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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia

CHIP Report | **23-00108-149** | **April 23, 2024**

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Figure 1. *Louis A. Johnson VA Medical Center in Clarksburg, West Virginia. Source: https://www.va.gov/clarksburg-health-care/locations/* (*accessed August 30, 2023*).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
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 Louis A. Johnson VA Medical Center, which includes multiple outpatient clinics in West Virginia. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

The OIG initiated an unannounced inspection of the Louis A. Johnson VA Medical Center during the week of April 17, 2023. 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 and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued six recommendations to the Director, Chief of Staff, and Associate Director in the following areas of review: Medical Staff Privileging, Environment of Care, and Mental Health. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered

with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 24.

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 C and D, pages 27–28, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Louis A. Johnson VA Medical Center 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 they can make informed decisions 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]

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:[4]

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

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

[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): 13, https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae F. 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] CHIP site visits addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The Louis A. Johnson VA Medical Center includes multiple outpatient clinics in West Virginia. General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review the week of April 17, 2023.[5] During the site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline for further review.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[6] 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 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.

[5] The OIG's last comprehensive healthcare inspection of the Louis A. Johnson VA Medical Center occurred in August 2021. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in May 2021.

[6] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[7] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their organization's vision and strategy, and "practice systems thinking and collaboration across boundaries."[8] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[9]

To assess this medical center's leadership and risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and medical center leaders' responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The medical center had a leadership team consisting of the Director; Chief of Staff; Associate Director, Patient Care Services; and Associate Director. The Chief of Staff and Associate Director, Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for about a year. Both the Director and Chief of Staff started in October 2021, although the Director reported serving as the acting director since January 2021. The Associate Director was assigned in December 2021 and the Associate Director, Patient Care Services in April 2022.

[7] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[8] Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[9] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement White Paper, 2017.

To help assess executive leaders' engagement, the OIG interviewed the Director; Chief of Staff; Associate Director, Patient Care Services; and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

The Director stated when executive leaders began, there was a need to build trust with staff after the patient murders that occurred at the facility in 2017 and 2018, followed by the sentencing in 2021 of a former employee for those crimes.[10] The Director described actions taken by the executive leaders to demonstrate their presence and show support, such as leadership rounds (regular visits to staff in patient care locations) during various hours including evenings and on weekends. The Director reported the executive leaders completed a leadership team building program with the VA National Center for Organization Development in January 2023 and continue to meet regularly for team development activities.[11]

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $308,383,852 had increased by about 5 percent compared to the previous year's budget of $293,505,314.[12] The Chief of Staff explained that leaders used funding to staff ambulatory primary care teams and make medical management improvements; for example, staff had previously placed patients who needed cardiac monitoring in the intensive care unit, but they later added the capability for continuous cardiac monitoring in other inpatient locations. Additionally, the Associate Director stated leaders adjusted compensation for nurses and providers to match community salaries, and the Chief of Staff reported hiring a critical care provider, a primary care provider, and other specialty care providers.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[13] 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 facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation

[10] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021.

[11] The National Center for Organization Development provides organizational health services to VA such as individual and organizational assessments, organizational consultation, and intervention and business management support. "VHA National Center for Organization Development," Department of Veteran Affairs, accessed January 30, 2024, https://ia601406.us.archive.org/10/items/www.va.gov/www.va.gov/NCOD/NCOD_Brochure.pdf.

[12] Veterans Health Administration (VHA) Support Service Center.

[13] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

without fear of reprisal.[14] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

The medical center's results suggested that, overall, staff felt they could safely disclose a suspected violation. The Director discussed the executive team's actions to promote a culture of safety, such as empowering staff to *stop the line*, recognizing them with HeRO awards, writing daily kudos for staff on communication boards, rounding with patient safety staff, and maintaining open-door policies.[15] The Director said leaders also encouraged front-line staff to become involved in process improvement work groups and root cause analysis investigations.[16] The Director described holding a weeklong event in September 2022 called Failure Fair, whose purpose was to reassure staff that it was okay to fail and to demonstrate how failure leads to learning. The Director explained that an executive leader spoke on each day of the fair about high-reliability organization principles, the leader's failures, and how workplace improvements occurred because of the errors.

