discussed how QSV staff were actively engaged with service leaders and assisted them with action plan implementation, tracking, and monitoring.

The OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and College of American Pathologists.³⁰ Additionally, the OIG reviewed results from the Long Term Care Institute's inspection of the medical center's CLCs and observed two open recommendations from the last inspection conducted in March 2021.³¹

²⁸ 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."

²⁹ VA OIG, *Mammography Program Deficiencies and Patient Results Communication at the Washington DC VA Medical Center*, Report No. 20-00563-68, February 25, 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." "About the College of American Pathologists," College of American Pathologists, accessed February 20, 2019, <https://www.cap.org/about-the-cap>. According to the College of American Pathologists, for 75 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." Additionally, as stated in VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

³¹ "About Us," Long Term Care Institute, accessed December 8, 2020, <http://www.ltcior.org/about-us/>. The Long Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings."

Table 9. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (<i>Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center, Report No. 17-01757-50, January 28, 2019</i>)	May 2018	18	0
OIG (<i>Inadequate Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center, Report No. 19-07507-214, July 28, 2020</i>)	October 2019	11*	0
OIG (<i>Mammography Program Deficiencies and Patient Results Communication at the Washington DC VA Medical Center, Report No. 20-00563-68, February 25, 2021</i>)	December 2019	7	7 [†]
TJC Hospital Accreditation	March 2020	47	0
TJC Behavioral Health Care Accreditation		14	0
TJC Home Care Accreditation		12	0

Source: OIG and TJC (inspection/survey results received from the Accreditation Specialist on August 25, 2021).

*The OIG directed 1 recommendation to the VA Capitol Health Care Network Director and 10 recommendations to the Medical Center Director.

[†]As of June 2022, only one recommendation remained open.

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 10 lists the reported patient safety events from May 21, 2018 (the prior OIG CHIP site visit), through August 22, 2021.³²

Table 10. Summary of Selected Organizational Risk Factors (May 21, 2018, through August 22, 2021)

Factor	Number of Occurrences
Sentinel Events	8
Institutional Disclosures	5
Large-Scale Disclosures	0

Source: Washington DC VA Medical Center’s Patient Safety and Risk Managers (received August 23 and 26, 2021).

The Executive Director reported being informed of serious adverse patient events through meetings with the Patient Safety Manager; Associate Director, Clinical Services; or Associate Director, Patient Care Services and reading patient safety reports in daily huddles, which is an expectation for all senior leaders.

The OIG reviewed the eight sentinel events and five institutional disclosures that occurred since the last OIG CHIP visit in May 2018 and identified deficiencies regarding sentinel event identification and the institutional disclosure process. These are discussed in greater detail in the findings and recommendations section.

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 Washington DC VA Medical Center is a high complexity (1b) affiliated medical 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 leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.” Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as “notifications”) as “a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.”

Veterans Health Administration Performance Data for the 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.”³³ 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.³⁴

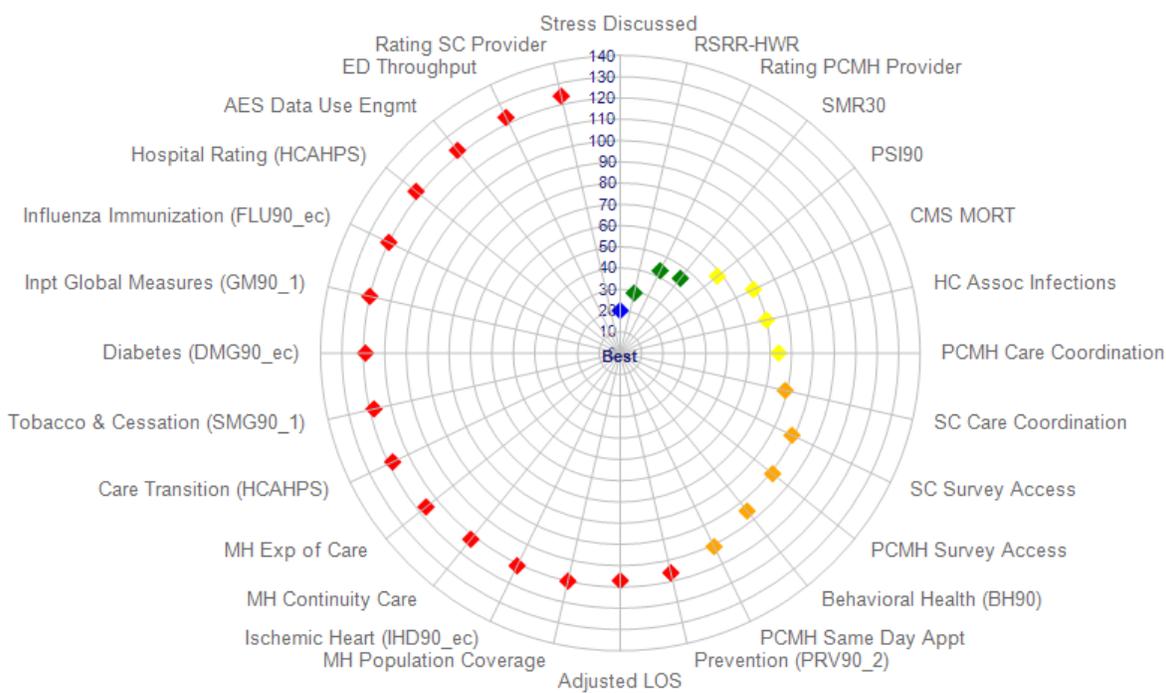
Figure 5 illustrates the medical center’s quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2020. Figure 5 shows the Washington DC VA Medical Center’s performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, stress discussed, rating [of] patient-centered medical home (PCMH) provider, and acute care 30-day standardized mortality ratio (SMR30)). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, specialty care (SC) care coordination, adjusted length of stay (LOS), mental health (MH) continuity [of] care, and rating [of] SC provider).³⁵

The executive leaders were generally knowledgeable within their tenure and scope of responsibilities about VHA data and factors contributing to poor performance on specific SAIL measures. In individual interviews, the executive leadership team members were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance.