Table 1. All Employee Survey Question: Ability to Disclose a Suspected Violation (FYs 2020 through 2022)

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
Louis A. Johnson VA Medical Center	3.8	3.7	3.9

Source: VA All Employee Survey (accessed November 22, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

The Chief of Staff reported that the medical center had the highest percentage of responses (99.51 percent) in VA's All Employee Survey in FY 2022 and was in the top 10 percent in terms of improvement in scores. The leader reported efforts to promote participation in the survey

[14] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

[15] Stop the line is a manufacturing phrase used in health care. It is also a high-reliability organization principle and element of VHA's culture of safety that empowers staff to take action if they believe something is wrong. "Stop the Line for Patient Safety," VHA National Center for Patient Safety, accessed June 8, 2023, https://www.patientsafety.va.gov/professionals/stop-the-line.asp. "The National HeRO Award is…reserved to honor employees who advance VHA's journey to high reliability through demonstration of VHA's HRO [high-reliability organization] principles in action." Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, "VA Recognizes HeRO Award Winners for Safety Initiatives, COVID-19 Efforts," press release, September 18, 2020, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5523.

[16] A root cause analysis investigation is a focused review to identify the actual system- and process-related contributing factors of the event. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.)

during its opening month in June 2022, such as holding a chili cook-off, spirit days with games and activities, and designated days for celebratory clothing (for example, wearing red, white, and blue on America Monday).

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to 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.[17] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time.

The medical center's inpatient score decreased slightly in FY 2021 but increased by more than four points the next year, suggesting that patients' willingness to recommend the hospital to family and friends increased. The Director explained the 2021 trial of the former employee convicted for the deaths of patients at the medical center took an emotional toll on staff and led to high nursing turnover, which likely contributed to decreased patient satisfaction. The Associate Director stated nursing shortages led to difficulty staffing inpatient beds, causing leaders to close the medical/surgical inpatient unit and combine its services with the intensive care unit until they were able to hire new staff. The Director described changes that contributed to improved patient satisfaction in FY 2022, which included adding providers who worked only in the hospital setting to improve inpatient coordination of care, initiating 24-hour cardiac monitoring, and hiring a critical care provider.

The FY 2022 survey results also indicated that patients' satisfaction with their primary care improved from the prior year, whereas satisfaction with specialty care declined. The Chief of Staff stated primary care teams were fully staffed at the time of the OIG review, but clinic space for providers to see patients remained a challenge. To address this issue, leaders opened a new clinic in fall 2022 and planned another for summer 2023. The Chief of Staff said the decline in patient satisfaction with specialty care was likely due to provider shortages. Therefore, leaders expanded telehealth appointments for dermatology, hospice and palliative care, oncology, and cardiology services, and hired new rheumatology, endocrinology, infectious disease, and hospice and palliative care providers.

The Director also reported participating in veteran focus groups to better understand patient concerns. The leader described improvements made from the group feedback, including an automated reimbursement system providing veterans same-day travel pay, travel office pagers to reduce overcrowding in the travel area, a bedside medication delivery program, and a service

[17] "Patient Experiences Survey Results," VHA Support Service Center.

recovery program in which every month leaders called dissatisfied patients to ensure their issues were resolved.[18]

Table 2. Survey of Healthcare Experiences of Patients (FYs 2020 through 2022)

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	70.8	69.7	70.5	68.9	75.3
Patient-Centered Medical Home: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	82.5	86.0	81.9	84.0	81.7	85.2
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	84.8	87.1	83.3	84.0	83.1	83.8

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed patient-centered medical home and specialty care results on December 8, and inpatient results on December 14, 2022).

**The response average is the percent of "Definitely yes" responses.*
†*The response average is the percent of "Very satisfied" and "Satisfied" responses.*

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[19] According to The Joint Commission's standards for leadership, a culture of safety and continual process

[18] VHA defines service recovery as one of the fundamental elements of customer service and a process involving staff's ability to quickly identify concerns, communicate resolution actions, and provide an "opportunity to turn a potentially negative experience into a positive one" for veterans, families, beneficiaries, caregivers, and survivors. VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020.

[19] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 20, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

improvements lead to safe, quality care for patients.[20] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[21]

"A sentinel event is 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)."[22] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's 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."[23] Lastly, a large-scale disclosure is "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."[24] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[25]

The Director said the medical center's Quality and Risk Management department had experienced staff turnover in key positions, partly because staff were looking for changes or promotion opportunities, and reported being pleased that new staff were enthusiastic and learning quickly. At the time of the OIG's visit, the Chief of Quality and Risk Management described being in the position for less than a month but serving temporarily in the position several times during the past two years. The prior risk manager, although recently promoted, still covered some of the risk manager position duties, while a risk manager from another medical center temporarily served remotely in the position. The Director stated they had added a second risk manager position and human resources staff were recruiting for both positions. The Director said two new patient safety managers had been in their positions under six months but explained

[20] The Joint Commission, *Standards Manual*, E-dition, July 1, 2022. A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

[21] Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

[22] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission's definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

[23] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[24] VHA Directive 1004.08.

[25] VHA Handbook 1050.01; VHA Directive 1050.01(1).

that these employees had a mentor from another medical center and also met weekly with the VISN Patient Safety Officer to receive guidance in their new roles.

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. For patient safety events, a patient safety manager stated that during new employee orientation, staff viewed a training video about the Joint Patient Safety Reporting system, and managers met with each new nurse to demonstrate how to enter events into the system.[26] The Director reported the executive team reviewed all Joint Patient Safety Reporting system events from the previous 24 hours in daily morning meetings with the Chief of Quality and Risk Management, patient safety managers, and risk managers; on Mondays, the discussion included the weekend's 72-hour report. The Chief of Staff stated service chiefs reviewed adverse events with the unit manager before communicating each incident to the executive team, who then reviewed them with Quality and Risk Management department staff and developed investigation plans for each event. For adverse events that warranted an institutional disclosure, the Chief of Staff reported completing the disclosure process while risk managers monitored and tracked the process to completion.

The patient safety managers reported reviewing safety events and close calls at monthly patient safety forums and town hall meetings. Additionally, during environment of care rounds, patient safety managers discussed safety issues with staff. The patient safety managers also described the medical center's safety recognition program, which included leaders recognizing staff who reported safety events and close calls with HeRO awards during town halls and sharing kudos for staff recognized in the Director's morning meetings.

The OIG noted the medical center offered free gun safety locks to help reduce the risk of suicide and injury for veterans.[27] The Director stated gun safety locks were located in bins throughout the medical center, including the pharmacy area, which the OIG observed. The Director also reported the Veterans Crisis Line phone number was printed on the locks and the packaging contained suicide prevention information. The Suicide Prevention Coordinator stated they distributed an average of 400 gun locks monthly.

At the time of the OIG review, there was an open recommendation from a previous OIG report related to prevention and management of disruptive behavior training.[28] During the inspection, the OIG reviewed evidence sufficient to support leaders having completed improvement actions and sustained compliance and therefore closed the recommendation.

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[26] VHA uses the Joint Patient Safety Reporting system for data management of patient safety events such as medical errors and close calls/near misses. "VHA National Center for Patient Safety," Department of Veterans Affairs, accessed February 2, 2024, https://www.patientsafety.va.gov/about/faqs.asp.

[27] Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, "Reducing Firearm & Other Household Safety Risks for Veterans and Their Families," August 2022.

[28] VA OIG, *Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 21-00292-73, January 31, 2022.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[29] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[30] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[31]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[32] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[33]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[34] 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."[35] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[36]

The OIG team interviewed key managers and staff and reviewed relevant documents.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

[29] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[30] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

[31] VHA Directive 1100.16.