³³ “Strategic Analytics for Improvement and Learning (SAIL) Value Model,” VHA Support Service Center, accessed March 6, 2020, <https://vssc.med.va.gov>. (This is an internal website not publicly accessible.)

³⁴ “Strategic Analytics for Improvement and Learning (SAIL) Value Model.”

³⁵ 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. Washington DC VA Medical Center quality of care and efficiency metric rankings (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.”³⁶ The model “leverages much of the same data” used in the Centers for Medicare & Medicaid Services’ (CMS) *Nursing Home Compare* and provides a single resource “to review quality measures and health inspection results.”³⁷

Figures 6 illustrates the medical center’s CLC quality rankings and performance compared with other VA CLCs as of March 31, 2021. Figure 6 displays the CLC metrics with high performance

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

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

(blue and green data points) in the first and second quintiles (for example, new pressure ulcer (newPU)–short-stay (SS), activities of daily living (ADL)–long-stay (LS), and catheter in bladder (cath) (LS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, number of hospital visits per 1000 residents (numhosp) (LS), and newly received antipsychotic medications (antipsy) (SS)).³⁸ The executive leaders were also generally knowledgeable within their tenure and scope of responsibilities about factors contributing to poorly performing CLC SAIL measures.

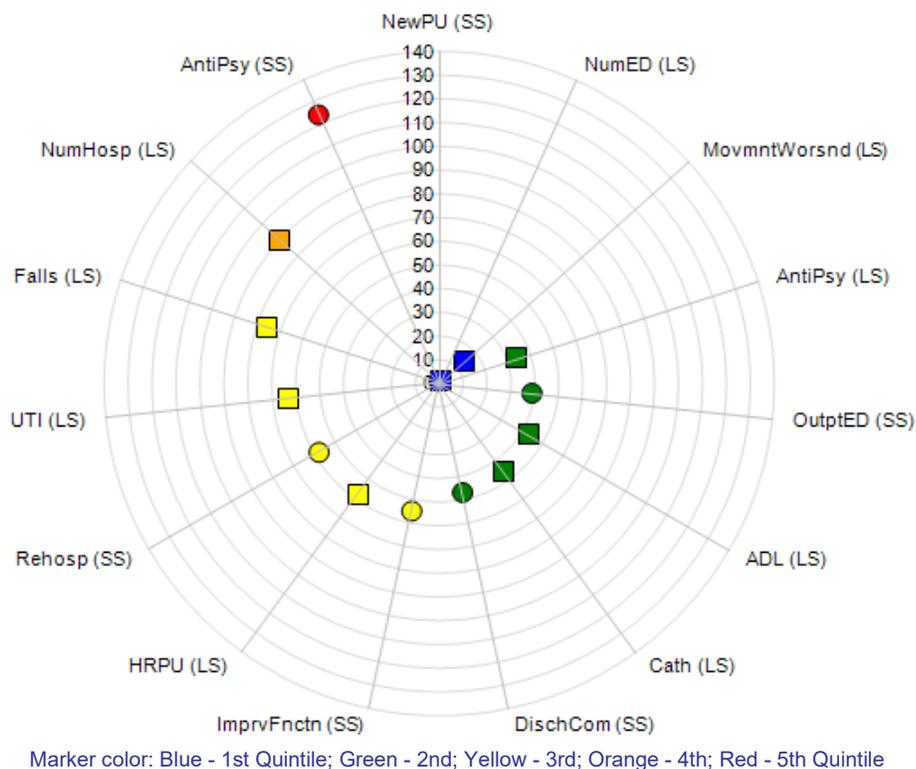


Figure 6. Washington DC VA Medical Center CLC quality measure rankings for FY 2021 quarter 2 (as of March 31, 2021).

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

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

At the time of the OIG inspection, the executive team had worked together for over three months. The Deputy Executive Director, who was assigned in May 2021, was the newest

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

member of the team. The Associate Director, Clinical Services (previously titled Chief of Staff) had served on the team the longest.

The Executive 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 medical center’s FY 2020 annual medical care budget increased 15 percent compared to the previous year, and the executive leaders were able to discuss interim strategies to address occupational shortages.

Selected employee satisfaction survey responses demonstrated satisfaction with leaders and maintenance of an environment where staff felt respected, and discrimination was not tolerated. Patient experience survey scores generally reflected lower care ratings compared to VHA averages and highlighted opportunities for leaders to improve patients’ inpatient and outpatient care experiences.

The executive leaders were generally knowledgeable, based on their tenure and scope of responsibilities, about VHA data and factors contributing to poor performance on specific SAIL measures. In individual interviews, the executive leadership team members were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. However, the OIG’s review of the medical center’s sentinel events and disclosures identified vulnerabilities for organizational risk.

VHA defines adverse events as “events that cause death or disability, lead to prolonged hospitalization, require life-sustaining intervention or intervention to prevent impairment or damage, or that are reasonably expected to result in death or serious or permanent disability, or that are sentinel events as defined by The Joint Commission.”³⁹ TJC defines a sentinel event as a “patient safety event (not primarily related to the natural course of a patient’s illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).”⁴⁰ VHA established the Patient Safety Program to develop a system to prevent patient harm in which leaders are accountable for identifying sentinel events, conducting a review to determine the root cause, implementing actions to prevent future occurrences, and maintaining an accurate record of all events.⁴¹ Furthermore, VHA recognizes that the disclosure of harmful events is “consistent with the VA core values of integrity, commitment, advocacy, respect, and excellence” and requires leaders to inform or disclose to a patient or patient’s personal representative when an adverse event occurs.⁴²

³⁹ VHA Directive 1004.08.

⁴⁰ The Joint Commission, *Comprehensive Accreditation Manual for Hospitals* (January 2022), “Sentinel Event Policy.”