[32] VHA Handbook 1050.01; VHA Directive 1050.01(1).

[33] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

[34] 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. VHA Directive 1190.

[35] VHA Directive 1190.

[36] VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[37] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[38]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[39] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[40]

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[41]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[42] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires facilities to have credentialing and

[37] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] VHA Handbook 1100.19.

[42] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[43]

The OIG interviewed key managers and staff and reviewed the privileging folders of 25 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires service chiefs to document professional practice results in the LIPs' profiles and report them to an executive committee of the medical staff. VHA also requires an executive committee of the medical staff to review the service chief's recommendation along with clinical competence information when recommending privileging to the director.[44] The OIG found some LIPs' folders lacked documentation that service chiefs reviewed the results of professional practice evaluations. As a result, the Medical Executive Committee (this medical center's executive committee of the medical staff) did not have documentation to support the service chiefs' recommendations before making its privileging recommendations to the Director. This resulted in LIPs providing care without a proper evaluation of their practices. The Credentialing and Privileging Manager reported documentation was incomplete due to service chiefs' lack of attention to detail.

Recommendation 1

1. The Chief of Staff ensures service chiefs document professional practice evaluation results in practitioners' profiles, and the Medical Executive Committee reviews service chiefs' recommendations along with clinical competence information when making privileging recommendations to the Director.

[43] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

[44] VHA Handbook 1100.19; VHA Directive 1100.21(1).

Medical center concurred.

Target date for completion: November 1, 2024

Medical center response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The Chief of Staff Service, in collaboration with the Service Chiefs, shall ensure that all Licensed Independent Practitioners (LIP) Ongoing Professional Practice Evaluations data is thoroughly reviewed for the current appointment period and results taken into consideration prior to making recommendations for reappointment. The Credentialing Analyst shall conduct audits of all practitioners professional practice evaluations for LIP prior to the file being presented to the Professional Standards Board. The audit will include ensuring documentation that the service chief reviewed the results of the professional practice evaluation. This will be tracked in the Professional Standards Board until six consecutive months of 90 percent compliance is maintained. The numerator is the number of Ongoing Professional Practice Evaluations with data used in re-privileging decision[s] by the Professional Standards Board and the denominator is the total number of all Licensed Independent Practitioners presented to Professional Standards Board.

VHA requires the Focused Professional Practice Evaluation process to "be defined in advance, using objective criteria accepted by the LIP."[45] The OIG did not find evidence LIPs consistently accepted the evaluation criteria in advance. When LIPs are not aware of the evaluation criteria, they may not understand expectations. The Credentialing and Privileging Manager attributed the noncompliance to an oversight by staff in the medicine/specialty service and the Credentialing and Privileging Office. The OIG did not make a recommendation, but without VHA requiring documentation that LIPs were informed of the criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

[45] VHA Handbook 1100.19; VHA Directive 1100.21(1).

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[46] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[47]

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[48]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and physically inspected six patient care areas:

- Community living center (Hero's Haven)
- Emergency Department
- Intensive care unit (Warrior Care)
- Medical/surgical inpatient unit (Patriot Care)
- Mental health inpatient unit (Courage Cove)
- Primary care clinic (Blue Team)

[46] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

[47] VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[48] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013 (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC),* August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

Environment of Care Findings and Recommendations

VHA requires all medical facilities to provide a safe and clean environment of care.[49] The OIG found unlocked Emergency Department supply carts in patient rooms, which provided an opportunity for patients and visitors to access medical supplies, including needles. In other areas, the OIG found electrical cords stretched taut or creating tripping hazards and extension cords being used due to a lack of outlets.[50] The OIG also found dust in rooms used to store clean supplies and equipment. Failure to maintain a safe and clean environment unnecessarily increases the risk of injuries and contamination. The Emergency Department Nurse Manager reported having forgotten to lock the carts after stocking. The Chief of Facilities Management reported being unaware the cords were creating safety risks and of the areas needing additional electrical outlets. The Assistant Chief of Logistics stated staff were not following expectations for cleaning supply rooms.

Recommendation 2

2. The Associate Director ensures staff keep patient care areas safe and clean.

Medical center concurred.

Target date for completion: November 1, 2024

Medical center response: The Associate Director evaluated and determined no additional reasons for noncompliance. The Emergency Room Nurse Manager initiated new programing of the intravenous supply carts, to automatically lock, in April 2023. Tripping hazards identified within the inpatient care areas were related to pandemic response and supplies. These supplies have been removed, and tripping hazards eliminated. Environmental Management Service (EMS) will conduct supervisory inspections within a minimum of one patient care area per month. Inspections will include identification of dust and dirt, and findings will be remediated at the time of inspection. The denominator will be the number of EMS supervisory inspection concerns identified in patient care areas per month. The numerator will be the number of identified EMS supervisory inspection concerns remediated within twenty-four hours of identification per month. A minimum of 90 percent compliance will be achieved for six consecutive months. EMS leadership will report data to the Environment of Care Committee, which is chaired by the Associate Director.

[49] VHA Directive 1608.

[50] The OIG observed electrical cord safety hazards in the intensive care unit, medical/surgical inpatient unit, and community living center.

VHA requires staff to regularly test panic alarms in the mental health inpatient unit and document VA police response times.[51] The OIG found no evidence of regular panic alarm testing or documentation of police response times, which could result in an unsafe environment for patients, visitors, and staff. The Chief of Police reported being unaware of the requirement.

Recommendation 3

3. The Director ensures staff regularly test panic alarms in the mental health inpatient unit and document VA police response times.

Medical center concurred.

Target date for completion: November 1, 2024

Medical center response: The Director evaluated and determined no additional reasons for noncompliance. The Director will ensure that Police Service conducts panic alarm testing on a monthly basis within the Inpatient Mental Health Unit and Emergency Department. Panic alarm testing will include documentation of response times by Police Service. Police Service will report compliance with Police Service panic alarm response time documentation to the Executive Leadership Board monthly until a benchmark of 100 percent compliance is met for six consecutive months. The denominator will be the number of required panic alarm monthly tests (minimum 1 per unit per month); the numerator will be the number of completed panic alarm tests with recorded police response times completed monthly.

VHA requires staff to ensure a safe, therapeutic, and healing environment of care.[52] The OIG observed conditions on the mental health inpatient unit that did not align with the mental health environment of care requirements, despite staff documenting the standards as met on the FY 2022 Mental Health Environment of Care Checklist.[53] Failure to address environmental safety concerns could result in patient, visitor, or staff injury. The Chief of Facilities Management was unable to provide a reason for the inaccuracies.

The Mental Health Environment of Care Checklist prohibits the use of plastic bags in the mental health inpatient unit due to the increased risk of patients' self-harm such as by suffocation. The OIG observed plastic bags in several locations, including common areas used by patients. The

[51] VHA Directive 5019.02(1), *Harassment, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration*, September 12, 2022, amended October 13, 2022; VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)," October 18, 2022.

[52] VHA Handbook 1160.06.

[53] The OIG observed an alcohol-based hand sanitizer hanging in the patient day room and sinks in the patient bathrooms that could serve as anchor points.

Mental Health Inpatient Unit Manager reported staff never leave patients unattended in these areas.[54]

VHA also requires staff to ensure areas in emergency departments used for mental health comply with the Mental Health Environment of Care Checklist requirements.[55] An Emergency Department nurse reported to the OIG that staff used the department's mental health intervention room for patients with and without mental health conditions but did not evaluate the room using the Mental Health Environment of Care Checklist. Failure to review environmental safety concerns in the Emergency Department's mental health intervention room could result in patient, visitor, or staff injury. The Chief of Quality and Risk Management reported receiving VISN guidance that using the checklist was not necessary because a designated staff member monitored patients with suicidal behaviors while they were in the Emergency Department.

Recommendation 4

4. The Director ensures staff maintain a safe environment in the mental health inpatient unit.

Medical center concurred.