⁴¹ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

⁴² VHA Directive 1004.08.

The OIG reviewed the eight sentinel events and five institutional disclosures that occurred since the last OIG CHIP visit in May 2018. The OIG identified that one of the five institutional disclosures had been attempted but was not completed. The OIG found that the Associate Director, Clinical Services documented an attempt to contact the patient’s family to disclose this adverse event, which resulted in an injury requiring transfer of the patient to a local hospital for surgery. Leaders did not identify this adverse event as a sentinel event.

The OIG also noted that for the eight sentinel events identified by medical center leaders, five were patient falls, three of which resulted in deaths; and the remaining three events involved a retained foreign body, outpatient suicide, and a dialysis complication. The OIG found that leaders only conducted institutional disclosures for two of those sentinel events. Failure to identify sentinel events and conduct institutional disclosures may lead to missed opportunities for staff to recognize safety trends and report patient harm, delays in mitigating risks of future events, and patients’ reduced trust in the organization. Facility leaders did not offer any reasons for noncompliance but discussed possible solutions with the OIG.

Recommendation 1

1. The Executive Director evaluates and determines reasons for noncompliance and ensures leaders identify adverse events as sentinel events when criteria are met and conduct institutional disclosures as required.

Medical center concurred.

Target date for completion: January 31, 2023

Medical center response: The Executive Director evaluated the record of sentinel events and institutional disclosures from the survey observation period and found inconsistent tracking of disclosures after sentinel events. The Patient Safety Manager and Risk Manager will document each sentinel event in a tracking log, initiating the process of institutional disclosure. The Patient Safety Manager and Risk Manager will audit compliance with tracking log, including documentation of completed disclosure, monthly. The Patient Safety Manager will report progress to the Quality Safety and Value Executive Council as part of the quarterly executive brief of the Patient Safety Committee. Compliance to the tracking log will be monitored until a benchmark of 100% is met for 6 consecutive months.

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.⁴³ 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.⁴⁴

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.”⁴⁵ “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.”⁴⁶

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.

⁴³ “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>.

⁴⁴ VHA, Office of Emergency Management, *COVID-19 Response Plan*, March 23, 2020.

⁴⁵ 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.”

⁴⁶ 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.

The OIG reported 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.⁴⁷

⁴⁷ VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, Report No. 21-03917-123, April 7, 2022.

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.⁴⁸ 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.⁴⁹ 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."⁵⁰

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 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."⁵¹ 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."⁵² 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

⁴⁸ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

⁴⁹ VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

⁵⁰ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

⁵¹ VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

⁵² VHA Directive 1026.01.

Next, the OIG assessed the medical center’s processes for conducting protected peer reviews of clinical care.⁵³ 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.”⁵⁴ Peer reviews are “intended to promote confidential and non-punitive” processes that consistently contribute to quality management efforts at the individual provider level.⁵⁵ 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 unit⁵⁶
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews⁵⁷
- 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.”⁵⁸ 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;

⁵³ 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.”

⁵⁴ VHA Directive 1190.

⁵⁵ VHA Directive 1190.

⁵⁶ VHA Directive 1190.

⁵⁷ VHA Directive 1190. A peer review is assigned a Level 3 when “most experienced and competent clinicians would have managed the case differently.”

⁵⁸ “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.”⁵⁹ 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 events⁶⁰

The OIG reviewers interviewed 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.⁶¹

Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for QSV oversight functions, protected peer reviews, and surgical work group processes. However, the OIG identified a weakness in the Systems Redesign and Improvement Program.

VHA requires facilities to have a designated systems redesign and improvement coordinator.⁶² The Chief of QSV reported that the systems redesign and improvement coordinator position had been vacant for the past six years. This may have resulted in inadequate program oversight and contributed to missed opportunities for continuous system improvement. The Chief of QSV indicated that leadership turnover and issues with classifying the position’s grade contributed to the delay in filling the position. The chief also confirmed that leaders recently drafted a systems redesign and improvement coordinator position description that met VHA program requirements and planned to begin recruitment efforts. The Deputy Chief of QSV acknowledged efforts to improve the program and explained that in September 2020, staff began to track projects; participate on the Quality, Safety and Value Executive Council and VISN Systems Redesign Review advisory group; and educate staff on systems redesign and improvement principles and techniques. The Deputy Chief also stated that VISN staff and two new Systems Redesign and Improvement Specialists assisted with these efforts.

⁵⁹ “NSO Reporting, Resources, & Tools.”

⁶⁰ VHA Directive 1102.01(1), *National Surgery Office*, April 24, 2019, amended May 22, 2019.

⁶¹ For CHIP visits, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

⁶² VHA Directive 1026.01.

Recommendation 2

2. The Executive Director evaluates and determines any additional reasons for noncompliance and designates a systems redesign and improvement coordinator.

Medical center concurred.

Target date for completion: December 31, 2022

Medical center response: The Executive Director evaluated for additional reasons for noncompliance, and none were identified. The facility designated a new Systems Redesign Coordinator position reporting to the Deputy Director of the Medical Center. The facility is currently working with VISN 5 Human Resources to post the position and will request closure upon the issuance of a final job offer.

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.”⁶³ 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.”⁶⁴

VA requires all RNs to hold at least one active, unencumbered license.⁶⁵ RNs who hold a license in more than one state are not eligible for 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.⁶⁶ 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.⁶⁷ 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.⁶⁸

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 111 RNs hired from July 1, 2020, through July 25, 2021. The OIG determined whether

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

The OIG also reviewed credentialing files for 30 of the 111 RNs to determine whether medical center staff completed primary source verification prior to the appointment.

⁶³ VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012. (This directive was rescinded and replaced on September 15, 2021, by VHA Directive 1100.20, *Credentialing of Health Care Providers*. The two documents contain similar language regarding credentialing procedures.)

⁶⁴ VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

⁶⁵ 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.”