Target date for completion: January 1, 2025

Medical center response: The Director evaluated and determined no additional reasons for noncompliance. In March 2024, Standard Operating Procedure (SOP) 118-138 Patient Safety and Environment of Care Rounding on the Inpatient Mental Health Unit was published. The SOP ensures a safe environment of care on the Inpatient Mental Health Unit (IMHU). The SOP includes procedures for completing environmental rounds every four hours within the IMHU by nursing staff. Education of the SOP is being completed and initiation of rounding will start by March 16, 2024. The denominator will be the number of monthly required environmental rounds. The numerator will be the number of completed monthly environmental rounds with remediation as needed. Compliance will be achieved with a benchmark of 90 percent for six consecutive months. The Chief Nurse, Critical and Acute Care will present data monthly to the Executive Leadership Board.

Recommendation 5

5. The Director ensures staff maintain a safe environment in the Emergency Department for mental health patients.

[54] The OIG found plastic bags in a seclusion room and in the patient intake room, which is also used as a visitation room.

[55] VHA Directive 1167; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)."

Medical center concurred.

Target date for completion: January 1, 2025

Medical center response: The Director evaluated and determined no additional reasons for noncompliance. An interdisciplinary team conducted a Mental Health Environment of Care assessment utilizing the Mental Health Environment of Care Checklist in the Emergency Department in June 2023. An environment of care checklist was reviewed for utilization within the Emergency Department. The checklist is posted in the Emergency Department and included within the electronic health record note titled "Continuous Close Observation Flow Sheet." The Emergency Department Nurse Manager will conduct an audit of patients evaluated in the Emergency Department with complaints of suicidal and homicidal ideations to ensure documentation of the Continuous Close Observation Flow Sheet note with a statement that the Patients Safety Environmental Checklist was utilized to create a safe environment. The denominator will be the number of patients evaluated by the Emergency Department with complaint of suicidal or homicide ideations, the numerator will be the number of Continuous Close Observation Flow Sheet notes with documentation that the environmental checklist was utilized. Compliance will be achieved with a benchmark of 90 percent for six consecutive months. The Emergency Department Nurse Manager will present data monthly to the Executive Leadership Board.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[56] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[57] The suicide rate for veterans was higher than for nonveteran adults during 2020.[58] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[59]

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[60] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[61]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[62]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 22 patients who had a positive suicide screen in FY 2022 and received primary care services.

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[56] VA Secretary memo, "Agency-Wide Required Suicide Prevention Training," October 15, 2020.

[57] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 20, 2023.

[58] VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

[59] Congressional Research Service, "Veteran Suicide Prevention," IF11886 version 2, July 29, 2021.

[60] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," November 23, 2022.)

[61] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

[62] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. "Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

In ambulatory care settings, VHA requires designated staff to complete the Comprehensive Suicide Risk Evaluation following a positive suicide risk screen. Staff should complete the evaluation on the same calendar day unless it is "not logistically feasible or clinically appropriate," such as in situations where urgent or emergent care is needed. In these situations, once staff confirms patient safety, they should complete the evaluation within 24 hours of the positive screen.[63] The OIG determined staff did not complete the evaluation for 45 percent of patients who had a positive screen, based on electronic health records reviewed. Of the completed evaluations, the OIG found staff did not complete 25 percent of them on the same calendar day or within 24 hours of the positive screen in situations appropriate for same-day evaluation.

Failure to complete the Comprehensive Suicide Risk Evaluation, or to complete it on the same day, poses a safety risk because patients with suicidal thoughts and behaviors might go unidentified and untreated as a result. The Associate Chief of Staff for Ambulatory Care reported multiple reasons for the deficiencies, including lack of consistent processes for staff to hand patients off to the provider and employee turnover, which created challenges for remaining providers to complete all documentation required for a patient visit.

Recommendation 6

6. The Chief of Staff ensures designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.

[63] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)."

Medical center concurred.

Target date for completion: March 1, 2025

Medical center response: The Chief of Staff evaluated and determined no additional reasons for noncompliance. The Chief of Staff will ensure that providers complete the Comprehensive Suicide Risk Evaluation (CSRE) on the same day as a positive suicide risk screen in all ambulatory care settings. Workflows were developed to aid ambulatory care areas with which provider would assist with completion of the CSRE in the event of a positive Columbia-Suicide Severity Rating Scale in October 2023. The suicide prevention team continues to provide education on CSRE compliance to licensed ambulatory providers in multiple settings to include new employee orientation and chief of staff forums. Additionally, the Suicide prevention team monitors the corporate data warehouse suicide risk identification process fall-outs each business day. The suicide prevention team assists with completion of follow up with the Veteran and completes individual education with the provider. The Suicide Prevention Team will audit electronic health records containing a positive Columbia-Suicide Severity Rating Scale screening monthly for completion of a Comprehensive suicide Risk Evaluation completed on the same day. Measure of compliance will use number of electronic health records with a positive Columbia Suicide Severity Rating Scale screen as the denominator and the number of subsequently completed comprehensive Suicide Risk Evaluations, on the same day, as the numerator. A minimum compliance of 90 percent will be achieved for six consecutive months. The Suicide Prevention Coordinator will present the monthly audit numerator, denominator, and compliance percentage monthly to the Medical Executive council, which is attended by the Chief of Staff.

Report Conclusion

To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed inspection of five clinical and administrative areas and provided six recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this medical center. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines six OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Director, Chief of Staff, and Associate Director. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs document professional practice evaluation results in practitioners' profiles, and the Medical Executive Committee reviews service chiefs' recommendations along with clinical competence information when making privileging recommendations to the Director.
Environment of Care	• Staff keep patient care areas safe and clean. • Staff regularly test panic alarms in the mental health inpatient unit and document VA police response times. • Staff maintain a safe environment in the mental health inpatient unit. • Staff maintain a safe environment in the Emergency Department for mental health patients.
Mental Health: Suicide Prevention Initiatives	• Designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.

Appendix B: Medical Center Profile

The table below provides general background information for this mid-high complexity (1c) affiliated medical center reporting to VISN 5.[1]

Table B.1. Profile for Louis A. Johnson VA Medical Center (540) (October 1, 2019, through September 30, 2022)

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	$242,697,255	$293,505,314	$308,383,852
Number of:			
• Unique patients	21,284	21,604	21,952
• Outpatient visits	290,605	314,286	293,575
• Unique employees§	887	869	845
Type and number of operating beds:			
• Community living center	38	38	38
• Domiciliary	30	30	15
• Medicine	33	33	33
• Mental health	10	10	10
• Surgery	7	7	7
Average daily census:			
• Community living center	16	11	11
• Domiciliary	7	10	8
• Medicine	16	16	12
• Mental health	5	3	2

[1] VHA medical facilities are classified according to a complexity model; a designation of "1c" indicates a facility with "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated medical center is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Average daily census cont.			
• Surgery	1	2	0

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

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

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

†October 1, 2020, through September 30, 2021.*

‡October 1, 2021, through September 30, 2022.*

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 12, 2024

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

Subj: Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia

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 Louis A. Johnson VA Medical Center in Clarksburg, West Virginia.
2. I have reviewed the comments provided by the Medical Center Director and concur with the corrective actions outlined in the response. Recommendations # 1, 2, 3, 4, 5, and 6 will remain open and in progress.
3. Should you require any additional information please contact VISN 5 network office.

(Original signed by:)

Robert M. Walton, FACHE

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: March 1, 2024

From: Director, Louis A. Johnson VA Medical Center (540)

Subj: Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia

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

1. I have reviewed the report entitled "Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia."
2. Actions are ongoing to resolve all six open facility recommendations outlined in this report.
3. The courteous and professional manner that was displayed by OIG staff during this review is appreciated.

(Original signed by:)

Piper Knight for
Barbara Forsha, MSN, RN, CPPC, ET
Executive Director, Louis A. Johnson VA Medical Center

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