⁶⁶ 38 U.S.C. § 7402.

⁶⁷ VHA Directive 2012-030.

⁶⁸ VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

The OIG found that RNs hired from July 1, 2020, through July 25, 2021, were free from potentially disqualifying licensure actions. However, the OIG found vulnerabilities in the primary source verification process.

VHA requires the medical center director to ensure that “all licenses including not only current licenses, but all previously held, must be verified through primary source verification” prior to RN appointment.⁶⁹ The OIG found that 10 of 30 RNs’ credentialing files reviewed (33 percent) lacked evidence that staff completed primary source verification for each license held prior to entrance on duty. Failure to verify each nursing license could result in the inappropriate hiring of nurses, which could subsequently affect the provision of quality care. The Supervisory Program Credentialing Specialist reported that 50 percent of positions in the credentialing service were vacant at the time of the virtual OIG inspection. The Specialist also explained that VHA changed the position descriptions for dependent credentialers nationally, which lowered the pay rate and made it difficult to recruit and retain staff in these positions. Additionally, the Specialist reported that the ongoing need to hire and train new staff contributed to inadequate quality assurance checks and delayed or missed licensing database searches in the process of primary source verifications.

Recommendation 3

3. The Executive Director evaluates and determines any additional reasons for noncompliance and makes certain that credentialing staff complete primary source verification of all registered nurses’ licenses prior to initial appointment.

Medical Center concurred.

Target date for completion: December 31, 2022

Medical Center response: Under the direction of the Executive Director, the Associate Director, Patient Care Services (ADPCS) convened a group to evaluate any additional reasons for noncompliance. Identifying a process gap, the facility has developed a standard procedure for verifying and completing primary source verification for all existing licenses prior to initial appointment. The ADPCS will monitor compliance to this standard through a monthly, randomized audit of 25% of newly-onboarded registered nurse license records until 100% compliance is sustained for a period of six months. Monthly reports of progress will be provided to the Quality Safety and Value Executive Council for monitoring.

⁶⁹ VHA Directive 2012-030.

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.⁷⁰ 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 34 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 OIG found the medical center addressed all the indicators of expected performance above, except for staff’s timely reporting of adverse events to the FDA.

The FDA, under the Emergency Use Authorization, required that the “prescribing health care provider and/or the provider’s designee are/is responsible for mandatory reporting of all medication errors and adverse events” potentially related to and occurring during remdesivir treatment within seven calendar days from the onset of the event.⁷⁸ The OIG found that staff reported two adverse events to the FDA but did not report them within seven calendar days. Staff reported one event in eight calendar days and the other three months after it occurred. Timely reporting of adverse events to the FDA supports transparency and evaluation of medication safety. The Chief of Pharmacy indicated that the three-month delay was a clerical error in which staff documented the event twice in the adverse event reporting system but had not forwarded the information to the FDA.

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

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

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

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

Mental Health Findings and Recommendations

The OIG found the medical center generally complied with the completion of all required elements in the Columbia-Suicide Severity Rating Scale and suicide safety plans by the required staff. However, the OIG identified a deficiency with the completion of mandatory training by staff who develop suicide safety plans.

VHA requires staff to complete mandatory suicide safety plan training prior to developing suicide safety plans with patients.⁸⁵ The OIG found that 4 of 30 staff responsible for suicide safety plan development (13 percent) had not completed the mandatory training. Lack of staff training may lead to inadequate safety planning with patients who are at risk for suicide. The Associate Chief of Staff for Mental Health reported that supervisors believed staff completed the training since they were not listed on the supervisor's deficiency report and identified the lack of assigned training as an oversight.

Recommendation 4

4. The Associate Director, Clinical Services evaluates and determines any additional reasons for noncompliance and ensures staff complete mandatory suicide safety plan training prior to developing suicide safety plans.

Medical Center concurred.

Target date for completion: January 31, 2023

Medical Center response: The Associate Director, Clinical Services evaluated this process for additional reasons for noncompliance and identified none. The facility developed a standard process for communicating suicide safety plan training requirements for newly hired staff. The Deputy Chief, Clinical Services will monitor completion of mandatory suicide safety plan training by new staff through direct report from service line chiefs to the Mental Health Executive Committee monthly. The Deputy Chief, Clinical Services will continue to monitor compliance until a benchmark of 100% compliance is met for six consecutive months.

⁸⁵ 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*.

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.⁸⁶

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.”⁸⁷ 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.⁸⁸

The medical center was assessed for its adherence to various requirements:

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

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

Care Coordination Findings and Recommendations

The OIG observed general compliance with the requirements for an inter-facility transfer policy, completion of the required VA *Inter-Facility Transfer Form* or facility-defined equivalent, and transmission of patients’ active medication lists to receiving facilities. However, the OIG identified deficiencies with the monitoring and evaluation of inter-facility transfers, transmission

⁸⁶ VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

⁸⁷ VHA Directive 1094.

⁸⁸ 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.

of patients' advance directives to receiving facilities, and communication between nurses at sending and receiving facilities.

VHA requires the Chief of Staff (Associate Director, Clinical Services) and Associate Director, Patient Care Services to ensure that "all transfers are monitored and evaluated as part of VHA's Quality Management Program."⁸⁹ The OIG did not find evidence that staff monitored and evaluated patient transfers from August 1, 2020, through July 31, 2021. Failure to monitor patient transfer data could prevent identification of deficiencies that jeopardize the health of vulnerable patients. The Clinical Coordinator explained that staff had not monitored and evaluated transfers but began audits in March 2021, after receiving guidance and a monitoring tool from the VISN. The coordinator added that staff would report audit results to the Patient Flow Committee beginning in September 2021.

Recommendation 5

5. The Associate Director, Clinical Services and Associate Director, Patient Care Services evaluate and determine reasons for noncompliance and ensure staff monitor and evaluate all inter-facility transfers as part of VHA's Quality Management Program.

Medical Center concurred.

Target date for completion: December 31, 2022

Medical Center response: With the Associate Director, Clinical Services, the Associate Director, Patient Care Services reviewed these survey findings and found no additional reasons for non-compliance with the requirements of inter-facility transfer. The Patient Flow Clinical coordinator implemented a documentation audit tool to provide real-time monitoring of all required elements of inter-facility transfer. To ensure the ongoing evaluation and quality monitoring of all inter-facility transfers, audit data will be presented monthly to the Patient Flow Committee. The facility will demonstrate six months of 90% or above compliance to the monitoring process.

VHA requires the Chief of Staff (Associate Director, Clinical Services) and Associate Director, Patient Care Services to ensure that transferring physicians or the assigned designees "send all pertinent medical records available, including...documentation of the patient's advance directive made prior to transfer, if any" to the receiving facility.⁹⁰ For the six patients who had an advance directive, the OIG found that all electronic health records lacked evidence that staff sent a copy to the receiving facility. As a result, there was no assurance that receiving facility staff could immediately determine the patient's healthcare preferences should an emergency occur. The

⁸⁹ VHA Directive 1094.

⁹⁰ VHA Directive 1094.

Chief, Emergency Department reported that it had not been usual practice to send advance directives with the patients until August 13, 2021, when staff updated a checklist in the transfer packet to include this step. Additionally, the Director of Patient Flow and a Hospitalist stated that maintaining training in the Emergency Department was challenging as most providers are contracted. Due to the low number of patients identified for this requirement, the OIG made no recommendation.

VHA states that nurse-to-nurse communication during the inter-facility transfer process is essential and allows for questions and answers from staff at both the sending and receiving facility.⁹¹ The OIG did not find evidence of nurse-to-nurse communication for 26 percent of inter-facility transfers (95% CI: 12.81 and 41.02 percent), which is statistically significantly above the 10 percent deficiency benchmark. This could result in staff at the receiving facility lacking the information needed to care for patients. The Nurse Manager of Patient Flow stated that one reason nursing staff may have missed documenting the communication was because there are different documentation templates available but only the transfer template contains a specific field to record that nurse-to-nurse communication occurred.

Recommendation 6

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

Medical Center concurred.

Target date for completion: January 31, 2023

Medical Center response: The Associate Director, Patient Care Services evaluated additional reasons for noncompliance and found none. The Associate Director, Patient Care Services has implemented a new note in the electronic medical record for the documentation of the nurse-to-nurse handoff. The Associate Director, Patient Care Services will monitor the interfacility documentation tool completion as stated in the response to the previous recommendation, recommendation #5. Nurse-to-nurse communication is tracked as an element in the referenced documentation audit tool. The facility will demonstrate six months of 90% or above compliance with documentation of nurse-to-nurse communication. The progress of this action plan will also be tracked monthly in the Patient Flow Committee.

⁹¹ 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.”⁹² 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.”⁹³ 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 team⁹⁴
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings⁹⁵
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction⁹⁶
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants⁹⁷

⁹² VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

⁹³ VHA Directive 2012-026.

⁹⁴ 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.”

⁹⁵ 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.”

⁹⁶ 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.”

⁹⁷ 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 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.⁹⁸ VHA also requires that employee threat assessment team members complete the appropriate team-specific training.⁹⁹ 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 complied with the establishment of a local policy for reporting and tracking disruptive behavior, implementation of a disruptive behavior committee, use of the Disruptive Behavior Reporting System, and completion of the Workplace Behavioral Risk Assessment. However, the OIG identified deficiencies with the Employee Threat Assessment Team, members' consistent attendance at Disruptive Behavior Committee meetings, and staff completion of required trainings.¹⁰⁰

VHA requires facilities to establish an employee threat assessment team.¹⁰¹ Additionally, the members of the team are required to complete specific workplace violence prevention program training.¹⁰² The Associate Director, Support Services stated that the Employee Threat Assessment Team had not met since February 2020 and the five members assigned prior to August 2021 had not completed all required training. This could result in employees' unaddressed disruptive behaviors that undermine a culture of safety. The Associate Director, Support Services reported not being aware of all the required training and explained that the team previously met monthly but stopped due to the COVID-19 pandemic.

⁹⁸ DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

⁹⁹ DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018.

¹⁰⁰ The Employee Threat Assessment Team reports to the Safety and Health Leadership Council.

¹⁰¹ DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

¹⁰² DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

Recommendation 7

7. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures Employee Threat Assessment Team meetings are held and members complete training, as required.

Medical center concurred.

Target date for completion: January 31, 2023

Medical Center response: The Executive Director evaluated the facility processes related to the Employee Threat Assessment Team (ETAT) and found no additional reasons for noncompliance. The Associate Director, Support Services will assure that all active members of the ETAT are assigned the required training for their role. Training noncompliance will be reported at the Employee Threat Assessment Team meeting by the meeting Chair. The Chair of the Employee Threat Assessment Team will report progress of this action, including meeting occurrence, attendance, and compliance to training requirements, to the Safety and Health Leadership Executive Council until 90% or above compliance to meeting occurrence is maintained for six consecutive months.

VHA requires facilities' clinical executives—the Chief of Staff (Associate Director, Clinical Services) and Nurse Executive (Associate Director, Patient Care Services)—to establish a disruptive behavior committee or board that includes a senior clinician chairperson, clerical and administrative support staff, a patient advocate, and representation from the Prevention and Management of Disruptive Behavior Program, patient safety and/or risk management, VA police, and Union Safety Committee.¹⁰³ The disruptive behavior committee is responsible for coordinating with clinicians, recommending amendments to treatment plans that may reduce patients' risk of violence, collecting and analyzing disruptive patient incidents, identifying system problems, and recommending to the leaders other actions related to the problem of patient violence.¹⁰⁴

The OIG reviewed Disruptive Behavior Committee attendance for 10 meetings held from August 1, 2020, through July 31, 2021. However, the OIG was unable to evaluate the attendance of required members for 5 of 10 meetings due to the lack of documentation. For the 5 meetings held between March and July 2021, where attendance was documented, the OIG found that clerical and administrative support staff did not attend the meetings. Absence of clerical and administrative support staff may impede the accomplishment of required tasks, including recording meeting attendance for required members. The previous Disruptive Behavior Committee Co-Chair reported managing multiple responsibilities with no administrative support

¹⁰³ VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010, corrected copy February 3, 2011.

¹⁰⁴ VHA Directive 2010-053.

as a reason attendance was not documented. The current Disruptive Behavior Committee Co-Chair acknowledged being unaware that clerical and administrative support staff were required to attend.

Recommendation 8

8. The Associate Director, Clinical Services and Associate Director, Patient Care Services evaluate and determine any additional reasons for noncompliance and make certain that required members attend Disruptive Behavior Committee meetings.

Medical Center concurred.

Target date for completion: January 31, 2023

Medical Center response: The Associate Director, Clinical Services and Associate Director, Patient Care Services evaluated and did not determine any additional reasons for noncompliance. In response to the survey findings, the Co-Chairs of the Disruptive Behavior Committee developed a template attendance record form, reflecting the roles/titles of required and optional Disruptive Behavior Committee attendees (i.e., Police Service, Patient Safety, Office of Patient Experience and Advocacy, etc.), to ensure that the presence of attendees is documented and monitored. The Co-Chairs of the Disruptive Behavior Committee (DBC) will complete the attendance record at each DBC meeting. The DBC Co-Chairs will report attendance and participation compliance to the Quality Safety and Value Executive Council until 90% or above compliance to attendance reporting is maintained for six consecutive months.

VHA also requires facility leaders to ensure employees complete prevention and management of disruptive behavior training based on the risk level assigned to their work areas.¹⁰⁵ The OIG found that 25 of 30 employees (83 percent) had not completed the required training. This could result in employees' lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Prevention and Management of Disruptive Behavior Program Coordinator stated that face-to-face trainings remained suspended due to the COVID-19 pandemic. The Talent Management System Administrator stated that some trainings were not assigned due to an oversight.

¹⁰⁵ DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*.

Recommendation 9

9. The Executive Director evaluates and determines any additional reasons for noncompliance and ensures employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.¹⁰⁶

Medical Center concurred.

Target date for completion: January 31, 2023

Medical Center response: The Executive Director reviewed and evaluated additional reasons for noncompliance and did not discover any additional reasons. The Prevention and Management of Disruptive Behavior (PMDB) Coordinator will implement a new tracking spreadsheet and reporting process for monitoring overall employee compliance with completion of PMDB Part 2 low risk workplace training, Part 2 moderate/high workplace training and Part 3 high risk workplace training reflective of the annual Workplace Behavioral Risk Assessment (WBRA). This data will be reported monthly by the PMDB Coordinator to the Disruptive Behavior Committee until 90% or greater compliance is maintained for no less than six consecutive months.

¹⁰⁶ The OIG recognizes that COVID-19 has affected facility operations and makes no comment on the timeline for safely accomplishing this important training.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed review of eight clinical and administrative areas and provided nine recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this medical center. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. 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 reducing vulnerabilities that may lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Executive Director; Associate Director, Clinical Services; and Associate Director, Patient Care Services. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Leadership and Organizational Risks	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • Leaders identify adverse events as sentinel events when criteria are met and conduct institutional disclosures as required. 	<ul style="list-style-type: none"> • None
COVID-19 Pandemic Readiness and Response	<ul style="list-style-type: none"> • Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback • Vaccine administration 	<p>The OIG reported 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.</p>	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • The Executive Director designates a systems redesign and improvement coordinator.
RN Credentialing	<ul style="list-style-type: none"> • RN licensure requirements • Primary source verification 	<ul style="list-style-type: none"> • Credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment. 	<ul style="list-style-type: none"> • None
Medication Management: Remdesivir Use in VHA	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	<ul style="list-style-type: none"> • Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements 	<ul style="list-style-type: none"> • Staff complete mandatory suicide safety plan training prior to developing suicide safety plans. 	<ul style="list-style-type: none"> • None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Nurse-to-nurse communication occurs between sending and receiving facilities. 	<ul style="list-style-type: none"> • Staff monitor and evaluate all inter-facility transfers as part of VHA's Quality Management Program.
High-Risk Processes: Management of Disruptive and Violent Behavior	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Employee Threat Assessment Team meetings are held and members complete training, as required. • Required members attend Disruptive Behavior Committee meetings. • Employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.

Appendix B: Medical Center Profile

The table below provides general background information for this high complexity (1b) affiliated medical center reporting to VISN 5.¹

**Table B.1. Profile for Washington DC VA Medical Center (688)
(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	\$618,891,638	\$637,118,388	\$733,720,701
Number of:			
• Unique patients	73,986	80,953	85,730
• Outpatient visits	727,913	794,766	773,496
• Unique employees [§]	2,725	2,964	3,033
Type and number of operating beds:			
• Community living center	90	90	90
• Intermediate	26	26	26
• Medicine	73	73	73
• Mental health	0	28	28
• Neurology	8	8	8
• Surgery	40	40	40
Average daily census:			
• Community living center	68	93	55
• Intermediate	5	0	0
• Medicine	82	90	69
• Mental health	12	13	13
• Neurology	2	0	0

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 “1b” indicates a facility with “medium-high volume, high-risk patients, many complex clinical programs, medium-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 [‡]
<ul style="list-style-type: none"> Surgery 	13	13	9

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
Fort Belvoir, VA	688GA	6,999	4,849	Dermatology Poly-trauma	–	Nutrition Pharmacy Weight Management
Washington, DC	688GB	661	304	–	–	Nutrition
Charlotte Hall, MD	688GD	3,839	1,812	Cardiology Hematology/ Oncology Poly-trauma	–	Nutrition Pharmacy Prosthetics
Camp Springs, MD	688GE	5,779	4,491	Anesthesia Dermatology Neurology	–	Dental Nutrition Weight Management

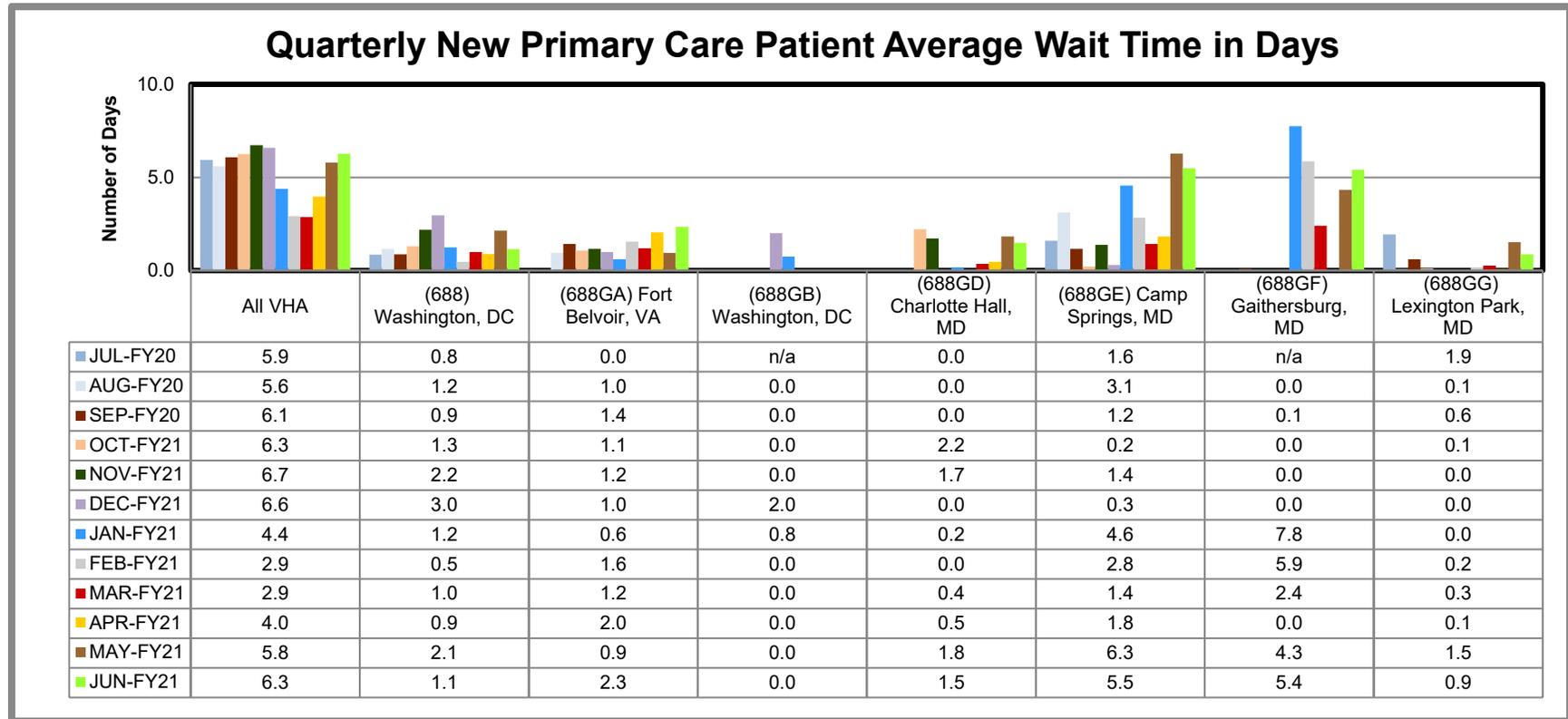
¹ VHA Directive 1230(4), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended June 17, 2021. An encounter is a “professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.” Specialty care services 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
Gaithersburg, MD	688GF	2,306	2,743	Dermatology Endocrinology Pulmonary/ Respiratory Disease	–	Dental Nutrition Pharmacy Social Work Weight Management
Lexington Park, MD	688GG	1,007	1,191	–	–	Nutrition
Washington, DC	688QA	–	439	–	–	–

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

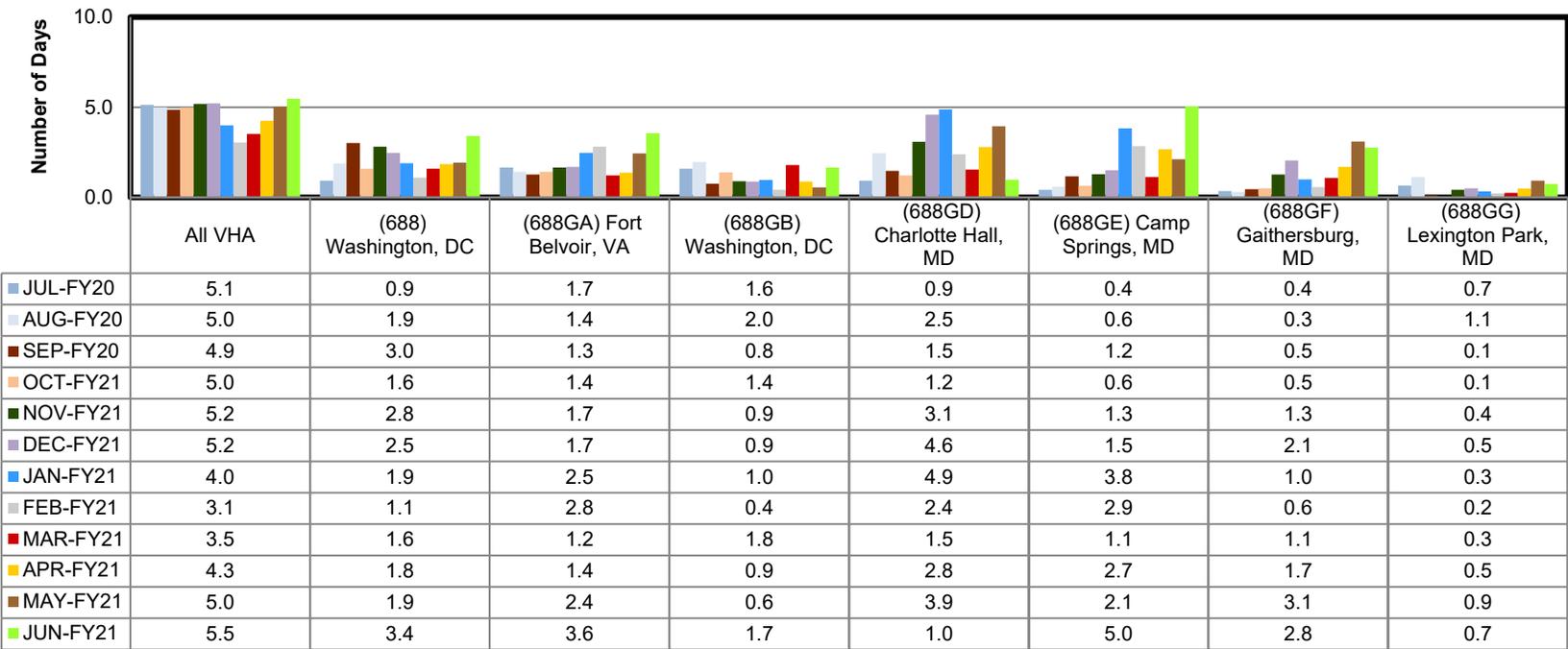


Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, <https://vssc.med.va.gov>, accessed October 21, 2019. (This is an internal website not publicly accessible.)

Note: The OIG did not assess VA’s data for accuracy or completeness. The OIG omitted (688QA) Franklin Street, DC as no data were reported.

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

Quarterly Established Primary Care Patient Average Wait Time in Days



Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, <https://vssc.med.va.gov>, accessed October 21, 2021. (This is an internal website not publicly accessible.)

Note: The OIG did not assess VA’s data for accuracy or completeness. Note: The OIG omitted (688QA) Franklin Street, DC as no data was reported.

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

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 (HCAHPS)	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
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

Measure	Definition	Desired Direction
MH exp of care	Mental health experience of care	A higher value is better than a lower value
MH population 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 PCMH provider	Rating of primary care providers (PCMH survey)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care survey)	A higher value is better than a lower value
RSRR-HWR	All cause hospital-wide readmission rate	A lower value is better than a higher value
SC care coordination	Care coordination (specialty care)	A higher value is better than a lower value
SC survey access	Timeliness in getting specialty care urgent care and routine care appointments (specialty care survey access composite)	A higher value is better than a lower value
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
ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
AntiPsy (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
AntiPsy (SS)	Short-stay measure: percent of residents who received an antipsychotic medication.
Cath (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
DischCom (SS)	Short-stay measure: percentage of short-stay residents who were successfully discharged to the community.
Falls (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
HRPU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
ImprvFnctn (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
MovmntWorsnd (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
NewPU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
NumED (LS)	Long-stay measure: number of residents who have had an outpatient emergency department (ED) visit per 1000 patients.
NumHosp (LS)	Long-stay measure: number of residents who were re-hospitalized after a nursing home admission per 1000 long-stay residents.
OutptED (SS)	Short-stay measure: percent of short-stay residents who have had an outpatient emergency department (ED) visit.
Rehosp (SS)	Short-stay measure: Rehospitalized after nursing home stay.

Measure	Definition
UTI (LS)	Long-stay measure: urinary tract infection.

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: May 24, 2022

From: Director, VA Capitol Health Care Network (10N5)

Subj: Comprehensive Healthcare Inspection of the Washington DC VA Medical Center

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

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

1. I have reviewed and concur with the findings and recommendations in the Office of Inspector General's (OIG's) draft report entitled Comprehensive Healthcare Inspection of the Washington DC VA Medical Center.
2. I have reviewed and concur with the Medical Center Director's response and corrective actions to the recommendations.
3. Furthermore, recommendations #1, 2, 3, 4, 5, 6, 7, 8, and 9 will remain open and in progress.
4. Thank you for this opportunity to focus on continuous performance improvement. Should you require any additional information please contact the VISN 5 Quality Management Officer.

(Original signed by:)

Robert M. Walton, FACHE

Appendix H: Executive Director Comments

Department of Veterans Affairs Memorandum

Date: May 23, 2022

From: Executive Director, Washington DC VA Medical Center (688/00)

Subj: Comprehensive Healthcare Inspection of the Washington DC VA Medical Center

To: Director, VA Capitol Health Care Network (10N5)

1. Thank you to the CHIP Healthcare Inspection Team for the professional review of the organization that was completed. I have reviewed the draft report and concur with the findings and recommendations.
2. Attached are the facility responses to the nine (9) recommendations, including actions that are in progress to correct the identified opportunities for improvement.

(Original signed by:)

Michael Heimall

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Inspection Team	Erin Allman, MSN, RN, Team Leader Keri Burgy, MSN, RN Kimberley De La Cerda, MSN, RN Janice Fleming, DNP, RN Donna Murray, MSN, RN Teresa Prunte, MHA, BSN, RN Kristie Van Gaalen, BSN, RN Michelle Wilt, MBA, BSN, RN
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Other Contributors	Melinda Alegria, AUD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Ashley Fahle Gonzalez, MPH Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN-BC Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Krista Stephenson, MSN, RN Caitlin Sweany-Mendez, MPH Robert Wallace, ScD, MPH Elizabeth K. Whidden, MS, APRN
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